

Children & Young People's CAMHS Transformation Plan Version 2 16/10/15

The purpose of the Transformation Plan is to help improve the emotional wellbeing and mental health of children and young people (aged < 18) living in Bath & North East Somerset (B&NES). This plan evidences the strong partnership approach and commitment to emotional health and wellbeing; that is well established in B&NES. It aims to further transform local provision with greater co-production with schools, colleges and service users; with the intended outcome of B&NES "families" having improved resilience and positive emotional wellbeing. The Plan co-ordinates the planning and commissioning of services to ensure that resources in all partner agencies are used in the most effective way to improve children and young people's emotional health.

1. National Context

DoH evidence¹ confirmed that

- The cost of mental health problems to the economy in England has recently been estimated at £105bn, with treatment costs expecting to double in the next 20 years.
- 50% of lifetime diagnosed cases of mental illness start by the age of 14
- Poor mental health in childhood is associated with poor childhood and poor adult outcomes.
- 10% of children at any one time have mental health problems

The 2010 national public health strategy² gave equal weight to both mental and physical health and focused on tackling the underlying causes of mental ill-health. The strategy noted;

- Intervening early for children with mental health problems has been shown not only to reduce health costs but also realise larger savings such as improved educational outcomes, reduced unemployment and less crime.
- 25-50% of mental health problems are preventable through interventions in the early years.

¹ *Healthy Lives, Healthy People (Nov 2010) and No Health Without Mental Health (Feb 2011)*

² *Healthy Lives, Healthy People (Nov 2010),*

National strategy expects early intervention and preventative services to be provided by partnership working between the NHS, local government and the third sector.

A number of documents have been published since 2011 which illustrate the government's commitment to improve mental health for all age groups.

The most recent and important one for children and young people, published in 2015 is: *Future in Mind*

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

Others relevant documents are listed in Appendix 1:

2. Links with Children and Young People's Plan (CYPP)

- a) The CYPP 2014-2017 - the commissioning and delivery plan to improve the general health and wellbeing of children and young people across B&NES - outlines the Children's Trust Board's vision and priorities for the period 2014-17.

The vision is:

'We want all children and young people to enjoy childhood and to be well prepared for adult life.'

The CYPP's 3 key outcomes are:

Children and Young People are Safe
Children and Young People are Healthy
Children and Young People have Equal Life Chances

The vision for good mental health for children and young people is:

'All children and young people, from birth to their eighteenth birthday, are supported to develop and maintain good mental health, a sense of well-being and emotional resilience. Any children and young people with emotional difficulties and mental health disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.'

Bath & North East Somerset commissioners aim to commission and develop services which:

- Help children & young people learn the skills they need to stay emotionally healthy
- Ensure the delivery of a comprehensive range of services to tackle mental health problems before they become entrenched

- Work with adult mental health services to minimise the impact of parental mental ill-health on children and young people
- Identify children & young people who need extra support and provide it as early as possible for as long as it is needed
- Meet children & young people in the most accessible place possible
- Periodically review services to ensure resources are being used in the best possible way

b) The following commissioning principles are promoted:

Multi-agency working: a key principle of the strategy is that mental health is the ‘business’ of all agencies, and a joint approach is required to improve children & young people’s mental health. There is a commitment to an integrated care pathway for children & young people with emotional and behavioural difficulties which addresses how universal, targeted and specialist services work together to best meet the needs of children, young people and their families. Children & young people may have a ‘lead professional’ to help coordinate services.

Early Intervention: There is a focus on early intervention; in terms of early in the life cycle, early identification of difficulties and early intervention. Hence multi-agency services that promote the mental health of all children & young people (including building resilience) and provide early identification and preventative interventions are commissioned alongside services to meet the needs of children & young people with established or complex problems. Interventions are best provided ‘nearest’ the child or young person i.e. provided by practitioners with the ‘lowest level of specialism’ (but nevertheless with the necessary skills and competencies).

Evidence-based practice: Services should provide mental health care which is based upon the best available evidence, including relevant NICE guidelines.

Addressing inequalities: Services must be provided to children & young people regardless of their ethnicity, gender, sexual orientation and/or religion. All services should pro-actively consider the specific needs of children and young people

- from black and minority ethnic groups (including migrant families),
- with physical and learning disabilities
- who are - or are at risk of becoming - young offenders
- who are - or are at risk of entering - the care system
- who are lesbian, gay, bisexual, transgender or questioning their sexuality
- who are being bullied or discriminated against for other reasons e.g the way they look or their economic circumstances

Service User involvement: All services should have a commitment to increasing the participation of service users, parents and carers in the planning and evaluation of services to ensure that services are designed around the needs of children, young people and their carers as opposed to the needs of individual agencies.

