# Children's Services and Education Scrutiny Board

**Monday 5 February, 2018 at 5.00 pm**
**Committee Room 1**
**at the Sandwell Council House, Oldbury**

## Agenda

(Open to Public and Press)

1. Apologies for absence.

2. Members to declare:-
   (a) any interest in matters to be discussed at the meeting;
   (b) the existence and nature of any political Party Whip on any matter to be considered at the meeting.

3. Update on Children's Mental Health.

4. Update on Children's Oral Health.

5. Independent Reviewing Officer Annual Report 2016-2017.

6. Update on the Sandwell Children's Trust

7. Chair and Vice Chair Work Group Updates.

**J Britton**
**Chief Executive**
Sandwell Council House
Freeth Street
Oldbury

**Distribution:**

Councillor J Underhill (Chair),
Councillor S Phillips (Vice-Chair), Councillor C White (Vice-Chair),
Councillors Allen, Ashman, Y Davies, Hickey, L Horton, Preece, Rouf, Shaeen.

Co-opted Members:-

Rev P French (Church of England Diocese representative)
Vacant (Roman Catholic Archdiocese representative)
Tahira Majid (Primary School Governor representative)
Vacant (Secondary School Governor representative)

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This document is available in large print on request to the above telephone number. The document is also available electronically on the Committee Management Information System which can be accessed from the Council's web site on www.sandwell.gov.uk

**Agenda Item 1**

## Apologies

To receive any apologies from members

**Agenda Item 2**

## Declarations of Interest

Members to declare:-
- (a) any interest in matters to be discussed at the meeting;
- (b) the existence and nature of any political Party Whip on any matter to be considered at the meeting.

Sandwell
Metropolitan Borough Council

**Agenda Item 3**

# REPORT TO
# CHILDREN'S SERVICES AND EDUCATION SCRUTINY BOARD

**05 February 2018**

| | |
|---|---|
| **Subject:** | Childrens Mental Health |
| **Cabinet Portfolio:** | Councillor Simon Hackett - Cabinet Member for Children's Services |
| **Director:**<br>( | Executive Director of Children's Services – Jim Leivers<br>Executive Director of Adult Social Care, Health and Wellbeing- David Stevens<br>Director of Public Health-Ansaf Azhar |
| **Contribution towards Vision 2030:** | ❤ |
| **Contact Officer(s):** | Valerie de Souza, Public Health Consultant<br>valerie_desouza@sandwell.gov.uk |

| **DECISION RECOMMENDATIONS** |
|---|
| **That Children's Services and Education Scrutiny Board:**<br>1. Consider the content of the update report on Mental Health Services in Sandwell for Children & Young People.<br>2. Make any comments and recommendations as necessary. |

## 1 PURPOSE OF THE REPORT

1.1 To provide an overview/update on Child and Adolescent Mental Health Services (CAMHS) provision locally.

## 2 IMPLICATIONS FOR SANDWELL'S VISION

2.1 Provision of a comprehensive service for children and young people locally ensures that:

2.2 Sandwell is a place where children and young people can live healthy lives (Sandwell vision).

2.3 Children and young people have access to local services that are evidence based, and in line with current local/national priorities.

## 3 BACKGROUND AND MAIN CONSIDERATIONS

3.1 The report is for info only, and will inform on current provision, providing elected members with the opportunity to understand the CAMHS landscape better, and seek clarification if needed.

## 4 THE CURRENT POSITION

4.1 Following the publication of "Future in Mind" – promoting, protecting and improving our children and young people's mental health and wellbeing (report of the government's Children and Young People's Mental Health Taskforce in 2015), Sandwell & West Birmingham Clinical Commissioning Group worked with the Local Authority and 3rd sector partners to develop the 'Sandwell' Local Transformation Plan for Children and Young People's Mental Health and Wellbeing for the period 2015 -2020.

4.2 The CCG submitted the local Transformation Plan (LTP) in October 2015 and it was fully assured with an 88% assurance rating from NHSE.

4.3 Sandwell's LTP set out the local areas joint response to Future in Mind, including the use of new resources. CCGs received a total of £149M in 2016-17 and will receive a further £170m in 2017-18 to fund these developments.

4.4 NHS England required all LTPs to be 'refreshed' annually. This requirement was set out in the Planning Guidance, for implementing the Five Year Forward View for Mental Health.

4.5 The aim of refreshed plans is to confirm that there has been progress on the delivery of the planning commitments for Children & Young Peoples Mental Health & Wellbeing.

4.6 Sandwell's 2017-18 'refresh' was submitted in October 2017, and was fully assured by NHS England in November. Only two refreshed plans within the West Midlands were fully assured (Sandwell and Wolverhampton).

4.7 The 2017-18 refreshed LTP was approved by the CAMHS Board and the Health & Wellbeing Board.

4.8 The document is published on the CCG website, and on the Local Authorities 'Local Offer' website.

4.9 Sandwell's LTP is a 'living' document. The joint work to improve outcomes set out in the initial plan, requires continued commitment to working together to ensure success.

4.10 Sandwell's LTP details current provision, the future vision and progress to-date **(see attached).**

## 5 CONSULTATION (CUSTOMERS AND OTHER STAKEHOLDERS)

5.1 Children & young people, parents, carers and other stakeholders have been widely consulted. The LTP included the pledge to engage with stakeholders annually.

## 6 ALTERNATIVE OPTIONS

6.1 There are no alternative options.

## 7 STRATEGIC RESOURCE IMPLICATIONS

7.1 Funding implications are detailed in the current position above, there are no further resource implications for Sandwell Council to report.

## 8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 There are no legal and governance considerations to report.

## 9 EQUALITY IMPACT ASSESSMENT.

9.1 All NHS provision is subject to an Equality Impact (EI) assessment.

## 10 DATA PROTECTION IMPACT ASSESSMENT

10.1 There are no date protection implications.

## 11 CRIME AND DISORDER AND RISK ASSESSMENT

11.1 There are no crime and disorder or risk implications.

## 12 SUSTAINABILITY OF PROPOSALS

12.1 There are no sustainability implications.

## 13 HEALTH AND WELLBEING IMPLICATIONS (INCLUDING SOCIAL VALUE)

13.1 There are no further health and wellbeing implications further to those detailed in the body of the report.

## 14 IMPACT ON ANY COUNCIL MANAGED PROPERTY OR LAND

14.1 There are no implications for any Council managed property or land.

## 15 CONCLUSIONS AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

15.1 The report is for info only, and will inform on current provision, providing elected members with the opportunity to understand the CAMHS landscape better, and seek clarification if needed.

## 16 BACKGROUND PAPERS

a. **Five Year Forward View:** NHSE/PHE/CQC 2014
**b. Future in Mind:** NHSE 2015
**c. Improving mental health support for our children and young people:** Social Care Institute for Excellence 2017

## 17 APPENDICES:

**Sandwell's Refreshed Local Transformation Plan: 2017-18**

**Ansaf Azhar**
**Director of Public Health (Interim)**

# FIVE YEAR FORWARD VIEW

October 2014

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# FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

# EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider **- Primary and Acute Care Systems -** combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS’ ability to undertake research and apply **innovation** – including by developing new ‘test bed’ sites for worldwide innovators, and new ‘green field’ sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS’ long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

# CHAPTER ONE
# Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

*The health and wellbeing gap:* if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

*The care and quality gap*: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

*The funding and efficiency gap*: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

***BOX 1: FIVE YEAR AMBITIONS ON QUALITY***

*The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.*

*We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.*

*We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.*

# CHAPTER TWO

# What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

## Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

*Incentivising and supporting healthier behaviour.* England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

*Local democratic leadership on public health.* Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

*Targeted prevention.* While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

*NHS support to help people get and stay in employment.* Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

*Workplace health.* One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

***BOX 2.1: A HEALTHIER NHS WORKPLACE***

*While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.*

**Empowering patients**

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

## Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

*Supporting carers.* Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

*Encouraging community volunteering.* Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

*Stronger partnerships with charitable and voluntary sector organisations.* When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

*The NHS as a local employer.* The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

## The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

***BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA***

*About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.*

*For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.*

*But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.*

# CHAPTER THREE

# What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

## Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This “social prescribing service” has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients’ experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

## One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What’s right for Cumbria won’t be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn’t mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let ‘a thousand flowers bloom’. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

**_BOX 3.1: A new deal for primary care_**

*General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:*

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

**New care model – Multispecialty Community Providers (MCPs)**

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

**New care model – Primary and Acute Care Systems (PACS)**

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

### New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

**New care model – viable smaller hospitals**

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

**New care model - specialised care**

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

**New care model - modern maternity services**

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

**New care model – enhanced health in care homes**

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

**How will we support the co-design and implementation of these new care models?**

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local ‘five year plans’ by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations’ interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

***BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH***

*Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.*

*Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.*

*This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a* *fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.*

# CHAPTER FOUR
# How will we get there?

This ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

## We will back diverse solutions and local leadership

As a nation we’ve just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no ‘right’ answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of ‘special measures’.

### We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

### We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high.

**We will exploit the information revolution**

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

## We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

*Accelerating innovation in new ways of delivering care*

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

### We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

*Demand*

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

*Efficiency*

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

*Funding*

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

**BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER**

*One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.*

*So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:*

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will* *also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.*

Better treatment and care for all. *It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

*But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.*

# ABBREVIATIONS

| | |
|---|---|
| **A&E** | Accident & Emergency |
| **AHSCs** | Academic Health Science Centres |
| **AHSNs** | Academic Health Science Networks |
| **BCF** | Better Care Fund |
| **CCGs** | Clinical Commissioning Groups |
| **CQC** | Care Quality Commission |
| **CT** | Computerised Tomography |
| **EBITDA** | Earnings before interest, taxes, depreciation and amortisation |
| **GP** | General Practitioner |
| **HEE** | Health Education England |
| **IPC** | Integrated Personal Commissioning |
| **IVF** | In Vitro Fertilisation |
| **LTCs** | Long term conditions |
| **NHS IQ** | NHS Improving Quality |
| **NHS TDA** | NHS Trust Development Authority |
| **NIB** | National Information Board |
| **NICE** | National Institute for Health and Care Excellence |
| **NIHR** | National Institute of Health Research |
| **PHE** | Public Health England |
| **RCTs** | Randomised Controlled Trials |
| **TUC** | Trades Union Congress |
| **WHO** | World Health Organisation |

CareQuality Commission

NHS
Health Education England

Monitor
Making the health sector work for patients

NHS
England

Public Health England

tda
Trust Development Authority
Quality. Delivery. Sustainability.

Department of Health

NHS England

# Future in mind

## Promoting, protecting and improving our children and young people's mental health and wellbeing

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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The Report

# Foreword from Norman Lamb, Minister of State for Care and Support

Our childhood has a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care.

But, too often, children and young people's emotional wellbeing and mental health is not given the attention it needs. Far too many families have experienced poor children's and adolescent mental health care. This isn't endemic, and we have made great progress in the last few years, but it remains unacceptable that not every child or young person gets the help they need when and where they need it. Some don't get any care at all, and their problems escalate to a crisis point. This isn't due to lack of good will – there are many highly skilled and highly valued staff working with children and young people who want to make a real and lasting difference to their lives but there are barriers in the system itself which prevent change.

I have been changing that system. Since 2011, my Department and NHS England have invested over £60 million in the Children and Young People's Improving Access to Psychological Therapies programme. We have funded the development of MindEd – giving more advice to health professionals about how to help young people with mental ill-health. We have put more mental health beds for young people in the system, as well as training new case workers to offer help where it is needed. But this isn't enough – we need to be ambitious if we want children and young people to live happy, healthy lives.

This is why I set up the Children and Young People's Mental Health and Wellbeing Taskforce. I wanted to identify what the problems were, what was stopping us from providing excellent mental health care for young people. The Taskforce brought together professionals from across the education, health and care system to figure this out. They also worked with charities and community organisations and, importantly, they brought in young people and their families, too. We needed a comprehensive view to understand the wide-ranging issues affecting our mental health service.

This is the Government report of the work of the Taskforce and it sets out what we need to do to overcome the status quo. We need a whole child and whole family approach, where we are promoting good mental health from the earliest ages. We need to improve access to interventions and support when and where it is needed, whether that's in schools, GP practices, hospitals or in crisis care. We mustn't think about mental health in a purely clinical fashion. We need to make better use of the voluntary and digital services to fill the gaps in a fragmented system. Crucially, we must make it much easier for a child or young person to seek help and support in non-stigmatised settings. This is where the voluntary sector can be so valuable. We need a simpler system, breaking down the barriers which tiers create, looking at some of the innovative practices which are already happening in this country and abroad.

Anyone who works with or for young people knows that this isn't just about funding. What is needed is a fundamental shift in culture. A whole system approach is needed focusing on prevention of mental ill health, early intervention and recovery. We owe this to young people. It is with their future in mind that we must all commit to, and invest in this challenge.

# Foreword from Sam Gyimah, Parliamentary Under Secretary of State, Department for Education

In the Department for Education we want all children and young people to have the opportunity to achieve and develop the skills and character to make a successful transition to adult life. Good mental health is a vital part of that. The challenges young people face are hugely varied – from stress and anxiety about exams to incredibly serious and debilitating long-term conditions. Everyone who works with children and young people has a role in helping them to get the help they need.

That is why I am so pleased to be the first minister in the Department for Education with a specific responsibility for child and adolescent mental health. And why I wanted the department to work closely with the Taskforce to look at how we can make a better offer to children and young people. I believe success in this area comes from Government departments working closely together. We want to make sure young people no longer feel that they have to suffer in silence, that they understand the support that's available for them and that they see mental health services as something that can make a real difference to their lives.