Clear service expectations and outcomes: Services will be commissioned against clear expectations, outputs & outcomes, detailed in service specifications and monitored to ensure compliance and quality.

c) Links with other strategic work;

- There are links to the Suicide Prevention Strategy Group and the Self-Harm Steering Group via the Mental Health representative from Public Health. Some actions from the Suicide Prevention Strategy Action Plan form part of the Action Plan for the EHWB Strategy. The current Suicide Prevention Strategic Plan and Action Plan can be viewed here: <http://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/suicide-prevention-strategy-2012>
- Perinatal Mental Health.
B&NES is working towards creating a perinatal mental health strategy. The working group consists of commissioners and providers from maternity, adult mental health, children and adolescent mental health and health visiting and primary care services.

3. Promoting and protecting good Mental Health

The Mental Health Foundation³ believes that good mental health is characterised by a child's ability to fulfil a number of key functions and activities, including:

- The ability to learn
- The ability to feel, express and manage a range of positive and negative emotions
- The ability to form and maintain good relationships with others
- The ability to cope with and manage change and uncertainty

There are a number of 'protective' and 'risk' factors known to be associated with good emotional health. These are reproduced in Appendix 2.

4. Prevalence of emotional and mental ill-health in Bath and North East Somerset

³ <http://www.mentalhealth.org.uk/>

Symptoms of poor emotional health may differ according to a child's personality, personal history, community and environmental factors. Symptoms include behavioural problems, substance misuse, self-harm, suicide attempts, eating disorders, depression, anxiety, obsessions and episodes of psychosis.

Local Profile of CYP

- 2013 population estimates for the 0-17 population living in households in B&NES was 34,214. This is 19% of the total population. ONS mid-year population estimates)
- Planned housing: The Core Strategy 2014 cites an increase in housing of 13,000 with the main areas for development being: Bath (7,020); Keynsham (2,150) and Somer Valley (2,470).
- 6,273 (25%) are lone parent households. Lone parents with dependent children rose by 17% between the 2001 and 2011 census.
- 2013 school census data suggests that B&NES school population (4-18 years) is 21,408 in total (January 2013), of which 10.72% classify themselves as BME (i.e. non-white British). In 2015 the population of BME under 5's was 14.6% (1,307) with the highest density in Central Bath (Parkside Children's Centre area – at 24.5%, or 255 children; Moorlands CC area 21%; Weston 19% and St. Martin's 18.7%).
- The growing under 5 y/o BME population is further evidenced by looking at the % of new-born BME children born in the last year. This was 20.2% compared with 13.6% of current 4 year olds.
- The 2011 Census showed the population of Bath & North East Somerset to be 90% White British and 10% other ethnicities.
- In 2014, 1.70% of primary school children and 1.30% of secondary school children and young people had statements of special educational needs compare with the national English average of 2.8%. (DfE National Statistics: Special Educational Needs in England: January 2015).
- 2013-14, only 19.6% of SEND children attained 5+A*-C grades at GCSE compared to 69.2% of 'non SEND' children in B&NES. This gap is wider than the national England gap of 43.9%.
- According to the 2011 Census:
 - 1.09% of children aged 15 and under in B&NES were providing some (1+ hours) unpaid care per week, similar to the South West (1.21%) and England (1.11%).
 - 3.0% of young people aged 16-24 in B&NES were providing some (1+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (4.8%).
 - 0.21% of children aged 15 and under in B&NES were providing considerable (20+ hours) unpaid care per week, the same as the South West and England.
 - 0.6% of young people aged 16-24 in B&NES were providing considerable (20+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (1.0%).

- In addition, in the 2015 SHEU survey of school pupils (see later), 186 pupils (6% of respondents) said they cared for family members after school on the day before the survey, suggesting caring roles may be unreported in the Census.
- The JSNA in Bath and North East Somerset is a “live” document that is updated on ongoing bases, as new data/feedback becomes available.

Local intelligence regarding emotional health and wellbeing

Intelligence on the emotional health and wellbeing of children and young people B&NES, alongside mental health problems, comes from a number of sources. The following data is predominately drawn from [Bath and North East Somerset's Joint Strategic Needs Assessment](#), Public Health England (2014) [CYP MH profile](#), National Child and Maternal Health Intelligence Network, [CAMHS Needs Assessment Tool](#) and the Authority's Schools Health Related Behaviour Survey.

a. Self reported difficulties

B&NES Public Health, commission The Schools Health Education Unit (SHEU) to complete a Health Related Behaviour Survey in both primary and secondary schools on a biennial basis. The surveys have been developed by health and education professionals, and cover a wide range of topics. The SHEU Surveys in B&NES in 2015, 2013 and 2011 asked school children in B&NES a number of questions linked to their wellbeing in terms of satisfaction with life, the extent to which they worry about things and their self-esteem.

Data from this survey can inform planning and discussion on the basis that a large number of B&NES' pupils complete it. At time of writing only secondary school data for 2015 is available with year 8 (1,648) and 10 students (1,487) having participated. It should be noted, however, that those completing the survey do not represent a random sample of young people in the authority and excludes those attending non-participating schools (2 out of 14 secondary schools), young people absent on the day due to illness or exclusion, those with limited access to computers, those attending schools elsewhere and those who opted out. Primary school data will be analysed, summarised and reported by December 2015. Each school has additional access to its 'own' data and, in conjunction with public health colleagues, can think about addressing specific issues pertinent to their individual school e.g. revising PHSE programmes.

The survey asks a number of questions relating to emotional health and wellbeing. When it is stated that something is significantly higher/lower it means that the difference is statistically significant

Satisfaction with life

When rating how satisfied they felt with their life using a scale of 1 to 10, of the pupils surveyed, a significantly higher proportion of girls (19%) rated their satisfaction as low (0-4) compared to boys (8%). A significant proportion of those who were eligible for a free school meal in the last six years also scored their satisfaction lower compared to those non-free school meal pupils (13%)

Bullying

A quarter of young people surveyed said they felt afraid to go to school sometimes because of bullying. This was significantly higher for girls (33%) than boys (16%) and significantly higher for pupils who had been eligible for free school meals in the last six years (32%), compared to those who hadn't (24%). Appearance, size and weight were the main reasons pupils cited for having been picked on or bullied.

Self-esteem

The survey generated self-esteem scores based on the pupils' responses to a set of ten statements taken from a standard self-esteem enquiry method. The scale is based on social confidence and relationships with friends. The scores range from 0-18. A significantly higher proportion of girls (28%) had a med-low self-esteem score (9 or less) compared to boys (15%). The proportion of pupils that stated that they had been eligible for free school meal in last six years that had a med-low self-esteem score was significantly higher (29%) than non-free school meals pupils (20%).

Worries

The survey asked pupils how much they worried about a range of issues. A significantly higher proportion of girls (64%) said they worried a lot about at least one of the issues than boys (48%). The issues girls most worried about were: exams and tests (70%), the way they look (57%), family (49%) and career (48%). Boys also worried about these issues, though to a lesser extent, with over half worrying about exams and over 40% family and career.

Coping with low self-esteem and worries

When surveyed pupils were asked what they were likely to do when they had a problem that worried them. Over two third of boys (66%) and nearly two thirds of girls (58%) said that they would talk to an adult. Over two thirds (65%) of girls and nearly a half (48%) of boys said they would talk to a friend. A significant of proportion of girls (37%) and boys (26%) however said that they would keep worries to themselves. 20% of girls and 12% of boys said they eat when they are worried and 15% of girls and 12% of boys turn to the internet or social media. 10% of girls and 3% of boys said they self-harm.

94% of boys and 88% of girls said that they have at least one adult they can trust.

b. Seeking support at school

In 2014/15, School Nurses (including 2 FE College nurses) in B&NES had 1869 contacts with young people which related to emotional or mental health.

In quarter one of 2015/16, the majority of School Nurse face-to-face contact time was spent supporting children and young people with their mental health, predominantly with anxiety but also a significant proportion with issues around self-harm. The data recording is currently limited to just the number of contacts, so it is not possible to indicate how many children and young people this equates to.

The school nursing service allocates its capacity by reference to a matrix which reflects local inequalities e.g. free school meals, indices of income deprivation etc. Access to the service is also monitored by pupils home postcode place in Index of Multiple deprivation. A pilot school nurse health review of vulnerable Year 9 pupils is being undertaken in two secondary schools.