Many schools already support their pupils' mental health. But we can do more to help schools develop knowledge about mental health, identify issues when they arise and offer early support. That is why we have been working alongside the Taskforce to develop work on teaching about mental health with the PSHE Association, and develop a new strategy to encourage more and better use of counselling in schools.

Support can come from other places too. The voluntary sector can be especially effective in reaching out in a way that makes sense to children and young people. That is why DfE has, for the first time, identified mental health as a specific priority within its £25m voluntary sector grant scheme – from April we will be supporting a range of exciting projects. Children's services are also looking for innovative ways to make mental health an integral part of support for the most vulnerable, and our Social Care Innovation Programme will continue to fund projects developing this work.

But not every adult who works with children and young people can be a mental health expert. Schools and children's services often raise with me the problems with access to specialist support for children who need it, when what they can provide reaches its limits. That is why I welcome the drive to put the needs of children and young people at the heart of specialist mental health services, to break down the complex tiers of services and to establish clear responsibility for putting in place a coherent offer of services.

This report shows that real success comes from collaboration and sets a challenge to all those working with children and young people. Only by working in partnership, sharing expertise, and making best use of finite resources can we achieve the improvements in mental health outcomes that we all want to see, and make a reality of the vision.

# Foreword from Simon Stevens, CEO of NHS England

There is now a welcome national recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven’t kept up. The treatment gap and the funding gap are of course linked.

Fortunately that is now changing. However in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, overmedicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the hard task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I’m pleased to give it NHS England’s full support.

# Your future in mind – an open letter to children and young people

A few months ago, we were asked by the Government to work out what needs to be done to improve children and young people's mental health and wellbeing. Growing up is meant to be one of the very best times in anyone's life but it can also be tough. There are many pressures and some young people, such as looked-after children and those leaving care, are exposed to situations and experiences that can make them particularly vulnerable.

Experiencing mental health concerns is not unusual. At least one in four of the population experience problems at some point in their lives. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18. Although mental health issues are relatively common, it is often the case that children and young people don't get the help they need as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders can stop some young people achieving what they want in life and making a full contribution to society.

**We were asked to work together and see how your mental health and wellbeing could best be supported to give you the best start in life.**

That means we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track. We believe that asking people who use services what they think about what happens now is vital. They are the ones who know what needs to change. So our first thought was to ask you – children, young people and those who care for you – how things could work better.

We also knew that lots of good work had been done in the past, so we looked at previous reports and reviewed all the evidence we have. We asked a group of people with a mix of experience and expertise that included young people, parents, people working in schools, in the voluntary sector, and in services as well as people who work for the Government to come together as a 'Taskforce' to help look at all the information we have and think about how we could improve.

**What we have come up with is a vision that we hope reflects what you as well as your parents, carers and professionals told us was needed, with ideas about how to make it happen.**

We have set out the vision by describing how we think the system should work for young people. The report lays out a map of how we could make those ambitions a reality. In this report, we tell you what we think can change now, but also what we think will take more time. Not all the changes can be made straight away, some are longer term ambitions. But we believe substantial progress can be made over the next five years if we act now to make children and young people's mental health a priority.

Do let us know what you think about this report. You can add your comments to our blogs (see links below) and also share your opinions on Twitter using **#youngmentalhealth**.

And finally let's remember that there is one change that we can all contribute to. We can all look out for those children and young people who might be struggling right now. We can confront bullying and we can make it OK to admit that you are struggling with your mental health. We can end stigma. And we can support our friends in their treatment and recovery.

Let's make a start.

**Dr Martin McShane, NHS England**

J Rouse

**Jon Rouse, Department of Health**

Useful links:

Taskforce website: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

Jon Rouse's blog: https://jonrouse.blog.gov.uk/

Dr Martin McShane's blog: www.england.nhs.uk/category/publications/blogs/martin-mcshane

# Our vision for children and young people's mental health

**You have goals and ambitions you want to achieve. We want you to grow up to be confident and resilient so you can develop and fulfil these goals and make a contribution to society. To do this we must make sure:**

Your parents and carers get the help they need to support you through your childhood and into adult life. Other adults such as GPs, midwives, health visitors, teachers and other people who work in schools, should understand emotional and mental health in children and young people, and know what to do and where to go if they are worried about you or those who care for you.

If you are having difficulty, you shouldn't have to wait until you are really sick to get help, and those around you should be understanding. Asking for help shouldn't be embarrassing or difficult and you should know what to do and where to go.

**When you need help, you want to find it easily and to be able to trust it. To make sure this happens, we need to make sure that:**

There are websites and apps that you know you can trust and use to help yourself and find out information on how to get more help.

You have a choice about where you can get advice and support from a welcoming place. You might want to go somewhere familiar, such as your school or your doctor. Or you might want to go to a drop-in centre, or access the help you need online. But wherever you go, the advice and support you are offered should be based on the best evidence about what works. All the professionals you meet should treat you as a whole person, considering your physical and mental health needs together.

**You are experts in your care and want to be involved in how mental health services are delivered and developed, not just to you and those who support you, but to all the children, young people and families in your area. To do this we must make sure that:**

All services give you the opportunity to set your own treatment goals and will monitor with you how things are going. If things aren't going well, the team providing your care will work with you to make changes to achieve your goals. You have the opportunity to shape the services you receive. That means listening to your experience of your care, how this fits with your life and how you would like services to work with you. It means giving you and those who care for you the opportunity to feedback and make suggestions about the way services are provided. Services should tell you what happened as a result.

**When you need help, you want it to meet your needs as an individual and be delivered by people who care about what happens to you. This means that:**

You should only have to tell your story once, to someone who is dedicated to helping you, and you shouldn't have to repeat it to lots of different people. All the services in your area should work together so you get the support you need at the right time and in the right place.

If you have a crisis, you should get extra help straightaway, whatever time of day or night it is. You should be in a safe place where a team will work with you to figure out what needs to happen next to help you in the best possible way.

If you need to go to hospital, it should be on a ward with people around your age and near to your home. If you need something very specialised, then you and your family should be told why you need to travel further, and the service should stay in touch to get you home as soon as possible. And while you are in hospital, we should ensure you can keep up with your education as much as you can.

Throughout your care, there are likely to be changes so that you get the right care at the right time. You'll have the opportunity to make informed choices about your treatment and care. You'll keep getting help until you're confident that you're well enough to no longer need it.

If you need help at home, your care team will visit and work with you and your family at home to reduce the need for you to go into hospital. If you do need to go in to hospital, the team should stay in touch and help you to get home quickly.

If you need to move from one service to another, you'll be involved in conversations to prepare you for this and to agree exactly what is happening and when. You'll make the move when you feel ready for it. If you have to move from one area to another, the people responsible for your care will sort this out and involve you, so that you do not have to start from scratch.

You'll keep getting help until you're confident that you're well enough to no longer need it, even if sometimes you can't or don't want to attend appointments. If you don't keep your appointments, someone should get in touch to find out what they can do to help, not just leave you to it.

**You want to know that, whatever your circumstances, you get the best possible care, support and treatment when you need it. You'll be able to get help wherever you are in the country, and the help you get where you live won't be worse than if you lived somewhere else. To make this happen we will need to make sure:**

The people responsible for organising and delivering services to you know which services to provide to best help you and other children, young people and families in your community. The people who fund and provide your service should be dedicated to offering the best mental health services possible, and will be honest and open about how they do that as well as about how they are working to improve it.

# 1. Executive summary and key proposals

1.1 The Children and Young People's Mental Health and Wellbeing Taskforce[1] was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

1.2 Key themes emerged which now provide the structure of this report. Within these themes, we have brought together core principles and requirements which we consider to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

1.3 **In summary, the themes are:**

- **Promoting resilience, prevention and early intervention**
- **Improving access to effective support – a system without tiers**
- **Care for the most vulnerable**
- **Accountability and transparency**
- **Developing the workforce**

## The case for change

1.4 Mental health problems cause distress to individuals and all those who care for them. One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

1.5 The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change. We set this out in full in **Chapter 3.**

1.6 Evidence presented to the Taskforce also underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. These include:

i. **Significant gaps in data and information and delays in the development of payment and other incentive systems.** These are all critical to driving change in a co-ordinated way.

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[1] *Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference.* Available at: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

ii. **The treatment gap.** The last UK epidemiological study[2] suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm.

iii. **Difficulties in access.** Data from the NHS benchmarking network and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems.

iv. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall though the net has been highlighted in numerous reports.[3]

v. **Access to crisis, out of hours and liaison psychiatry services are variable** and in some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vi. **Specific issues facing highly vulnerable groups of** children and young people and their families who may find it particularly difficult to access appropriate services.

1.7 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

## Making it happen

1.8 The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.

1.9 Providers must monitor, and commissioners must consider, the extent to which the interventions available fit with the stated preferences of young people and parents/carers so that provision can be shaped increasingly around what matters to them. Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.

1.10 Delivering this means making some real changes across the whole system. It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

- **Place the emphasis on building resilience, promoting good mental health, prevention and early intervention** (Chapter 4)

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[2] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[3] National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

- **Simplify structures and improve access**: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).
- **Deliver a clear joined up approach**: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.
- **Harness the power of information**: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).
- **Sustain a culture of continuous evidence-based service improvement** delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8**).**
- **Make the right investments**: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

1.11 In some parts of the country, effective partnerships are already meeting many of the expectations set out in this report. However, this is by no means universal, consistent or equitable.

## A National ambition

1.12 This report sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. **Many of these are cost-neutral, requiring a different way of doing business rather than further significant investment.**

1.13 **There are a number of proposals in this report which require critical decisions, for example, on investment and on local service redesign, which will need explicit support from the next government, in the context of what we know will be a very tight Spending Review.** We are realistic in this respect. At both national and local level, decisions will need to be taken on whether to deliver early intervention through an ‘invest to save’ approach and/or targeted reprioritisation, recognising that it will take time to secure an economic return for the nation.

**The Government's aspirations are that by 2020 we would wish to see:** *(The numbers in brackets refer to the proposals in and at the end of each chapter)*

1. **Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled.** This would be delivered by:
   - a hard hitting anti-stigma campaign which raises awareness and promotes improved attitudes to children and young people affected by mental health difficulties. This would build on the success of the existing Time to Change campaign; (3)
   - with additional funding, we could also empower young people to self-care through increased availability of new quality assured apps and digital tools. (5)
2. **In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.** With additional funding, this would be delivered by:
   - a five year programme to develop a comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health. (17)
3. **A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families.** This will ensure children and young people have easy access to the right support from the right service at the right time. This could be delivered by:
   - joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation; (48)
   - having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services, responsible for developing a single integrated plan. We envisage that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements; (30)

- transitions from children's services based on the needs of the young person, rather than a particular age. (15)

4. **Increased use of evidence-based treatments with services rigorously focused on outcomes.** With additional funding, this would be delivered by:
    - building on the success of the CYP IAPT transformation programme and rolling it out to the rest of the country. (44)
5. **Making mental health support more visible and easily accessible for children and young people.** With additional funding, this would be delivered by:
    - every area having 'one-stop-shop' services, which provide mental health support and advice to children and young people in the community, in an accessible and welcoming environment. This would build on and harness the vital contribution of the voluntary sector; (16)
    - improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools. This would include integrating mental health specialists directly into schools and GP practices. (16)
6. **Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.** This would be delivered by:
    - ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented; (12)
    - no young person under the age of 18 being detained in a police cell as a place of safety; (19)
    - implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. (13)
7. **Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.** With additional funding, this would be delivered by:
    - enhancing existing maternal, perinatal and early years health services and parenting programmes. (4)
8. **A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.** This would include:
    - ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services. (24)
9. **Improved transparency and accountability across the whole system, to drive further improvements in outcomes.** This would be delivered by:
    - development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level; (36)
    - clearer information about the levels of investment made by those who

commission children and young people's mental health services; (38)

- subject to decisions taken by future governments, a commitment to a prevalence survey for children and young people's mental health and wellbeing, which is repeated every five years. (39)

10. **Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.**

## Local Transformation Plans

1.14 Delivering the national ambition will require local leadership and ownership. We therefore propose the development and agreement of **Transformation Plans for Children and Young People's Mental Health and Wellbeing** which will clearly articulate the local offer. These Plans should cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

1.15 In terms of local leadership, we anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways. Lead commissioners should ensure that schools are given the opportunity to contribute to the development of Transformation Plans.

1.16 To support this, NHS England will make a specific contribution by prioritising the further investment in children and young people's mental health announced in the Autumn Statement 2014 in those areas that can demonstrate robust action planning through the publication of local Transformation Plans.

1.17 What is included in the Plan should reflect the national ambition and principles set out in this report and be decided at a local level in collaboration with children, young people and their families as well as providers and commissioners. Key elements will include commitments to:

### Transparency

- A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing.
- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

### Service transformation

- A requirement for all partners, commissioners or providers, to sign up to a series of agreed principles covering: the range and choice of treatments and interventions available; collaborative practice with children, young people and families and involving schools; the use of evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision.

### Monitoring improvement

- Development of a shared action plan and a commitment to review, monitor and track improvements towards the Government's aspirations set out in this Report, including children and young people having timely access to effective support when they need it.

## Next steps in 2015/16

1.18 **At a national level, we will play our part to deliver the ambition by:**

- delivering waiting times standards for Early Intervention in Psychosis by April 2016;
- continuing development of new access and waiting times standards for Eating Disorder;
- commissioning a new national prevalence survey of child and adolescent mental health;
- implementing the Child and Adolescent Mental Health Services Minimum Dataset, which will include the new CYP IAPT dataset;
- continuing to focus on case management for inpatient services for children and young people, building on the response to NHS England's Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report;[4]
- testing clear access routes between schools and specialist services for mental health by extending the recently established co-commissioning pilots to more areas;
- improving children's access to timely support from the right service through developing a joint training programme to support lead contacts in mental health services and schools. This will be commissioned by NHS England and the Department for Education and tested in 15 areas in 2015/16. DfE will also support work to develop approaches in children's services to improve mental health support for vulnerable children;
- improving public awareness and understanding of children's mental health issues, through continuing the existing anti-stigma campaign led by Time to Change and approaches piloted in 2014/15 to promote a broader national conversation;
- encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing through a new counselling strategy for schools, alongside the Department for Education's other work on character and resilience and PSHE.

1.19 **In the medium to longer term, the Taskforce would like a future government to consider formalising at least some parts of this national ambition to ensure consistency of practice across the country.** This would also give a more precise meaning to what is meant by the existing statutory duties in respect of parity of esteem between physical and mental health, as they apply to children and young people.

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[4] CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

# 2. Introduction

2.1 Children and young people's mental health really matters, not only for the individual and their family, but for society as a whole. The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of children and young people. Their mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. They want an integrated child, youth and family friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

2.2 Over half of all mental ill health starts before the age of fourteen years, and seventy-five per cent has developed by the age of eighteen.[5] The life chances of those individuals are significantly reduced in terms of their physical health, their educational and work prospects, their chances of committing a crime and even the length of their life. As well as the personal cost to each and every individual affected, their families and carers this results in a very high cost to our economy.

2.3 A great deal of work has been done in recent years to try to address the emotional wellbeing and mental health needs of children and young people. There is a wealth of evidence and good practice to build on. Key strategies, reports and initiatives include the National Service Framework[6] in 2004, Every Child Matters in 2003 and the work of the National Advisory Council in 2008.[7] More recently, the Children and Young People's Health Outcomes Forum[8] and Chief Medical Officer's Annual Reports in 2012 and 2013 have maintained the focus on improving children's mental health outcomes at national level.

2.4 The Government has made clear its commitment that mental health services for people of all ages should have parity of esteem with physical health services[9] and called on all parts of the health system to put children, young people and their families right at the heart of decision-making and improve every aspect of health services – from pregnancy through to adolescence and beyond.[10] A major programme of investment

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[5] Murphy M and Fonagy P (2012). *Mental health problems in children and young people.* In: Annual Report of the Chief Medical Officer 2012. London: Department of Health.

[6] Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health.

[7] National Advisory Council (2011). *Making children's mental health everyone's responsibility.* London: National Advisory Council.

[8] Department of Health (2012). *Report of the Children and Young People's Health Outcomes Forum*. London: Department of Health.

[9] HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health.

[10] Department of Health (2013). *Improving Children and Young People's Health Outcomes: a system wide response*. London: Department of Health.

and standard-setting has laid the groundwork for significant improvements in the care that children and young people with mental health problems receive.

2.5 Good progress is being made on this agenda with the investment of:

- £60m into the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme over 2011-15/16;
- £7m in an extra 50 CAMHS specialised Tier 4 beds for young patients in the areas with the least provision (as identified by the NHS England CAMHS Tier 4 Report, July 2014);
- £150 million over the next five years in England to improve services for children and young people with mental health problems, with a particular emphasis on eating disorders; and
- £3 million in the MindEd e-portal launched in March 2014. The e-portal provides clear guidance on children and young people's mental health, wellbeing and development to any adult working with children, young people and families.
- NHS England is investing £15 million in health provision in the Children and Young People's Secure Estate.

2.6 Achieving Better Access to Mental Health Services by 2020[11] outlines the first waiting time standards for mental health and includes a standard which will ensure that by 2016, at least 50% of people of all ages referred for early intervention in psychosis services will start treatment within two weeks. This is backed by £40 million investment.

2.7 Wider cross-government service transformation initiatives such as the Troubled Families programme aimed at turning around the lives of 120,000 families with a broad range of problems have provided further traction and levers for local areas to make progress. Problems in these families often include mental health issues in either the children or the parents. In response, local authorities are working with families using integrated whole family approaches to address problems collectively for all members of the family.

2.8 The Department for Education (DfE) is leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools. In addition, DfE has invested £36 million to develop and sustain evidence-based interventions for children in care, on the edge of care or custody and adopted children and their families, such as multisystemic therapy.[12]

2.9 Since 2011, the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme for children and young people has supported the transformation of local services. However, there remain significant and unacceptable gaps and variations in consistency and coherence within and across services and how they are commissioned. Services have worked hard to try to keep up with increasing demand, but this has been against a backdrop of fiscal constraint, particularly for local government.

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[11] Department of Health (2014). *Achieving Better Access to Mental Health Services by 2020.* London: Department of Health.

[12] Edward Timpson MP on better support for vulnerable adolescents. Addressed to the second European Multisystemic Therapy Conference. London, 12 May 2014. Transcript available at: www.gov.uk/government/speeches/edward-timpson-on-better-support-for-vulnerable-adolescents

2.10 At a service level, we know the importance of directly involving children, young people and their parents and carers in their own treatment, setting goals that have a meaning for them and using their feedback to guide their treatment and overall service development: it pays dividends in making services effective and efficient. Our knowledge about the evidence base has grown, and we have a much clearer picture of good models of care and how best to integrate services through strong collaborative working across the statutory, independent and voluntary and community sectors.

2.11 We therefore have some good work on which to build. However, this has to be set against a context of many local and specialist services struggling to cope with what benchmark surveys[13] demonstrate is increasing demand in a very tight financial environment. The Taskforce also found a lack of consistency in local systems' approach to, and prioritisation of child mental health. The next chapter of the report sets out the case for change in some detail, but we would want to make clear from the outset that there is an urgent need for change.

2.12 Last autumn, the publication of the NHS Five Year Forward View[14] brought statutory organisations together around a vision for the future of health and care in England that emphasises prevention, new models of care and local determination within national frameworks.

2.13 Nowhere could these principles be more relevant than in supporting the mental health and wellbeing of children and young people. To this end, the Minister for Care and Support, supported by colleagues in other government departments, set up the Children and Young People's Mental Health and Wellbeing Taskforce, co-chaired by the Department of Health and NHS England, to gather insights and evidence and inform this report.

2.14 The core group met five times, with a membership of over 60 participants from across health, social care, youth justice and education. Four working groups were formed, involving Taskforce members and others with specialist expertise, to look at the issues in more detail. 1600 children, young people, parents and carers were also involved through engagement activity led by YoungMinds. It is their voice and their experience which have been central to guiding and shaping this report.

2.15 This report has taken feedback from the working groups in the Taskforce, the engagement with children and young people, parents, carers and professionals and collated it with the established evidence base and previous reports. The work of the Taskforce was characterised from the outset by a shared sense of purpose that real change is necessary and, over time, achievable.

2.16 A number of key themes rapidly emerged. There is a need for good, transparent, regular data and information that is collected nationally. Prevention and early intervention are not only desirable but cost-effective. Support and treatment, especially in a crisis, need to be coordinated to make sure that different organisations and professionals know where responsibility lies and how to act effectively together. In addition, the needs of the more vulnerable should be recognised and addressed so they are not neglected or marginalised. Finally, interventions need to be evidence-based or contribute to research and evaluation so that the finite resources available are used to best effect.

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[13] NHS Benchmarking Collaborative 2014 – see www.nhsbenchmarking.nhs.uk/index.php

[14] NHS England (2014). *Five Year Forward View.* London: NHS England.

2.17 These themes form the basis of this report and guide the principles it sets out and the changes it proposes.

2.18 Some of the most significant decisions will require consideration by an incoming Government with a full term ahead of them. But there is also much that can be started now. The Taskforce has found examples of existing best practice from around the country and there is plentiful scope for further local as well as national innovation.

2.19 There is no time to waste.

# 3. The context and case for change

3.1 The prevalence of mental health problems in children and adolescents was last surveyed in 2004. This study estimated that:[15]

- 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder
- 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder
- This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder[16]

3.2 The most common diagnostic categories were conduct disorders, anxiety, depression and hyperkinetic disorders.

**Common mental health issues affecting children and young people**

Conduct disorders:

- 5.8% or just over 510,000 children and young people have a conduct disorder.

Anxiety:

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

Depression:

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

Hyperkinetic disorder (severe ADHD):

- 1.5% or just over 132,000 children and young people have severe ADHD.

3.3 Children with mental health problems are at greater risk of physical health problems; they are also more likely to smoke than children who are mentally healthy. Children and young people with eating disorders and early onset psychosis are particularly at risk, but it is important to note that many psychotropic drugs also have an impact on physical health.

3.4 Children with physical health problems also need their mental wellbeing and health supported.

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[15] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[16] YoungMinds Mental Health Statistics. Available at: www.youngminds.org.uk/training_services/policy/mental_health_statistics

**The interface between mental and physical health**

- 12% of young people live with a long-term condition (LTC) (Sawyer et al 2007).
- The presence of a chronic condition increases the risk of mental health problems from two-six times (Central Nervous System disorders such as epilepsy increase risk up to six- fold) (Parry-Langdon, 2008; Taylor, Heyman & Goodman 2003).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression (Campo 2012). There is a significant overlap between children with LTC and medically unexplained symptoms, many children with long term conditions have symptoms that cannot be fully explained by physical disease.
- Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50%[17] and doubles the risk of coronary heart disease in adults.[18]
- People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.[19]

## Economic argument

3.5 The economic case for addressing child and adolescent mental wellbeing is a strong one.

3.6 Mental health problems not only cause distress, but can be associated with significant problems in other aspects of life and affect life chances.

3.7 Despite this burden of distress, it is estimated that as many as 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age.[20] Evidence shows that, for all these conditions, there are interventions that are not only very effective in improving outcomes, but also good value for money, in some cases outstandingly so, as measured by tangible economic benefits such as savings in subsequent costs to public services.[21]

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[17] Mykletun A, Bjerkeset O, Overland S, Prince M, Dewey M, and Stewart R (2009). Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry* 195: 118-125.

[18] Hemingway H and Marmot M (1999). Evidence based cardiology: psychosocial factors in the aetiology and prognosis of coronary heart disease. A systematic review of prospective cohort studies. *British Medical Journal* 318: 1460–1467; Nicholson A, Kuper H and Hemingway H (2006). Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. *European Heart Journal* 27: 2763–2774.

[19] Parks J, Svendsen D, Singer P, Fonti ME, and Mauer B (2006). *Morbidity and Mortality in People with Serious Mental Illness (Thirteenth in a Series of Technical Reports)*. Alexandria, Virginia: National Association of State Mental health Program Directors (NASMHPD) Medical Directors Council.

[20] Children's Society (2008) *The Good Childhood Inquiry: health research evidence.* London: Children's Society

[21] Fonagy P, Cottrell D, Phillips J, Bevington D, Glaser D, and Allison E (2014). *What works for whom? A critical review of treatments for children and adolescents* (2nd ed.). New York, NY: Guilford Press.

3.8 The evidence base, both clinical and economic, for other conditions, such as eating disorders, self-harm or autistic spectrum disorders is not as strong, but the moral and ethical arguments to care, research and build an evidence base are undeniable.

3.9 The B-CAMHS surveys of mental health of children and adolescents show all forms of mental disorder are associated with an increased risk of disruption to education and school absence.[22,23] Research on the longer-term consequences of mental health problems in childhood adolescence has found associations with poorer educational attainment and poorer employment prospects, including the probability of 'not being in education, employment or training' (NEET).[24]

3.10 There is a strong link between parental (particularly maternal) mental health and children's mental health. Maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of just under £10,000 for every single birth in the country (see paragraph 4.4).

3.11 Social relationships can be affected both in childhood and adolescence and in adult life. Other increased risks include drug and alcohol use. Conduct disorder and ADHD are also both associated with an increased risk of offending and conduct disorder in girls with an increased risk of teenage pregnancy.

3.12 Bullying is reported by 34-46% of school children in England in recent surveys. A dose-response relationship exists, which means that children who are exposed to frequent, persistent bullying have higher rates of psychiatric disorder. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood.[25]

3.13 As well as the impact on the individual child and family, mental health problems in children and young people result in an increased cost to the public purse and to wider society. Those with acute conduct disorder incur substantial costs above those with some conduct problems, but not conduct disorder. A study by Friedli and Parsonage[26] estimated additional lifetime costs of around £150,000 per case – or around £5.3bn for a single cohort of children in the UK. Costs relating to crime are the largest component, accounting for 71% of the total, followed by costs resulting from mental illness in adulthood (13%) and differences in lifetime earnings (7%). More widely, in 2012/13, it was estimated the total NHS expenditure on dedicated children's mental health services was £0.70bn.

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[22] Meltzer H, Gatward R, Goodman R, Ford T (1999). *The mental health of children and adolescents in Great Britain.* The report of a survey carried out in 1999 by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Health Executive and the National Assembly for Wales. London: The Stationery Office.

[23] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[24] Goodman A, Joyce R, Smith JP (2011). The long shadow cast by childhood physical and mental health problems on adult life. *Proc Natl Acad Sci* 108(15): 6032-6037.

[25] Copeland WE, Wolke D, Angold A, Costello EJ (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry* 70(4): 419-426.

[26] Friedli L, Parsonage M (2007). *Mental Health Promotion: Building an Economic Case.* Northern Ireland Association for Mental Health.