Reports from the recent 2015 School Parliaments also highlighted pupils' attitudes to the importance of mental health



Final Young
Parliament Me Myself



Final Primary
Parliament Me Myself

c. Estimating prevalence of mental ill health

The prevalence of mental health problems in children and adolescents (aged 5 – 16 years) was last surveyed over 10 years ago in 2004. This study (Green et al 1.) estimated that at any one time, almost 1 in 10 children aged 5-16 years old had a clinically diagnosable mental disorder, causing distress to the child or having a considerable impact on their daily life. More recently Public Health England (2014) estimated that 8.4% of children and young people aged between 5 – 16 years in B&NES have a mental health disorder. This is similar to estimates for England (9.6%) as a whole and the South West (8.9%). Boys are more likely (11.4%) to experience mental health problems than girls (7.8%). Based on the same rates, the table below shows the **estimated** prevalence (note the true figure could vary from this) of mental health disorders by age group, gender and condition for B&NES' population aged 5 – 16 years (2014).

Table 1: *Estimated prevalence of mental health disorders by age group, gender and condition (2014). Total population 5-16 years of age (inclusive) = 22,853*

NUMBERS	5 to 10			11 to 16		
	Male	Female	All	Male	Female	All
All disorders	510	250	760	665	500	1160
Conduct disorder	355	135	490	404	235	640
Emotional disorder	105	125	230	225	305	525
Hyperkinetic disorder	140	150		125	30	150

Less common e.g. ASD, eating disorders	110	40	145	95	45	135
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Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014).

Public Health England also estimated the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 based on rates provided by Kurtz (1996 3). The following table shows these estimates for the population aged 17 and under in B&NES, 2014. It is important to note that these estimates do not make any adjustment for local characteristics which may impact on need for services.

Table 2: Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS per year in B&NES.

CAMHS Tier	Tier 1 (2014)	Tier 2 (2014)	Tier 3 (2014)	Tier 4 (2014)
BANES	5,165	2,410	640	30

Source: Office for National Statistics mid-year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Kurtz, Z. (1996).

d. Local specialist child and adolescent service (CAMHS)

Specialist CAMHS services in B&NES have been provided by Oxford Health NHS Foundation Trust (OHFT) since 2010. Additional services (PCAMHS), delivering lower level interventions, were commissioned from the same Trust in 2011. The funding, and hence the caseloads, for both services have remained fairly static since then. Approximately 550 children and young people are receiving P/CAMHS services at any one time. During 2014/15 there were 1239 discharges from P/CAMHS.

An approximate breakdown by referral agency is given below:

GPs	50%
Community Paediatricians	20%
School Nurses/Schools	15%
Social Care	7%
Other	8%

There is a single point of access to primary and specialist CAMHS. In 2014/15 the percentage of referrals not accepted by the CAMHS averaged 17%, although this ranged from 6% - 30% in different months.

During 14/15 the percentage of referrals assessed within 4 weeks was 95% for referrals to the Outreach service (which include urgent cases), 72% for more routine CAMHS referrals and 73% for PCAMHS. There is an ambition for 90% of accepted routine referrals to be assessed within 4 weeks.

The primary CAMHS service is currently commissioned by NHS B&NES CCG and costs £245,712 per year. The specialist CAMHS service, commissioned by NHS B&NES CCG for £1,924,680, includes a £392,000 contribution from the local authority. OHFT employs 24 (16.7 WTE) practitioners in specialist CAMHS, and a further 18 (16.1 WTE) in PCAMHS and the Outreach team.

The OHFT CAMHS service forms part of the Oxford and Reading CYP IAPT collaboration which formed in 2012. The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme delivered by NHS England that **aims to improve existing** CAMHS working in the community.

More detail is available here:



CYP IAPT Key Facts
Document Sept 14 (1)

Part of the CYP IAPT programme is training for CAMHS practitioners. To date, in B&NES the following numbers of staff have been trained:

Year 1, 2012/13	5 therapists trained in CBT, 1 in parenting.
Year 2, 2013/14	4 therapists trained in CBT, 1 in parenting.
Year 3, 2014/15	4 therapists trained in SFP, 1 in IPT-A.

A key part of IAPT has been the introduction of goal based measures to all patients in CAMHS and to introduce session by session Reported Outcomes Measures by all clinicians.

Eating Disorders

At least 1.1 million people in the UK are affected by an Eating Disorder (ED), with young people in the age-group 14-25 being most at risk of developing this type of illness. Based on the 2007 Adult Psychiatric Morbidity Survey and the BANES 16-24 resident population, it is estimated that in 2013 there were 3,879 young people aged 16-24 in the authority area with an eating disorder. Highest prevalence is in 16-24 year old girls.