3.14 In straitened financial times, ensuring best value for the taxpayer investment is vital. The Centre for Mental Health has analysed the return on investment from addressing the four common disorders in childhood.[27] For instance, it has been estimated that children with early conduct disorder are 10 times more costly to the public sector by the age of 28 than other children.[28]

3.15 The impact of mental health disorders extends beyond the use of public services. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child.[29]

> "The strength of the mental health of our future adult population is the responsibility of all departments of society – health, education, policing etc… children and young people with mental health difficulties cost all of these departments more money – it is in everyone's best interest to invest in the children and young people of today."
>
> A family support worker who took part in the Taskforce engagement exercises

3.16 The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively.[30] For example, the table below details the impact of group cognitive behavioural therapy for depressed adolescents.

3.17 It is important to note that this does not include wellbeing gains, but does measure the financial benefit to an individual due to improved employment opportunities as a result of managing their condition.

3.18 The benefits included in a benefit:cost ratio are *in addition to* the mental health and wellbeing improvements associated with evidenced interventions. In general, measured benefits include two main elements: (i) reductions in the use of public services because of better mental health, and (ii) increases in earnings associated with the impact of improved mental health on educational attainment. In the case of conduct disorder, there are also benefits to society resulting from reduced offending, including costs to victims and the community.

3.19 The inescapable fact is that failure to prevent and treat children and young people's mental health problems comes at a heavy price, not only for the wellbeing of the children concerned and their families, but also for taxpayers and society because of increased future costs.

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[27] Khan L, Parsonage M, Stubbs J for CentreForum's Mental Health Commission (2015). *Investing in children's mental health: a review of evidence on the costs and benefits of increased service provision*. London: Centre for Mental Health.

[28] Scott S, Knapp M, Henderson J, Maughan B. (2001). Financial cost of social exclusion: follow-up study of antisocial children into adulthood. *British Medical Journal* 323(7306): 191.

[29] Parsonage M, Khan L, Saunders A (2014). *Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health.

[30] National Institute for Health and Care Excellence. Mental health and wellbeing guidance. Available at: http://www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing

| **Group Cognitive Behavioural Therapy (CBT) for depressed adolescents**[31] | |
|---|---|
| **Aim** | Group CBT for depressed adolescents aims to improve general functioning and prevent the risk of a major depressive episode from occurring. It is a series of group sessions lead by a therapist, involving exploring ideas related to the condition and how to handle it. There is a suggested duration of three months of weekly meetings. |
| **Unit Cost** | £229 |
| **Total lifetime benefit** | £7,252 |
| **Lifetime benefit to taxpayers** | £3,520 |
| **Lifetime benefit to participants** | £3,455 |
| **Lifetime benefit to others** | £277 |
| **Lifetime benefit-cost ratio (benefits/costs)** | 31.67 |

## Levels of Investment

3.20 In 2012/13, NHS expenditure on child and adolescent mental health disorders was estimated to be £700 million (ie £0.70bn) or 6% of the total spend on mental health. Between 2006/7 and 2012/13, the proportion of mental health spending on children and young people has fallen.

3.21 NHS England is taking forward work on collecting comprehensive spending data on mental health services in the NHS.

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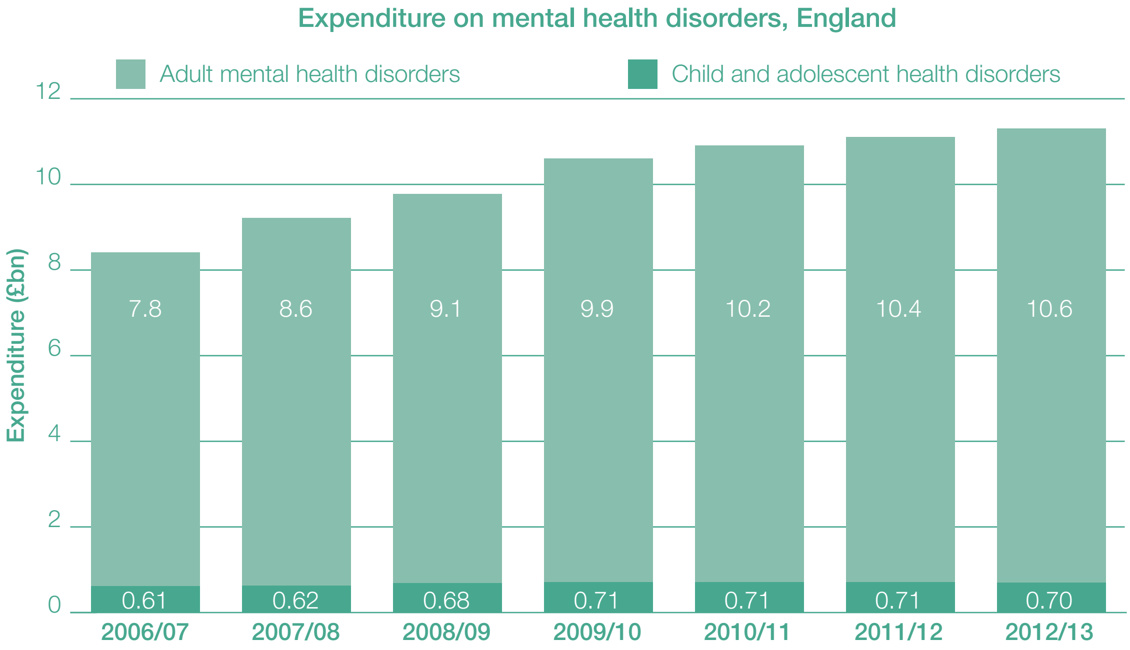
[31] Investing in Children. Group Cognitive Behavioural Therapy (CBT) for Depressed Adolescents. Available at: http://investinginchildren.eu/interventions/group-cognitive-behavioural-therapy-cbt-depressed-adolescents

## NHS expenditure on mental health



3.22 There is no national level information on current local authority social care or education spend on children and young people's mental health. However, from a number of surveys there would appear to be a pattern of increasing demand that local mental health services in many areas are struggling to meet.

3.23 The Department of Health and NHS England are working on improvements to overall mental health data and intelligence across the full life course.

## Issues to address

3.24 Evidence presented to and discussions in the Taskforce have underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services.

3.25 These include:

i. **Significant gaps in data, information and system levers.** There has been significant delay in national collection of outcomes metrics, access standards, development of payment and other incentive systems and their alignment across the health, education and social care systems, which are all critical to driving change in a co-ordinated way. Although there is locally collected data, there is a general lack of clarity about what is provided by whom, for what problem, for which child.

ii. **Investment levels.** The lack of data, information and system drivers have made Child and Adolescent Mental Health services (CAMHS) financially vulnerable. Historically, mental health services have suffered when the public sector is under financial pressure. NHS England and the Department of Health have initiated action to address this for health services for 2014/15 and 2015/16 but local government continues to face significant financial challenges and more work is needed.

iii. **The treatment gap.** The last UK epidemiological study[32] suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm. In addition, there are some groups with additional vulnerabilities (see below) who, due to a range of issues, are not given the priority they need.

iv. **Difficulties in access.** NHS benchmarking data and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in inpatient facilities. Since 2011, our best evidence is that these difficulties are the result of financial constraints accompanied by rising demand.[33]

v. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children's mental health across agencies with the potential for children and young people to fall though the net has been highlighted in numerous reports.[34] Co-ordination across the system, particularly for those children and young people with complex needs, is challenging where there is no lead agency accountable for the child or young person, despite the large number involved in providing services.

vi. **Access to crisis, out of hours and liaison psychiatry services are variable.** There are variations in access to appropriate or age-appropriate inpatient care close to home and available when needed. In some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vii. **Specific issues facing highly vulnerable groups.** All children and young people may experience adverse life events at some time in their lives, but some are more likely to develop mental health disorders eg following multiple losses and/or trauma in their lives, as a result of parental vulnerability or due to disability, deprivation or neglect and abuse. These children, young people and their families may find it particularly difficult to access appropriate services, or services may not be configured to meet their psychosocial needs. In addition, they sometimes find it more

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[32] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[33] Department of Health (2013). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence.* London: Department of Health.

[34] National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

difficult to access services they may find alienating and may have a lifestyle that is not conducive to meeting regular appointments.

3.26 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

# 4. Promoting resilience, prevention and early intervention

4.1 We need to value the importance of recognising and promoting good mental health and wellbeing in all people, not just focusing on mental illness and diagnosis. There is evidence that supporting families and carers, building resilience through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.[35]

4.2 It is therefore crucial that, locally, there is an integrated, partnership approach to defining and meeting needs. A wide range of professionals should be involved across universal, targeted and specialist services, through:

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

## Prevention and support from birth

4.3 If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. We should start by making efforts to ensure a safe and healthy pregnancy, a nurturing childhood and support for families in providing such circumstances in which to bring up children.

4.4 There is a strong link between parental (particularly maternal) mental health and children's mental health. For this reason, it is as important to look after maternal mental health during and following pregnancy as it is maternal physical health. According to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country.[36] Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS.

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[35] Annual Report of the Chief Medical Officer: *Health in Scotland 2011, Transforming Scotland's Health* (Chapter 3). Scottish Government: December 2012.

[36] Bauer A, Parsonage M, Knapp M, Iemmi V, and Adelaja B (2014). *The costs of perinatal mental health problems.* London: Centre for Mental Health.

**Current action to improve early support for parents, carers and children from birth (1 and 4)**

- The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.
- The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician.
- The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.
- Public Health England is publishing an update of the evidence base for the Healthy Child Programme[37] (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s).
- Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.
- In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.

4.5 The transfer of commissioning of 0-5 public health services to local government in October 2015 provides a great opportunity for local authorities, working through Health and Wellbeing Boards, to create a stronger focus on mental health in the early years and beyond. Public Health England's rapid review of the evidence base for the Healthy Child Programme (0-5) will help local services make use of the most up-to-date evidence base.

4.6 There is strong evidence of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. These are benefits to the individual child and family, as well as producing significant cost saving to the system as a whole. Such programmes should remain

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[37] Shribman S and Billingham K (2009). *Healthy Child Programme – Pregnancy and the First Five Years of Life.* London: Department of Health.

a priority for local authorities and better links developed with specialist services to work jointly on cases where families have difficulty engaging in groups or need intensive individual support before they are ready to join a group.

## The role of universal services in mental health promotion, prevention and early intervention

4.7 Universal services, including health visitors, Sure Start Children's Centres, schools, school health services including school nurses,[38] colleges, primary care and youth centres, play a key role in preventing mental health problems. Universal services support children and young people's wellbeing through delivering mental health promotion and prevention activities, which work best when they operate on a whole-system basis.

4.8 In our discussions with young people, they emphasised the difficulties many of them had faced in discussing their problems with their GP. Many of them also reported that their school was not an environment in which they felt safe to be open about their mental health concerns.

4.9 For their part, GPs, schools and other professionals such as social workers and youth workers often feel as frustrated as the children and their parents. They want to do the right thing, but have not necessarily been equipped to play their part or been provided with clear access routes to expertise and for referring to targeted and specialist support. Professionals working in child and adolescent mental health services are equally aware of the challenges that come from balancing identified need with available resource.

4.10 There is also a need for greater clarity about the core attributes that underpin mental health and resilience throughout life. The Department for Education is leading work to help schools ensure more pupils develop the character traits, attributes and behaviours, which, alongside academic achievement, underpin future success. The Department will work closely with all key stakeholders as this work develops, informed by insights and evidence on effective practice from its investment in character education projects and research, due in autumn 2016. Alongside this, Public Health England should continue to strengthen its work on core attributes that underpin mental health and resilience and the application of this by commissioners and service providers.

## GPs

4.11 General Practice and the primary care team have an important part to play in supporting families, children and young people to develop resilience and in identifying and referring problems early. GPs take a holistic approach to the whole family registered with them and are responsible for primary physical and mental health. There is significant potential in that the GP practice is a less stigmatising environment than a mental health clinic. Many GPs have improved accessibility to young people by using the 'You're Welcome' standards and self-audit.[39] Practices such as Herne Hill Group Practice in London, working with the voluntary sector organisation Redthread Youth, have gone further by creating the Well Centre with drop-in clinics for young people where they can discuss a range of issues and have access to specialist mental health support.

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[38] Chief Nursing Officer's Professional Leadership Team (2012). *Getting it right for children, young people and families.* London: Department of Health.

[39] Department of Health (2011). *You're Welcome – Quality criteria for young people friendly health services*. London: Department of Health.

4.12 There is also scope for GPs and other professionals with children and young people to consider referring for a wider range of interventions and services to support their mental health and wellbeing. The local offer could include commissioning approaches that support the ability for GPs to offer social prescribing, where activities such as sport are used as a way of improving wellbeing.

## Schools

4.13 Many schools are already developing whole school approaches to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do. Evidence shows[40] that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied.

4.14 The vast majority of secondary schools surveyed in recent CentreForum research[41] reported that they implement programmes to promote positive mental health universally across the student population, with 93% doing this within the context of Personal, Social, Health, and Economic (PSHE) education. The research also indicates that pupils in 86% of secondary schools surveyed have access to a trained/qualified counsellor(s), and almost all secondary schools (98%) have pastoral care services. While counselling services within schools are not intended as a substitute for other community and specialist mental health services, they can be a valuable complement to them.

4.15 We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing (**2**). This will build on the Department for Education's current work on character building, PSHE and counselling services in schools (see box for details). The named mental health lead for schools proposed in chapter five would also make an important contribution to leading and developing whole school approaches.

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[40] Brooks F (2012). Life stage: School Years. In: *Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays*. London: Department of Health.

[41] Taggart H, Lee S, McDonald L (2014). *Perceptions of wellbeing and mental health in English secondary schools: a cross sectional study.* London: CentreForum Commission.