The number of admissions for eating disorders in B&NES has increased although this may be due to changes in diagnosis rather than an actual increase in prevalence.

The local specialist ED service, provided by OHFT, meets latest NICE Guidance



ed nice audit.docx

But there are new access and waiting times which must be implemented:



cyp-eating-disorders
-access-waiting-time-

And the CAMHS provider, OHFT has developed a new specialist eating disorder service to meet these standards which will be part funded by new Transformation Plan funding:



SWB CAMHS ED
proposal final 02.09.

e. Inpatient (Tier 4) care

During 2014-15 there were 8 admissions to CAMHS beds for B&NES CYP, 5 of these to the 'local' beds at Marlborough House, 3 to more specialist provision out of area. The average length of stay as an inpatient was 164 days, although the median stay was x days, reflecting the complex needs of a very small number of CYP.

Between 2009 and 2012 OHFT were jointly commissioned by Wiltshire CCG and B&NES CCG to provide generic CAMHS beds and specialist community CAMHS (Tier 3). Since 2012 NHS England specialists have commissioned all CAMHS inpatient beds on behalf of CCGs.

The community Outreach Service for Children and Adolescents (OSCA) works particularly closely with inpatient facilities at Marlborough House, Swindon and Highfield Unit, Oxford to ensure that admissions are appropriate and timely, and that CYP are discharged as soon as they can be supported in their own homes.

The new Transformation Plan investment in specialist Eating Disorder Services may reduce both the need for some inpatient admissions associated with EDs and the length of stay required for those who are admitted. In addition, by 'in reaching' into acute hospitals the ED Service should also be able to reduce the length of stay in acute hospitals to those CYP with EDs who present with advanced physical deterioration.

In the near future there may be a national re-procurement of CAMHS beds, and local CCG commissioners are committed to working closely with NHS England to ensure that appropriate provision is secured for CYP from B&NES. The SW Strategic Clinical Network (SWSCN) facilitates discussions between NHS England, CCG commissioners and local CAMHS providers, and local children's health commissioners attend regularly and contribute to SWSCN's work.

In addition, there is a joint NHS England and CCG Co-Commissioning group which meets monthly. CAMHS is one of the top 5 key priorities on the co-commissioning agenda

f. Liaison and Diversion Services, also known as Court Assessment and Referral Service (CARS)

CYP from B&NES have been in receipt of the nationally specified and commissioned all-age Liaison and Diversion (L&D) services. L&D practitioners are based at the local custody suite (Keynsham) and aim to improve early identification of a range of vulnerabilities, (including but not limited to mental health, substance misuse, personality disorder and learning disabilities), in people coming into contact with the youth or criminal justice systems. Further to identification and assessment, individuals can be referred to appropriate treatment services so contributing to an improvement in health and social care outcomes, which may in turn positively impact on offending and re-offending rates. At the same time, the information gained from the intervention can improve fairness of the justice process to the individual, improve the efficiency of the criminal justice system, and ensure that charging, prosecuting and disposal decisions are fully informed. If offenders receive non custodial sentences then this may be on condition that they agree to engage with relevant support services. The L&D service may offer support to their first appointment and the capturing of outcomes.

Due to the possibility of some young offenders already 'being known' to CAMHS, the local CAMHS provider, OHFT has created a Memorandum of Understanding with AWP, to local L&D service. This clarifies working arrangements when the L&D service has concerns about a young person in custody or at the court or when CAMHS are contacted about someone who they think would benefit from an L&D assessment.



MOU Oxford Health
CAMHS -final.docx

In September 2015 a review of the Memorandum of Understanding concluded that arrangements were working well.

g. Crisis Concordat

The Crisis Concordat review and action plan is a joint plan between statutory public, community and third sector organisations in B&NES. The B&NES Mental Health Crisis Care Concordat sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas: Access to support before crisis point, urgent and emergency access to crisis care , quality of treatment and care when in crisis, recovery and staying well.

Oversight of the B&NES plan is via a Crisis Concordat Task Group with all agencies represented by senior local staff (this includes children's and adults mental health commissioners, substance misuse commissioner, police, acute trust, CAMHS, AWP, community services, ambulance service). The plan includes consideration for children and young people in mental health crisis and was commended for its strong partnership approach.