**Current action to support schools in promoting resilience and prevention of mental health problems**

- The Department for Education (DfE) is leading work to improve the quality of teaching about mental health within Personal, Social, Health, and Economic (PSHE) lessons in schools, and has commissioned the PSHE Association to produce guidance for schools in teaching about mental health safely and effectively, which will be available in spring 2015. Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self-harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.
- DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.
- DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.
- School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels. They can play a crucial role in supporting the emotional and mental health needs of school-aged children. School nursing services are universal and young people see them as non-stigmatising.[42]
- Inspection is a key lever to drive improvement. The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.

4.16 It is important that schools tackle bullying, including cyberbullying, robustly. The Government has continued to take action when required. By law, all schools must have a behaviour policy which includes measures to tackle all forms of bullying and they are held to account by Ofsted. The best schools create an ethos of good behaviour where pupils treat each other, and staff, with respect, understand the value of education, and appreciate the impact that their actions can have on others. The Department for Education has produced advice to help schools support pupils who are severely affected by bullying.[43]

4.17 Schools can help to contain cyber-bullying during the school day by banning or limiting the use of personal mobile phones and other electronic devices. Schools also have the power to search for, and if necessary delete, inappropriate images (or files) on electronic devices, including mobile phones.

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[42] Department of Health and Public Health England (2013). *Promoting emotional wellbeing and positive mental health of children and young people.* London: Department of Health.

[43] Department for Education (2013). *Departmental advice on preventing and responding to bullying.* London: Department for Education.

## Developing a national conversation

4.18 We need to create the space for an open national conversation about children and young people's mental health. Children, young people and their parents/carers need clearer awareness of what is good mental health and what is poor mental health, as well as better information about how to keep mentally and emotionally healthy.

4.19 To this end, the Taskforce proposed there could be a major national branded social marketing campaign with a mechanism for dialogue so it is a genuine two-way conversation – driven by children, young people, parents and carers (**3**). Options include building on the Time to Change campaign (www.time-to-change.org.uk/youngpeople) as well as looking for opportunities to address mental health and wellbeing issues with the Public Health England Rise Above[44] campaign. The Time to Change programme has already been associated with greater mental health literacy as well as less stigmatising attitudes.[45] In the last year or two, we have seen remarkable progress in reducing levels of stigma towards mental health conditions. It is now time we did the same for children and young people, to create a climate where there is as much interest in their emotional and cognitive development as there is in their academic development.

## Harnessing digital technology

4.20 The digital world has become of utmost importance with its potential to protect and enhance the mental health and wellbeing of our children and young people. We are raising a generation of 'digital natives' who differ from previous generations in the way they communicate. Electronic media has some positive influences, such as improved faster information processing; conversely, there are widespread concerns about potential negative effects, including decreased attention, hyperactivity, and excessive use.[46] There is high risk that children and young people are subject to harmful exposure to inappropriate material, to the risks of cyber-bullying, to potential grooming and exploitation[47] and to websites that reinforce negative behaviour, such as those encouraging excessive weight loss.

4.21 We recognise there is already a significant amount of work as part of the Government response on tackling child sexual exploitation as well as more broadly under the auspices of the National Group on Sexual Violence against Children and Vulnerable People. The need to influence and protect young people has a wide reach. Thus in the new computing programmes of study, which were introduced in September 2014, e-safety will be taught at all four key stages of school. It covers responsible, respectful and secure use of technology, as well as ensuring that pupils are taught age-appropriate ways of reporting any concerns they may have about what they see or encounter online.

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[44] Public Health England (2014). *Public Health England Marketing Strategy*. London: Public Health England.

[45] Evans-Lacko S, Malcolm E, West K, Rose D, London J, Rusch N, Little K, Henderson C, Thorniscroft G (2013). *Influence of Time to Change's social marketing interventions on stigma in England 2009-2011.* British Journal of Psychiatry 2012: 77-88.

[46] Department of Health (2013). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence.* London: Department of Health.

[47] National Crime Agency. CEOP Command. Available at: www.nationalcrimeagency.gov.uk/about-us/what-we-do/child-exploitation-online-protection-ceop

4.22 We also recognise the positive role of digital technology, which provides new opportunities to deliver the right information to children and young people and reduce stigma. For example, Mind has unveiled YouTube star and teen icon Zoe Sugg as its new Digital Ambassador, who has used her blog to share open and honest accounts of her own battles with anxiety and panic attacks, and launched the initiative **#DontPanicButton**.

4.23 The use of apps and other digital tools can empower self-care, giving children and young people more control over their health and wellbeing and empowering their parents and carers. Harnessing the potential of the web to promote resilience and wellbeing aligns with the principles set out in Personalised Health and Care 2020[48] and the priority it has already given to young people. Children and young people's mental health and wellbeing should be given the priority it deserves and the system should build on existing resources to support the intentions set out in this report – signalling the promise indicated by the National Information Board's Framework for Action.

4.24 We propose that the Government asks the National Information Board to work in close partnership with the Government Digital Service and young people themselves to develop a single framework for harnessing the power of digital technology and protecting young people from mental harm (**5**). Within this framework, we propose that Government considers incentivising the development of new apps and digital tools; and also whether there is a need for some form of kite-marking scheme based on research evidence to guide young people and their parents on quality.

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[48] National Information Board and Department of Health (2014). *Personalised Health and Care 2020: using data and technology to transform outcomes for patients and citizens.* London: Department of Health.

**Resilience, prevention and early intervention for the mental wellbeing of children and young people – chapter 4 summary**

Our aim is to act early to prevent harm, by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.

Much of what is needed can be done now by:

1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.
2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.
3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.

With additional funding, a future government should consider:

4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.
5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.

# 5. Improving access to effective support – a system without tiers

*"You have to fit into their paths and none of their paths fit you."*

*"Mental health isn't a one size fits all treatment, it really depends on the person."*

Young people who took part in the Taskforce engagement exercises.

5.1 Our discussions with professionals who work with children and young people revealed a strong, common theme – that it is essential that children and young people are at the heart of the work they do and the services that are provided for them. However, the tiers model,[49] a reasonable construct at its inception in 1995, defines the system in terms of the services that provide the care. In practice, this means that children and young people have to fit the services, rather than the services fitting the changing needs of the child or young person.

5.2 Furthermore, the tiers model has been criticised for unintentionally creating barriers between services, embedding service divisions and fragmentation of care. It often results in children or young people falling in gaps between tiers and experiencing poor transitions between different services. At its worst, it can even lead to commissioners and providers of different tiers of service effectively passing the buck to one another.

5.3 Many areas across the UK, such as Liverpool and Leeds, are already working to move away from the tiered structure by designing new local models which create a seamless pathway of care and support, and which address the need for the diversity of circumstances and issues with which families and young people approach mental health services. Alternative models can also be seen internationally. A further example of a more flexible needs-based model for structuring children and adolescent mental health services is the recently proposed 'Thrive model'.[50] We consider this model to have potential and that it should be evaluated and debated further.

5.4 The advantage of these models is that they have the potential to move away from an inflexible and restrictive system, towards one which enables agencies to commission and deliver support to allow children and young people to move more easily between services and to make collaborative choices about what would work best for them at given points in time. It obliges providers to place expertise at the front end of delivery systems to establish with children, young people and families, the intervention most appropriate to their current need. However, it is also important to note that there is no

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[49] The report on the Thrive model (see below) contains a description of the tiers model (page 5).

[50] Wolpert M, Harris R, Jones M, Hodges S, Fuggle P, James R, Wiener A, Mckenna C, Law D, Fonagy P (2014). THRIVE: *The AFC-Tavistock Model for CAMHS*. London: CAMHS Press. Available at: www.tavistockandportman.nhs.uk/sites/default/files/files/Thrive%20model%20for%20CAMHS.pdf

one size fits all. Models could and should be different in different types of locality; for example, a model which works well in rural Devon may fail to meet need if applied in inner-Manchester, and vice versa. This is why we have not dictated the local offer but been clear about the national ambition (**6**).

## Right time, right place, right offer

> *"There needs to be one point of access between patients and services that the patient can approach to find out anything they wish to know about the rest of the services involved and out there."*
>
> A young person who took part in the Taskforce engagement exercises.

5.5 The starting-point is that children and young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, clarity about what help is available, what might happen when they access it, and what to do while they are waiting.

5.6 Therefore, at the heart of any good local system should be cross-sector agreement to ensure clarity in respect of how services are accessed. Many areas are already using a **single point of access** to targeted and specialist mental health services through a multi-agency 'triage' approach, including areas working within the CYP IAPT programme such as Liverpool. There is a pressing need to develop these approaches more widely (**7** and **16**). Common features of a single point of access system include:

- One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.
- Initial risk assessment to ensure children and young people at high risk are seen as a priority.
- Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).
- Young people and parents are able to self-refer into the single point of access.

5.7 We propose the following to improve communication and access:

i. Create an expectation that there is a **dedicated named contact point in targeted or specialist mental health services** for every school and primary care provider, including GP practices (**8** and **16**). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers.

ii. Create an expectation that there should be a **specific individual responsible for mental health in schools,** to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (**8** and **16**). This individual would make an important contribution to leading and developing whole school approaches.

iii. Develop a joint **training programme** for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals (**9**).

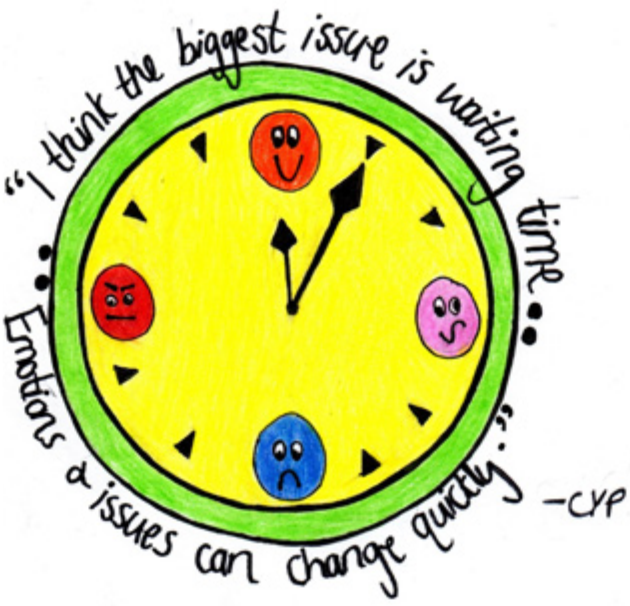
iv. Provide a key role for the voluntary and community sector to encourage an increase in the number of **one-stop-shop services**, based in the community (**7** and **16**). They should be a key part of any universal local offer, building on the existing network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment. There may also be a case in future for developing national quality standards for a comprehensive one-stop-shop service, to support a consistent approach to improving outcomes and joint working.

v. Enable greater access to **personal budgets** for children and young people (and their families) who have a longer term condition or disorder, to give them more choice and control over when and how they access which services

vi. Ensuring there is a strategic link between children's mental health services and services for children and young people with **special educational needs and disabilities** (SEND) (**10**). This should be matched by involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)

## Use of standards

5.8 NHS England has committed to developing access and waiting time standards in mental health. By 2020, the aim would be to provide a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. It is important that children and young people are taken fully into account as further access and waiting time standards are considered, subject to resource availability. Careful consideration will need to be given to which conditions are prioritised, working with experts, services and commissioners and building on current work to develop standards for eating disorders and the introduction of the standard for early intervention in psychosis. (**17**)



## A welcoming environment

> *"The fact that they showed human qualities helped me feel comfortable sharing."*
>
> A young person who took part in the Taskforce engagement exercises.

5.9 There are some changes that have little cost which could be implemented straightaway. Examples include a warm

**and** encouraging welcome for children, young people and parents/carers when they walk through the door; enabling and encouraging their involvement in their own treatment plans and reviews; having a positive attitude and culture within services and promoting effective participation. Young people say that these interactions make an enormous difference to how they feel, to their confidence in participating, and to counteracting the stigma associated with accessing mental health services.

5.10 Some children, young people and families find the formal setting of a clinic off-putting and are unwilling to attend. This can lead to them saying that they do not wish to be referred or not turning up – particularly for some highly vulnerable groups, such as those involved with gangs or those who have been sexually exploited. As a consequence, some services experience high rates of children, young people and families not attending appointments. It is important that services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer (see also paragraph 6.2). It may be necessary to find alternative ways to engage the child, young person or family.

5.11 Mental health practitioners and staff such as youth workers delivering interventions should follow existing good practice and give young people and families the choice to receive treatment away from traditional NHS mental health settings. This might mean that staff see them in public places, such as cafes and restaurants, or in schools, or home-based treatment and there are a number of areas where staff, including consultants, do so successfully. This may also help to re-engage the young person with clinical staff and to be able to attend clinical settings at a later stage. This is likely to lead to a better result than young people or families failing to attend and receiving no support.

## Peer Support

> *“Peer mentoring is a fantastic idea as young people should be able to feel like they aren’t the only one going through these problems.”*
>
> A young person who took part in the Taskforce engagement exercises.

5.12 Young people, as well as parents or carers, also have an important role to play in informing and supporting other young people and families about mental health prevention and access. Consultations carried out through YoungMinds’ Engagement Survey and other engagement activities have shown that young people have a strong desire to hear from other young people who have accessed mental health services and CYP IAPT reports suggest this is also a priority for parents and carers. Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with. It is proposed that further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision. (**11**)

## Digital access

> *"I particularly like websites that have in depth resources on conditions and treatments eg Mind and Rethink. They talk about issues objectively so sufferers don't feel patronised, but also offer supportive information. They allow me to access information easily and whenever I want."*
>
> A young person who took part in the Taskforce engagement exercises.

5.13 As we established in the previous chapter, children and young people and many parents and carers are digitally literate and told us they wanted better and more use made of the web. This could be expressed in a number of ways, but must be informed by the views and preferences of children and young people to be effective. The Taskforce believes a future government should look at options enabling children, young people, parents and carers to access high quality and reliable online information and support. One such option could be a national branded web based portal established using NHS Choices, in line with the recently published National Information Board framework.[51] (**18**) It could build on the successful MindEd website (www.minded.org.uk) aimed at professionals to provide national information about mental health and wellbeing in an engaging and reliable format. The NHS Choices content on adult mental health should link to the children and young people equivalent – the Youth Wellbeing Directory (youthwellbeingdirectory.com) and services are encouraged to register with the Directory.

## Community mental health provision

5.14 The availability and adequacy of the right mix of specialist community health services is critical to the success of THRIVE and similar needs based 'triage' models. Under these models, community mental health is not just a set of services to be referred into. It becomes a joined-up team, working proactively to support other professionals in their settings as well as managing caseloads in terms of higher level interventions. This can identify children and young people who may not present until they are in crisis at an early stage and improve support after discharge.

5.15 The shape and structure of these local teams cannot be defined at national level. However, national agencies can help by providing tools and best practice guidance which enable commissioners and providers to work together to assess the capacity and

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[51] National Information Board and Department of Health (2014). *Personalised Health and Care 2020: using data and technology to transform outcomes for patients and citizens.* London: Department of Health.

capability they require, and to enable efficient and effective prioritisation of resources, for example via www.chimat.org.uk.

## Dealing with crisis

5.16 The litmus test of any local mental health system is how it responds in a crisis. For children and young people experiencing mental health crisis, it is essential that they receive appropriate support/intervention as outlined in the Crisis Care Concordat,[52] including an out-of-hours mental health service (**12**). The challenge of supporting a child or young person in a crisis includes ensuring that there is a swift and comprehensive assessment of the nature of the crisis. There are examples around the country of dedicated home treatment teams for children and young people, but these are not universally available. Some children and young people end up in A&E, where access to appropriate and timely psychiatric liaison from specialist child and adolescent mental health services is not always available. Some are placed (not always appropriately) on paediatric or general adult hospital wards. The national development of all-age liaison psychiatry services in A&E Departments with targeted investment over this and the next financial year, as set out in the joint Department of Health and NHS England publication, Achieving Better Access to Mental Health Services by 2020, should mean that appropriate mental health support in A&E is more readily available. This needs to be carefully monitored.

5.17 For some children and young people, their route into specialist services is more extreme and is through detention by the police, under Section 136 of the Mental Health Act. Those who exhibit such distress and risk to themselves or others that a section 136 detention becomes warranted will need further support, which may not be purely from mental health services. There is broad support for legislating to ensure that no child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.[53] (**19**) It is also important to develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning. CQC should be asked to carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.

## Inpatient care

5.18 While community-based mental health services have a significant role in supporting children and young people in great need, there will always be some children and young people who require more intensive and specialised inpatient care. These must be age-appropriate and as close to home for the child or young person as possible.

5.19 The access and utilisation of specialised beds is a signal of how the whole system is working and therefore cannot be addressed in isolation. As the recent NHS England Tier 4 review[54] has demonstrated, there have been gaps in provision that NHS England is addressing. The key to commissioning the right type of care, in the right places is to adopt a whole system

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[52] Department of Health and Concordat signatories (2014). *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*. London: Department for Health.

[53] Department of Health and Home Office (2014). *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983*. London: Department of Health and Home Office.

[54] CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

commissioning perspective compatible with the type of model we describe in this chapter. This should address the role of pre-crisis, crisis, and 'step-down' services alongside inpatient provision. We return later in the report to the question of how we achieve a planning and commissioning framework, and information systems that can enable the system to make much better decisions about what inpatient capacity is required and to improve outcomes for children and young people for whom inpatient care cannot be avoided. There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision. This can provide clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care (**13**). In line with the NHS 5 Year Forward View, NHS England is exploring a range of options for future commissioning and more collaborative work.

## Use of residential care

5.20 If we are to improve outcomes for young people, especially those with learning disabilities, we must all learn from the lessons arising from the terrible events at Winterbourne View hospital, as to how people can become institutionalised. Children and young people with challenging behaviour can too easily be admitted to residential care unsuited to supporting their long-term health and wellbeing, and which does not support preparation for transition to adulthood and independent living. This is a group of vulnerable children and young people who already face the poorest outcomes, both in terms of their health and long-term independence and security. Sir Stephen Bubb's recent report highlighted the specific pressures which combine to force a young person into a residential setting: the lack of awareness of the individual's needs and wishes; the complexity of joint commissioning to deliver service transformation; the absence of viable alternative community-based provision; and the resource issues which inhibit its development.[55]

5.21 As highlighted in the Government's response to the Bubb report, in 2015/16 NHS England will lead partners in developing ways to strengthen the assurance that an admission is the best approach to care. This work will involve people with learning disabilities and their families and include:

- robust admission gateway processes for those with learning difficulties;
- a challenge process to check that there is no alternative to admission; and
- the agreement of a discharge plan on admission.[56]

5.22 Children and young people's mental health services must draw on this methodology and apply similar principles. (**14**)

5.23 There are likely to be some children and young people with mental health needs, usually those at risk of crisis, for whom an inpatient setting will be the most suitable. The effectiveness of care provided to children and young people in crisis can be assessed by the extent to which it meets their immediate needs, whilst providing a basis for long term support and improvement. There should be systemic safeguards in place to prevent it becoming their permanent home which include:

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[55] Transforming Care and Commissioning Steering Group (2014). *Winterbourne View – Time for Change. Transforming the commissioning of services for people with learning disabilities and/or autism*. London: ACEVO.

[56] NHS England (2015). *Transforming Care for People with Learning Disabilities – Next Steps*. London: NHS England.

i. ongoing strategic audits of admissions;

ii. a co-ordinated outcome focused care plan for each inpatient (this could be part of an Education, Health and Care plan where the child was eligible because of their learning disability);

iii. regular, comprehensive reviews of the suitability of the placement, against criteria focused on transition outcomes for the child or young person; and

iv. engagement with the young person and their family.

## Managing transitions

> *“I had a very bad transition from CAMHS to adult services. One day I was in CAMHS with plenty of support and then the next, the only support I knew of was a crisis number. It took over 6 months for me to have a proper assessment and be assigned a care co-ordinator, by which time I had suffered a complete relapse in my condition.”*
>
> A young person who took part in the Taskforce engagement exercises.

5.24 The issue of transition for young people is longstanding, but focusing on a moment in time masks the real issue, which is how we ensure better co-ordination of mental health services for young adults.

5.25 All young people face multiple and often simultaneous transitions as they move to adulthood. This can be from school to higher or further education or work. They may be in the process of leaving home or care. The families of those in the armed forces may be particularly affected by multiple moves. Young people transferring from children and young people’s mental health services differ from those leaving physical services in that, for many, adult mental health services are either not available or not appropriate. Adult mental health services are not universally equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder.

5.26 For some young people, the nature of adult mental health services and their emphasis on working with the individual rather than a more holistic approach including the family means that young people prematurely disappear from services altogether despite needing further support.[57,58]

5.27 Youth Information Advice and Counselling Services (YIACs) usually operate over the age of transition, often up to the age of 25. We also note that in some parts of the country, such as Birmingham and Norfolk, there is a move to develop mental health services for 0-25 year olds. This new development will be watched with considerable interest.

5.28 The key components of best practice transition which are valued by both young people and clinicians should be built into Joint Strategic Needs Assessments (JSNAs), joint strategies for young people’s and adult services and into all contracts between commissioners and providers of

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[57] Singh SP, Paul M, Ford T, Kramer T, Weaver T (2008). Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): A study of protocols in Greater London. *BMC Health Services Research* 8: 135.

[58] McLaren S, Belling R, Paul M, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013). ‘Talking a different language’: an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research* 13: 254.

young people's and adult services.[59,60,61] NHS England has published a model specification[62] based on best practice for transitions and a transfer/discharge protocol that can be used by local areas to support better transition planning and delivery.

5.29 The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care. (**15**)

5.30 Vulnerable young people, such as care leavers and children in contact with the youth justice system, may also be especially vulnerable at points of transition and local strategic planning on transition should take their needs into account.

> *"My university GP was wonderful and made the effort to contact my GP at home, along with former services I had used for treatment, to get full information on my history of mental health problems… this is the experience that I think everyone should be having."*
>
> A young person who took part in the Taskforce engagement exercises

5.31 We also acknowledge the difficulty of transitions for university students as having extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support both at home and at university, both from primary and secondary care services. We support the production of best practice guidance for CCGs and GPs around student transitions which encourages close liaison between the young person's home-based and university-based primary care teams and promotes adherence to NHS guidelines on funding care for transient populations.

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[59] Joint Commissioning Panel for Mental Health (2012*). Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*. UK: Joint Commissioning Panel for Mental Health.

[60] Hovish K, Weaver T, Islam Z, Paul M, Sing SP (2012). Transition Experiences of Mental Health Service Users, Parents, and Professionals in the United Kingdom: A Qualitative Study. *Psychiatric Rehabilitation Journal* 35(3): 251-257.

[61] McLaren S, Belling R, Moli P, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013). 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research* 13: 254.

[62] NHS England. Resources for CCGs. Available at: www.england.nhs.uk/resources/resources-for-ccgs/

**Improving access to effective support – chapter 5 summary**

Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time.

Much of what is needed can be done now by:

6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.
7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.
8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.
9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.
10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).
11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.
12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.
13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.
15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

With additional funding, a future government should consider:

16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.
17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.
18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.
19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.

# 6. Care for the most vulnerable

6.1 There are some children and young people who have greater vulnerability to mental health problems but who find it more difficult to access help. If we can get it right for the most vulnerable, such as looked-after children and care leavers, then it is more likely we will get it right for all those in need.

6.2 The aim is to support staff who work with vulnerable groups by providing access to high quality mental health advice when and where it is needed. Co-ordinated services should be provided in ways in which children and young people feel safe, build their resilience, so that they are offered evidence-based interventions and care, drawing on the expertise and engagement of all the key agencies involved. Children, young people and their families who have additional vulnerabilities and complex mental health needs should not have to fight for services, nor be offered services that are well-meaning, but are not evidence-based or which fail to meet their needs. The Taskforce members heard of cases where, if vulnerable young people had been able to access specialist advice and support more rapidly, it would have resulted not only in earlier and better outcomes, but also a significant saving to the public purse. In addition, not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up (this can apply to all children and young people – see also paragraph 5.10) (**20**).

## A flexible, integrated system to meet the needs of vulnerable children and young people

6.3 Mental health services need to work effectively within and in partnership with existing service delivery structures to help vulnerable children and young people – such as Early Help Services, services for Troubled Families, Child Protection and Safeguarding Services, as well as education, youth justice services and Multi-Agency Safeguarding Hubs. Staff in mental health services need to utilise and build on existing opportunities where agencies are already working with the child – for instance, looked-after care review meetings, child protection case conferences or youth justice assessments and the Common Assessment Framework.

6.4 There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence-based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs (**21**). The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern (**22**). Some children and young people will benefit from services which tackle problems across all family members, including adult mental health, substance misuse issues or complex cases that do not have a clear clinical diagnosis.

6.5 The most effective multi-agency arrangements have in place a clear sense of purpose shared by all agencies, together with shared assessment, case management and regular multi-agency case review processes overseen by multi-agency governance boards. The fact that mental health support is required does not necessarily mean that it is mental health services that are responsible overall for managing the case.

## Trauma-focused care

6.6 Experiencing or witnessing violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood. Many mental health service users of all ages have problems directly attributable to severe neglect and/or trauma in the early years. Some vulnerable children and young people – including those who are adopted, looked-after children, those in contact with the youth justice system and substance misusing young people – are more likely to have been affected during childhood and adolescence.

6.7 Enhanced training for staff working with children and young people would lead to greater professional awareness of the impact of trauma, abuse or neglect on mental health (**27**). This should be coupled with effective treatment, including:

- Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government's response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines[63] (whereby every young person is asked during the mental health assessment about violence and abuse) will be introduced from 2015-16[64] (**23**).
- Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral to a specialist mental health service (**24**).
- Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage (**25**).

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[63] National Institute for Health and Care Excellence (2014). *NICE public health guidance 50*. Available at: www.nice.org.uk/guidance/ph50/

[64] Casey L (2015*). Report of inspection of Rotherham metropolitan borough council.* London: Department for Communities and Local Government.

## Delivering care to vulnerable groups

6.8 There are some specific models of provision that the Taskforce considered to be particularly helpful to these groups. Whatever models are adopted, the professionals involved need to specifically address the need to seek out, listen to, and respond to the voices of vulnerable children and young people.

## A consultation and liaison mental health model:

6.9 Applying an approach whereby specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties is already best practice in some areas, for some very specific and highly vulnerable groups. Consultation and liaison teams can be used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision (including specialist services). There would need to be an identified specialist point of reference, including a senior clinician with specific expertise within mental health services. The roll-out of such teams could be piloted and, if successful, implemented at a sub-regional level (**28**).

## Embedding mental health practitioners in teams responsible for groups of vulnerable children and young people

6.10 Young people who are amongst the most excluded from society, such as those involved in gangs, those who are homeless and/or looked-after children, need support from people they trust. This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel (**29**). The embedded worker can develop a relationship with the young people through youth-led activities so that they are then able to respond as a familiar, trusted adult as the need arises, working with more specialist or intensive services as required. They can also impart basic mental health skills to frontline staff. This approach has been successfully developed by MAC-UK's INTEGRATE model (see www.mac-uk.org) which also incorporates the necessary governance structures essential for success. INTEGRATE requires a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.