The latest copy of the review and action plan is here



BNES MH Crisis
Concordat Review an

The CAMHS service forms part of the Crisis Concordat within B&NES. Regarding urgent and emergency access to crisis care, all young people up to the age of 18 who present at the local acute hospital (Royal United Hospital Bath) following an act of deliberate self-harm and who are admitted to either the Paediatric ward or the Observation Ward are assessed the following day by a clinician from the CAMHS Team. A full assessment of their mental health needs and mental state is undertaken and follow up assessment / intervention offered as appropriate to their needs.

There is a national determination to ensure that no young person is inappropriately detained in police cells by ensuring that there is sufficient provision of Place of Safety facilities for young people to be assessed under Section 136 of the Mental Health Act. Children and young people who are detained by the police under the Mental Health Act, are currently taken to a Place of Safety at Southmead Hospital in Bristol. To reduce the risk of children and young people being taken the Southmead unnecessarily, the Police Service and the CAMHS service have recently implemented a protocol in which the police consult the local CAMHS service before deciding to transport the CYP to Southmead.



S136 MoU tween
OHFT and police.pdf

5. Commissioning

B&NES CCG and LA have had integrated commissioning for a number of years, across a number of children and young people services. This has been further enhanced with Public Health becoming part to the Local Authority commissioning arrangements in 2014. More recently, the LA/CCG are working with other partners, including schools to maximize the use of resources, and a number the more recent pilots identified in Table 4 are being co-produced with schools.

Responsibility for commissioning local EHWB services lies with a number of agencies; CCG, Early Years (LA), Youth Service (LA), Schools and Colleges (LA and academies), Specialist Commissioning (National Commissioning Board), Public Health (LA) and Voluntary Sector funding. A model of comprehensive service provision is reproduced in Appendix 3.

Table 4: Services currently (October 15) commissioned to support the Emotional Health of Children and Young People



EHWB support
commissions Sept15.x

Previously there have been 7 EHWB strategic action plans for Bath and North East Somerset, the latest one dated 2014-2017. Significant progress has been made in the priorities identified within the previous strategies.

a. During the current year 2015/16, the following developments have been prioritised:

1. The consideration and development of a single point of access or 'single front door' to enable practitioners, parents/carers and CYP to contact and thereafter receive, at the earliest opportunity, the most appropriate help.
2. To improve school/college/CAMHS liaison by introducing 'Resilience Hubs' at each school and college. These Hubs will provide opportunities for monthly face-to-face meetings where CAMHS link workers, selected school/college staff, school/college nurses and independent counsellors can meet for consultation, training and mutual support.
3. To increase the level of therapeutic support offered to statutory social workers and parents/carers who are struggling to prevent the breakdown of fostering and adoptive placements. This will take the form of a CAMHS psychologist being seconded to the LA placements team. This additional service is being introduced as an attempt to readdress the inequality of Looked after Children who frequently suffer a higher incidence of mental ill-health.
4. To further increase the skills of a number of practitioners who work directly with families and schools whose younger children/pupils display behaviours which present barriers to learning
5. To improve the digital guidance for national and local EHWB services. This will include the published Transformation Plan, suggestions for CYP self-care, guidance for referrers etc. all presented in an informative and accessible manner.
6. To pilot a children and young people's on-line counselling service.
7. Ensure that transitions to adults services for all CYP, including those with EHCP plans, are well managed.

b. Since April 2015 a number of developments to support the transformation plan have begun:

1. *Pilot - Extended CAMHS support: for > 18 y/o's* who were receiving CAMHS interventions when they turned 18 and, although they are particularly vulnerable, do not meet the referral criteria for adult mental health services. This cohort will include, but is not restricted to, Care Leavers and will provide intensive emotional support.
2. *Pilot - Early Intervention in Psychosis:* Pilot to improve fidelity to the early intervention in psychosis model by building links with CYP substance misuse, developmental disorder, CAMHS, schools and other services.
3. *Pilot - School Based Counselling:* Independent counsellors have been commissioned to provide individual 'drop in' advice sessions and formal counselling sessions at seven secondary schools from September.
4. *Pilot - Resilience Hubs:* (See above) These complement school based counselling and have also started in the new academic year.
5. *Pilot - Mindfulness Pilot:* 32 members of staff from 2 secondary schools have undertaken an 8 week Mindfulness course. 2 staff from each school will now be trained to deliver Mindfulness in Schools sessions/resources directly to young people.
6. *KS4 resource packs:* Mental Health PSHE Resource packs for Key stages 3&4 are being developed in partnership between School Improvement and the CAMHS participation group.
7. *Specialist Family Support and Play re-procurement:* A review has resulted in a new combined service model being procured to provide early intervention with 5-13 years olds with a range of emotional and social issues.
8. *Protocol between CAMHS and police:* has been implemented to reduce inappropriate attendances at the S136 suite.
9. *Pilot - CAMHS self-referral for 16 and 17 y/o's:* is being trialled by provider
10. *ASD support service:* Additional SLT sessions have been commissioned to 'speed' up ASD diagnosis and a new parent support worker will visit families whose children with ASD refuse to attend school.
11. *Eating Disorder Specialist service:* Agreeing new service model with provider and neighbouring CCGs