6.11 A case study, Jay's story, highlighting this approach and the value of a familiar, trusted professional in engaging the most vulnerable and difficult to reach children and young people is set out in the Vulnerable Groups and Inequalities Task and Finish group report.

## Designated professionals

> *"We need services that understand we need to stick with young people who DNA and assertively engage them, instead of being pushed to close cases due to pressures on throughput. We also need services that can be responsive to risk and windows of opportunity for engagement, and to use these for long term work"*
>
> A CAMHS psychologist who took part in the Taskforce engagement exercises.
>
> *"I should be able to reach out to someone in any of the settings when I need, but for it all to be coordinated by one person."*
>
> A young person who took part in the Taskforce engagement exercises.

6.12 Children and young people in vulnerable groups are amongst the most complex seen in specialist services. Systems such as appointing a lead professional through a Common Assessment Framework (CAF), Team Around the Child or Family, or the Care Programme Approach (for those with severe mental health problems) already exist in many places. For some, the consistent application of these needs to be improved – particularly for vulnerable children and young people with complex needs who require care that is well-planned and co-ordinated with information shared effectively. A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way (**26**). This role could be allocated through a number of multi-agency processes, including the CAF or Team Around the Child or Family processes.

6.13 The decision about which plan to use will depend on the needs of the child and family, but the lead professional or Care Co-ordinator's role is to co-ordinate support and services from across agencies to meet the needs, for example, of children and young people in contact with the youth justice system, whose care may otherwise fall between several different agencies. For young people with more severe mental health difficulties or those transitioning to adult mental health services, the Care Programme Approach may be the most appropriate approach.[65]

## Reducing Health Inequalities and Promoting Equality

6.14 The Taskforce was told that some groups, for example, learning disabled children find it difficult to access specialist services. In addition, studies have shown marked health inequalities in relation to children and young people's mental health, with correlations between poor mental health and disadvantage – for example, children in low income families having a three-fold increased risk of developing mental health problems.[66] We know that improving children and young people's mental health and their access to mental health services will require solutions that are tailored to the needs of children and young people from all backgrounds, of all characteristics, and from all sectors of the community.

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[65] Department of Health (2008). *Refocusing the Care Programme Approach – Policy and Positive Practice Guidance.* London: Department of Health.

[66] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004.* A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

6.15 The Equality Act 2010 requires all public and voluntary sector organisations to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people. In addition, the Health and Social Care Act 2012 introduced duties on the Secretary of State for Health, NHS England and on CCGs to have regard to the need to reduce health inequalities.[67]

6.16 For NHS England and CCGs, the health inequalities duties mean they must consider the need to reduce inequalities in access and outcomes for patients. In meeting these duties, they will wish to demonstrate that they have considered how policies and services for children and young people vulnerable to, or receiving support for, mental health problems take account of need, not just demand, and give appropriate focus to those groups in the population which have poorer access or outcomes.

6.17 Whilst the health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes (**21**).

**Caring for the most vulnerable – chapter 6 summary**

Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.

Much of what is needed can be done now by:

20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.
21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.
22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.
23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.

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[67] Equality and Health Inequalities Team (2014). *Guidance for NHS commissioners on equality and health inequalities legal duties.* Leeds: NHS England.

24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.
25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.
26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.

With additional funding, a future government should consider:

27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.
28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.
29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.

# 7. Accountability and transparency

7.1 We have a wealth of information and many examples across the country of services moving towards greater integration and offering greater choice of evidence-based outcomes focused treatments working collaboratively with children and young people. However, this is not consistent and there is unacceptable variation.

7.2 Agreeing better models of care is not enough. Right now there are too many barriers to have confidence that such models would succeed because:

- the system of commissioning services is fragmented, with money often sitting in different budgets, in different organisations, in different parts of the system and without clear lines of accountability;
- there is limited access to the necessary information to know how a local system is working in respect of access and waiting times, how outcomes are achieved or if they provide value for money;
- there is poor information sharing within the system which hampers joint working; and
- the best practice standards, agreed as quality markers for accreditation systems, are not universally applied.

7.3 These are ingrained and systemic problems facing children and young people's mental health services that require strong leadership right across the whole system and at every level.

7.4 The recent changes to the national statutory framework for children and young people with special educational needs and disabilities (SEND) establish a platform for significant potential improvements over time for a cohort which includes some children and young people in need of mental health services. It is not possible to simply copy this model in respect of mental health, as support and treatment are quite different, but there are key features that are relevant:

- access to a wider range of local services through a transparent 'local offer';
- clarity over points of access and decision-making processes for more specialist support, including use of triage processes;
- co-ordination of assessment and planning around the individual child, involving all relevant services, facilitated by information sharing and a lead professional or key worker; and
- giving young people and parents more control, including greater use of personal budgets.

## Securing the best possible service for children and young people with mental health problems

7.5 We consider that there are a number of issues that need to be addressed in the organisational and accountability frameworks if we are to achieve transformation in the service offer.

7.6 There was strong support from many members of the Taskforce to make it a requirement at the local level for there to be **a lead accountable commissioning body** to co-ordinate commissioning and the implementation of evidenced-based care (**30**). Many members of the Taskforce also favour the creation of **a single, separately identifiable budget for children's mental health services.** These proposals build on the learning from those areas which are already jointly commissioning children's mental health services between Clinical Commissioning Groups and local authorities, in some cases with pooled budgets. We envisage in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements.

> *"If we are all working towards the same outcomes, planning in an integrated way to meet them, using clear accountability structures and a person-centred planning approach, then joint ownership of outcomes is inevitable. This is not easy to do – but… we can start."*
>
> A community services manager who took part in the Taskforce engagement exercises.

7.7 There is a need to address the ambiguity in **local authorities' role and responsibilities** in respect of child mental health commissioning. Although the statutory lever under the Children Act 1989 remains in place, along with responsibilities regarding looked-after children and care leavers, the financial position that local authorities are facing is challenging and there is no longer any ring-fenced budget for this provision within local authorities. As a result, we are seeing very different patterns of commitment and contribution across both public health and children's social care budgets. At the least, there should be full transparency in terms of individual local authorities' contribution.

7.8 The work of the lead commissioner should be based upon an agreed **local plan** for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/carers (**30**). The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health. Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing. As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.

7.9 Key drivers for the quality of any local offer should be the local Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The JSNA should address children and young people's health and wellbeing, including mental health (**31**). Health and Wellbeing Boards, supported by the local government-led health and wellbeing system improvement programme and Public Health England, should ensure that both the JSNA and the Joint Health and Wellbeing Strategy address children and young people's mental health needs effectively and comprehensively.

7.10 As well as drawing on the local plan, we consider that the local offer should be guided by a **national ambition** that clearly sets out the expectations and requirements for securing the best possible outcomes for children and young people's mental wellbeing. This will avoid the dangers of a postcode lottery while still ensuring a high degree of local flexibility. Over time, Government should consider whether elements of the national ambition should be placed on a more formal footing to ensure consistency of practice across the country.

7.11 Developing **an effective local system of care and support** requires access to diverse and flexible services. In adult social care, there is a now a statutory duty on local authorities to shape the market to ensure adequacy of local provision. While the situation is not precisely analogous in children and young people's mental health our assessment is that those local areas exhibiting best practice have access to a range of providers, and, in particular, have harnessed the strength of the voluntary and community sector.

7.12 There is a particular need to **co-ordinate the commissioning of community health and inpatient services** (**32**). Within the current statutory system, the former is the responsibility of local commissioners and the latter the responsibility of the national commissioner, NHS England. If we are serious about moving away from a tiered model, then this commissioning needs to be joined up. This need for co-commissioning has been recognised by NHS England. At the same time, however, we want to avoid the mistakes of the past where we ended up with a patchwork quilt of intensive community crisis support and inpatient services.

7.13 The National Institute for Health and Care Excellence has a crucial role to play in framing a national ambition through the development of **Quality Standards** as well as guidance for health and social care, which are commissioned by the Secretaries of State for Health and Education (**33**). The quality standards will need to describe cost-effective evidence-based practice. They should provide clear descriptions of high priority areas for quality improvement. They will help organisations by supporting comparison of current performance, using measures of best practice to identify priorities for improvement. Though not mandatory, they are an important driver for change in the new arrangements for commissioning and service delivery in health and social care. It would be helpful if their recommendations could include further advice regarding implementation across the whole care pathway.

7.14 In supporting implementation and delivery of high quality care, we consider that CQC and Ofsted – with their distinct roles and responsibilities in health and education – should develop **a joint cross inspectorate view** of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (**34**).

## Access to information

7.15 However, this is still not enough without access to information. Measurement is crucial to support continuous improvement. Support and services should be based on high quality, accurate data, but there are significant gaps in relation to children's mental health. The last children and young people's mental health prevalence survey was done over a decade ago, although the Department of Health has just started the process of commissioning the next one (**35**). We propose the commissioning of a regular prevalence survey of child and adolescent mental health every 5 years, giving particular consideration to including under-5s and ages over 15 (**39**). In addition, and in response to the growing international evidence base, the survey should be expanded to cover:

- New disorder codes (DSM 5, ICD-11) and conditions or issues that have grown in prominence since 2004, eg eating disorders, self-harm and the impact of social media and experience of cyberbullying; and
- The ability to analyse data by characteristics such as ethnicity and deprivation or whether a child is adopted or in care.

> *"If data collects meaningful information that can be useful for clinicians and patients alike to monitor their progress, data collection becomes part of the therapy."*
>
> A CAMHS psychologist who took part in the Taskforce engagement exercises.

7.16 At the same time, levels of investment in mental health services for children and young people should be transparent. Accurate information on current levels of spend on children's mental health across agencies is a key gap. NHS England is working to improve the quality of data on adult mental health spend from April 2015 so that it will be able to identify the overall spend in primary and community care as well as mental health services and specialist commissioning. This has been built into the NHS planning process at CCG level. We propose that, in the future, this activity is extended to cover children's mental health spend by the NHS. It is also proposed that further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment (**38**).

7.17 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence-based interventions to support evaluation of the effectiveness of the care commissioned (**35**). To build on this work, it is important that routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.

7.18 Data from the CAMHS Minimum Data Set will begin to flow no later than January 2016. It is likely that early data will be flawed and will take time for data completeness and quality to be such that conclusions can be drawn about access and waiting times. The Minimum Data Set does not cover investment levels. The implementation in 2015 and central flow of data through the Health and Social Care Information Centre (HSCIC) must be a key priority for implementation at a national and local level. This includes ensuring that commissioners are placing into contracts the requirements for meaningful data collection, including outcomes monitoring.

7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (**36** and **37**).

7.20 In the meantime, many providers are already collecting data that can be used by commissioners, for instance:

- Members of the NHS Benchmarking Collaborative.
- Outcomes data collected by members of Children's Outcomes Research Consortium (CORC).
- The CYP IAPT datasets and outcome measures.
- Data collected for CAMHS Currencies.
- Health and Justice data.

7.21 Commissioning Support Units and Academic Health Science Networks should therefore be supporting commissioners to analyse local data collections, share best practice and pool knowledge and skills, mentoring new commissioners and delivering learning sets. This should include promoting the use of existing benchmarking tools by commissioners, for example, the Fingertips tool on the Mental Health Intelligence Network and the service snapshots and other information supplied by Public Health England.

## To be accountable and transparent – chapter 7 summary

Far too often, a lack of accountability and transparency defeats the best of intentions and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

Much of what is needed can be done now by:

30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.
31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.
32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.
33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions
34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.
35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.
36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.
37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.
38. Making the investment of those who commission children and young people's mental health services fully transparent.

And subject to decisions taken by future governments:

39. Committing to a prevalence survey being repeated every five years.

# 8. Developing the workforce

8.1 Professionals working with and supporting children and young people want to make a real and lasting difference to their lives.

8.2 The national vision is for everyone who works with children, young people and their families to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them;
- excellent in their practice and able to deliver the best evidenced care;
- committed to partnership and integrated working with children, young people, families and their fellow professionals;
- respected and valued as professionals.

**There is consistency in children and young people's views about the workforce qualities and behaviour they would like to see:**

- A workforce which is equipped with the skills, training and experience to best support children and young people's emotional and mental wellbeing.
- Staff who are positive, have a young outlook, are relaxed, open-minded, unprejudiced, and trustworthy.
- Behaviour that is characterised by fairness, and a willingness to listen to, trust and believe in the child or young person.
- Everybody should work from a basis of asking and listening, being prepared to be helpful in creating understanding among other members of the workforce.
- Their processes should be transparent, honest, and open to being both inspected and clearly explained. Visible actions should result from such scrutiny, enabling children to voice their opinions.
- The workforce should provide real choice of interventions supported by enough resources to follow through, whilst remaining honest and realistic.

## A workforce with the right mix of skills, competencies and experience

8.3 Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions (**40**). Professionals need to be trained to be able to:

- Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.
- Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.
- Identify mental health problems early in children and young people.
- Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.
- Refer appropriately to more targeted and specialist support.
- Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.
- Work in a digital environment with young people who are using online channels to access help and support.

## Universal settings

8.4 Anybody who works with children and young people in universal settings such as early years provision, schools, colleges, voluntary bodies and youth services, should have training in children and young people's development and behaviours, as appropriate to their professional role.