Some of these developments are included in the tracker spreadsheet.

NOTE The strategic group are still currently working at conceptualising and describing services and pathways using the outcomes suggested by the Liverpool model (as opposed to Tiers), i.e.

- *Improved environments so that C&YP can thrive*
- *Increased identification of C&YP with early indicators of distress and risks*

- *Reduction in mild to moderate distress*
- *Reduction in the development of moderate to severe distress*
- *Reduction in life long distress*

6. Children and Young People participation

In B&NES, children and young people's views are used effectively and consistently to influence change, shape services, improve practice and service delivery and have so for a number of years. Children and young people contribute through models of co-production as set out in the Service User Engagement Framework (Commissioning Framework), Children In Care Councils, democratic processes, strategic development, the Children and Young People's Plan, the Early Help Strategy and through the groups that have been set up to hear the voices of seldom heard minorities.

The framework which provides guidance to help involve children and young people in the commissioning of services is currently being re-drafted. The greatest challenge is to engage young people who are not existing or potential users of a new commission.



CYP Commiss
Framework 2015.doc

The local 2014-2017 Participation Strategy sets out the locally agreed definition of participation and identifies the benefits of participation not only to children and young people but also to the adults who work with them, the organisation and services that are provided, and society as a whole. [LINK](#)

OHFT CAMHS service, having been the lead provider in the regional CYIAPT collaborative for the last 3 years, has developed effective CYP participation in line with the principles outlined in *Delivering With, Delivering Well* (reproduced in Appendix 4). The CAMHS participation group is usually consulted about pilot developments and is particularly key in suggesting and approving written and digital resources.

A very recent consultation by the local Youth Forum suggests that CYP

- do not always comprehend the range of services available,
- still perceive a stigma around mental health problems and
- would prefer to be informed of self care and further information in a variety of ways.

Further consultation is planned to determine the most appropriate website to host the Transformation Plan and to signpost useful digital resources.

7. Transformational Funding

B&NES is served by all elements of the model outlined in Appendix 3. Children's services are detailed above (Table 4) and are provided by a range of organisations including the LA, Sirona Care and Health, Oxford Health NHS Foundation Trust and smaller voluntary organisations.

Some of the proposals for driving improvement within the Transformation Plan will be cost-neutral, requiring a different way of helping C&YP within existing resources. However, the Government has committed additional monies to local areas based on the standard CCG allocation formula. For B&NES this is £333,463 per year. £95,191 has already been received by the CCG and this must be spent on improving the C&YP Eating Disorders Service. Pending approval of the Transformation Plan, the CCG will receive another £238,272 for 15/16 and thereafter £333,462 per year.

The proposed distribution for 15/16 funding is as follows:

1	Eating Disorder (includes training)	95,191
2	Therapeutic support for social care (6 months)	32,500
3	development of digital resources incl TP publishing, incl map of medicine	10,000
4	workforce capacity building (Theraplay, Thrive, Attachment Aware etc)	55,000
5	college resilience hubs (includes staff training)	5,000
6	school resilience hubs (includes staff training)	41,000
7	online counselling	16,000
8	school counsellors attending school Hubs	10,500
9	nuture outreach service in primary schools	40,000
10	commissioning capacity (7 months)	6,021
11	CYP/parent/carer consultation/coproduction/	5,000
12	stakeholder event -launch of resources and co-production of 16/17 plans	2,250
13	support for parents of 'non-engaging' children (scoping)	5,000
14	independent evaluation and consideration of 'single point of access'	10,000
		<u>333,462</u>

Funding (once agreed) to implement the plan will be monitored via the national Transformation Plan tracker excel spreadsheet.

8. Governance

- The EHWP Strategy Group acts as a sub-group for the Children's Trust Board and are required to produce 6 monthly reports to the Children's

Trust Board, LSCB and Health and Wellbeing Board as well as an annual review of performance.

- Formal monitoring of the Transformation Plan will be via a subgroup of the EHWP Strategy Group. Although this group does not include a CYP representative, the CYP Equalities Group will also receive the same 6 monthly report for scrutiny and comment. (This group includes representatives from the various children and young people participation groups and school equalities teams across B&NES including CAMHS service users, Children in Care, Youth Forum and the Member of Youth Parliament)
- There are strong links to the Local Safeguarding Children's Board (LSCB) with the EHWP group's social care representative also being a member of the LSCB.
- The CCG Children's Health Commissioning Project Manager engages with mental health events facilitated by the SW Strategic Clinical Network and the SW CAMHS Operational Delivery Network and contributed to the *Commissioning better CAMHS in the South West*, Oct 2014. This forum will continue to be used to give/receive national guidance and to share ideas, experiences and good practice.

Appendix 1

Chief Medical Officer's Annual Report: Our children deserve better: Prevention pays, October 2013
<https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

NSPCC - Prevention in mind, All babies count: spotlight on Perinatal Mental Health, June 2013
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

Public Health England – How healthy behaviour supports children's wellbeing, August 2013
<https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing>

Children and Young People's Mental Health Coalition report 'Overlooked and Forgotten', December 2013
http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

Mental health sub-group report of the children's outcomes forum, May 2013
<https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results>
Closing the Gap, Priorities for essential change in mental health, January 2014
<https://www.gov.uk/government/publications/mental-health-priorities-for-change>

Baby Bonds, Parenting, attachment and a secure base for children, The Sutton Trust, March 2014
<http://www.suttontrust.com/researcharchive/baby-bonds/>

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO

Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47 (3-4), 313–37.

Kurtz, Z. (1996) *Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people*. London. Mental Health Foundation

Appendix 2

Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
Easy Temperament	supportive caring parent	sense of belonging	involvement with significant other person (partner/mentor)	sense of connectedness attachment to and networks within the community
adequate nutrition	family harmony	positive school climate	availability of opportunities at critical turning points or major life transitions	participation in church or other community group
attachment to family	secure and stable family	pro-social peer group	economic security	strong cultural identity and ethnic pride
above average intelligence	small family size	required responsibility and helpfulness	good physical health	access to support services
school achievement	more than two years between siblings	opportunities for some success and recognition of achievement		community/cultural norms against violence
problem solving skills	responsibility within the family (for child or adult)	school norms against violence		
internal locus of control	supportive relationship with other adult (for a child or adult)			
social competence	strong family norms and morality			
social skills				
good coping style				
optimism				
moral beliefs				
values				
positive self-related cognitions				
physical activity				

Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

NB: the following tables list *influences* on the development of mental health problems not the *causes*.

Individual Factors	Family/social factors	School context	Life events and situations	Community and cultural factors
Prenatal brain damage	having a teenage mother	Bullying	physical, sexual and emotional abuse	socio-economic disadvantage
Prematurity	having a single parent	peer rejection	school transitions	social or cultural discrimination
birth injury		poor attachment to		

low birth weight, birth complications	absence of father in childhood	school	divorce and family break up	isolation
physical and intellectual disability	large family size	inadequate behaviour management	death of family member	neighbourhood violence and crime
poor health in infancy	antisocial role models (in childhood)	deviant peer group	physical illness	population density and housing conditions
insecure attachment in infant/child	family violence and disharmony	school failure	unemployment, homelessness	lack of support service including transport, shopping, recreational facilities
low intelligence	marital discord in parents		incarceration	
difficult temperament	poor supervision and monitoring of child		poverty/economic insecurity	
chronic illness	low parental involvement in child's activities		job insecurity	
poor social skills	neglect in childhood		unsatisfactory workplace relationships	
low self-esteem	long-term parental unemployment		workplace accident/injury	
alienation	criminality in parent		caring for someone with an illness/disability	
impulsivity	parental substance misuse		living in nursing home or aged care hostel	
alcohol misuse	parental mental disorder		war or natural disasters	
	harsh or inconsistent discipline style			
	social isolation			
	experiencing rejection			
	lack of warmth and affection			

Reproduced from: Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and early intervention for mental health-a Monograph, Mental Health and Special Programs branch, Commonwealth Department of Health and Aged Care, Canberra. Quoted in Making it Happen (DH 2001)