8.5 This does not mean that professionals working in universal services should step in where a more specialised service is needed. But it does mean that, for example, a teacher who sees that a child is anxious, in a low mood, not eating or socialising as children and young people usually do, is withdrawn or behaving uncharacteristically, understands this child may need help. MindEd (www.minded.org.uk) is a useful resource for promoting this level of awareness in all staff who work with children and young people.

## Targeted and specialist services

8.6 Staff who work in targeted and specialist services come from a range of professional backgrounds: social work, occupational therapy, nursing, clinical and educational psychology, psychotherapy, child and adolescent psychiatry and, with a growing number of 0-25 services, general adult psychiatry.

8.7 Staff in paediatric services make an important contribution to targeted and specialist mental health services for children and young people. Their role is likely to increase with a move towards greater integration between children's mental health provision and community paediatrics. The move towards 0-25 service models and integrated services means that, although discipline-specific training will remain the core of most professionals' training, interdisciplinary training and practice and cross-agency working will become increasingly important.

8.8 Basic training in all disciplines should include an understanding of the interface between physical and mental health. These interactions indicate the need for: greater awareness of mental health problems amongst paediatric staff; greater awareness of physical health problems amongst mental health staff and the development of services models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health. A paediatric nurse working with young people with diabetes, for example, should be able to identify whether that young person also requires emotional or mental health support. All of these recommendations have significant implications for the training of staff in the children and young people's workforce. Enhanced, multi-professional training across the physical and mental health interface will be a key part of improving the experience of children and young people with physical and mental health problems.

8.9 Effective access to support requires improved communication between universal, targeted and specialist services, backed by a clear shared understanding of roles and responsibilities across all those involved in the system, so that children and young people do not fall between services, and receive timely and appropriate support. This implies the use of local reciprocal multi-agency and multi-professional training programmes for those involved in children and young people's services. A good example is the reciprocal training programme between practice nurses and local community mental health trust nurses in Health Education England North Central & East London which is now available to be rolled out nationally.

8.10 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum. All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability. This was considered in detail by the Vulnerable Groups and Inequalities Task and Finish Group. In addition, there are skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE. The CYP IAPT programme was commissioned with a modest budget to deliver training for a limited range of therapies to a prescribed group as a part of its transformation role. There are gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings. Counsellors working in schools and the community have asked for further training to improve evidence-based care (**43**).

8.11 Skills and capabilities audits in the North West have shown not only deficits in terms of competencies but also gender and age issues that need to be addressed. 48% of staff in the survey were found to be due to retire in the next 10 years, and 90% were female.

8.12 The Taskforce highlighted a number of initiatives in progress which could and should contribute to supporting professional capabilities.

**Current action to develop workforce skills and competencies includes:**

For schools, the **Carter Review of Initial Teacher Training**[68] (ITT) reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development (**41**).

The revised **Foundation Programme curriculum for doctors** (covering the first two years of postgraduate training for doctors qualifying in the UK) will give increased prominence to mental health, and 45% of foundation trainees will rotate through a psychiatry post during their two years from 2016 to ensure that more doctors (many of whom will become GPs) have experience of working with patients with mental health issues. The opportunity should be taken to review whether a greater emphasis on children and young people's mental health could be incorporated.

The **CYP IAPT programme** currently works with partnerships covering 68% of the 0-19 population. The Service Transformation programme includes training for existing service leaders, supervisors and therapists in the NHS, social care and voluntary sector in a range of evidence-based programmes, with a Mandate commitment for both Health Education England and NHS England to plan further roll-out (**44**).

The **social work reform programme** is placing a much stronger focus on the skills and competencies needed by child and family social workers. This includes identifying child development, physical and mental health and education needs and working in partnership with other professionals and organisations to provide the help a child or young person needs.

The **Think Ahead initiative** will provide a new cadre of top graduates training to specialise in adult mental health social work, including work with young adults.

The sector skills councils such as **Skills for Care & Development** will also play an important role in shaping education and training for the workforce in support of the children and young people's mental health agenda.

## Developing a strategic approach to workforce planning

8.13 Adopting new commissioning arrangements with new models of contracting and performance monitoring would be a key driver to securing collaborative and co-ordinated working across local areas.

8.14 The established and proven CYP IAPT transformation initiative gives a platform on which to build and align the creation of a children and young people's mental wellbeing workforce across agencies that is fit for purpose.

8.15 Planning for mental health services for children and young people in the future requires a bottom-up consideration of the current competencies and capabilities of the existing workforce as well as an understanding of the capacity that will be required to deliver a workforce fit for the future. The role of Health Education England and Local Education and Training Boards will be crucial to establish local requirements and local practice through locally led needs assessments of current workforce capability and capacity.

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[68] Carter A (2015). *Carter review of initial teacher training.* London: Department for Education.

*"[We need] designated leaders to drive change across service and agency boundaries, and trained commissioners who know and understand how this would work and what they need to be commissioning. The Health Select Committee CAMHS report showed that many local authorities still do not consider children's emotional health and wellbeing and mental health as their core business. But of course it is! Their activity and priorities are the very foundation of building resilience and emotional intelligence in children."*

Office of the Children's Commissioner as part of the Taskforce engagement exercises.

8.16 It is proposed that the Department of Health and Department for Education should work together with HEE, the Chief Social Worker for children and others, to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sectors and independent sector as the first stage in determining a comprehensive cross-sector workforce and training strategy (**45**).

## Training for commissioners

8.17 Traditionally, especially in the NHS, investment in training has focused on the provision of services. There is, however, no recognised standard training programme for commissioners of children's services or mental health services for children and young people. The recent mental health commissioning and leadership programme developed by NHS England and Academic Health Science Networks is organised around the principles of: data for commissioning, the use of the evidence base and leadership. All programmes include a module on child and adolescent mental health provision, and attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services (**42**).

**Developing the workforce – chapter 8 summary**

It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.

Much of what is needed can be done now by:

40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments
41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.
42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.

With additional funding, a future government should consider:

43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.
44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.
45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.

# 9. Making change happen

9.1 This report sets out a vision for a comprehensive approach to promoting, supporting and treating our children and young people's mental health, and to supporting their families. We have made a set of proposals to enable this vision to be translated into national and local frameworks. There is undoubtedly an urgency to act and in this section we set out how we might make a start.

## Building the evidence base

9.2 Throughout the report, we have emphasised the paucity of good quality national information about meaningful outcomes as well as outputs in respect of child mental health services and how this can be corrected over the next few years, building on the early successes of the CYP IAPT programme.

9.3 If we are continuously to improve the mental health care and wellbeing of children and young people, we need data and evidence with which to do so (**49**). Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services. In some areas, evidence is weak or entirely lacking as to the best interventions. Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers' money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation.

9.4 This is one of the hardest challenges the system has: to secure acknowledgment of the limitations of our knowledge and not assume that interventions are without harm. There is good evidence that well-meaning interventions, with the best of intentions, can do more harm than good. A classic paper illustrating this is the McCord study of a multi-disciplinary approach to child delinquency. In the 30 year follow up of the two groups, control versus active, every outcome was worse in the active group.[69] Another was the mixed impact of suicide prevention in adolescents.[70] These examples illustrate the necessity to use an evidence base wherever possible and, if one is lacking, to ensure that research capacity is deployed to fill the gap.

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[69] McCord J (1978). A thirty year follow-up of treatment effects. *American Psychologist* 33: 284-289.

[70] Ploeg J, Ciliska D, Dobbins M, Hayward S, Thomas H, Underwood J (1996). A systematic overview of adolescent suicide prevention programs. *Canadian Journal of Public Health* 87(5): 319-324.

9.5 This re-emphasises the importance of NICE guidance and Quality Standards for those who plan, commission or provide services, and also the need for a world class research programme in child mental health and wellbeing supported by regular detailed prevalence surveys and reliable routinely collected comprehensive outcomes data.

## Making a start

9.6 There are a number of proposals in this report directed at a national level that can only be properly considered during the next Parliament. However, we are keen that progress is made during 2015/16. **Many of our proposals require a different way of doing business rather than further significant investment.**

9.7 National organisations must play their part but we believe that even more progress can be made rapidly at the local level.

9.8 This will require local leadership and ownership. We therefore propose the development and agreement of **Transformation Plans for Children and Young People's Mental Health and Wellbeing** which will clearly articulate the local offer (**46**). These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

9.9 We would anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways.

9.10 To support this, and in line with the announcement at the time of the Autumn Statement 2014, NHS England can make a specific contribution by prioritising further investment in those areas that can demonstrate robust action planning through the publication of local Transformation Plans that accord with the principles and ambitions set out in this report.

9.11 What is included in the Plan should be decided at a local level in collaboration with children, young people, families as well as provider and commissioner representatives and should address as many of the principles and proposals set out in the report as possible.

9.12 At the same time, NHS England and the Department of Health have recently invited proposals from CCGs to lead and accelerate co-commissioning arrangements for children and young people's mental health. The national response to this invitation was hugely encouraging and indicative of the potential to be harnessed by this report. Although only a limited number of areas could be chosen, as these projects develop, they will provide good examples of what can be achieved, alongside other relevant initiatives such as the Social Care Innovation Fund and the Department for Education's Voluntary and Community Sector Fund (**48**).

9.13 Lead commissioners should ensure that schools are given opportunities to contribute to the development of local Transformation Plans. The Department for Education is already leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based outcomes focused schools counselling strategy to encourage more and better use of counsellors in schools. This should equip schools to contribute to the development of the local Transformation Plans.

## Seeing it through

9.14 The transformation of our national and local approach to children and young people's mental health and wellbeing will take time, at least the period of the next Parliament, aligning with the timescales of the Five Year Forward View. Change at the national level will need co-ordination across policy, investment, commissioning, regulation, training and inspection. Local areas will need ongoing support and guidance. It represents a complex and difficult journey and it will need strong political will combined with senior level leadership to see it through and be successful. Our closing proposal is therefore that there should be some clear governance at the national level to oversee the transformation of children's mental health with clear accountability for progress to the relevant Accounting Officers and Ministers (**47**).

**Making Change Happen – chapter 9 summary**

Much of what is needed can be done now by:

46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.
47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.
48. Enabling more areas to accelerate service transformation.

With additional funding, a future government should consider:

49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.

# 10. Conclusion

10.1 The work of the Taskforce has revealed great potential to meet the desire for children and young people to have better support and care for their mental health. The economic argument and evidence for effective interventions make a strong case for putting national energy and effort into supporting the expectations that have emerged.

10.2 We have described a vision for our country in which child mental health and wellbeing is everybody's business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation.

10.3 We can start by doing what we know works, indeed already is working in some areas of the country, but is not being applied consistently.

10.4 The second step is to deliver the commitments already made and the initiatives already started that give us the fundamental building blocks that will help justify securing the third element.

10.5 With better data, transparency and accountability, the value of investment in mental wellbeing and care for child and young people can, and we believe will, be demonstrated and justified. A cycle of virtue can be created where, for each taxpayer's pound invested, the benefit for the individual and society can be realised with confidence.

10.6 In the meantime, there are targeted opportunities if resources can be identified through re-prioritisation and/or on an 'invest to save' basis. These have been set out clearly in the report and are illustrated by the additional money already identified for eating disorder services from April this year. And, of course, any local area can make a decision to re-prioritise its resources in favour of child mental health on the basis of existing national and local evidence of need and efficacy.

10.7 The work of the Taskforce has reconfirmed that we are by no means alone in the international community in grappling with how to give our children and young people a better start, to keep them safe and to help their mental health and resilience. It would be a hallmark of our progress if by 2020 we could truly say that England is leading the world in improving the outcomes for children and young people with mental health problems. We know that it is possible. But it will only happen if we decide with resolve and determination to place such a goal at the heart of the economic and social vision for our nation.

# Glossary and Acronyms

| | |
|---|---|
| A&E | Accident and Emergency |
| ADHD | Attention Deficit Hyperactivity Disorder<br>Neurodevelopmental disorder identified by behavioural symptoms that include inattentiveness and impulsiveness. |
| CAMHS | Child and Adolescent Mental Health Services |
| CBT | Cognitive Behavioural Therapy |
| CCGs | Clinical Commissioning Groups<br>Statutory bodies clinically led that include all of the GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. Each CCG has a constitution and is run by its governing body, and is overseen by NHS England. |
| CORC | CAMHS Outcomes Research Consortium |
| CQC | Care Quality Commission<br>Independent regulator of all health and social care services in England. |
| CYP IAPT | Children and Young People's Improving Access to Psychological Therapies Programme |
| DfE | Department for Education |
| DH | Department of Health |
| DSM-5 | Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition<br>Psychiatric classification and diagnostic tool, published in May 2013. The Fifth Edition superseded the Fourth Edition which had been in use since 2000. |
| HCP | Healthy Child Programme |
| HEE | Health Education England |
| HSCIC | Health & Social Care Information Centre |
| H&WBs | Health and Wellbeing Boards<br>Statutory bodies based on upper-tier and unitary authorities in England drawing together members of CCGs, local HealthWatch and the Local Authority. They are charged with assessing the needs of their local population producing Joint Strategic Needs Assessments and agreeing a Joint Health and Wellbeing Strategy. The board also has responsibility for promoting integration of health and care services. |

| | |
|---|---|
| ICD-10 | International Classification of Diseases, 10th Revision<br>The World Health Organization's medical classification list, in use since 1994. The 11th revision is due to be released in 2017. |
| ITT | Initial Teacher Training |
| JSNAs | Joint Strategic Needs Assessments<br>Process of reviewing and describing the current and future health and wellbeing needs of a local population. |
| LTC | Long Term Condition<br>A health problem for which there is currently no cure, but the symptoms of which may be managed with medication and other treatment. Examples include asthma and diabetes. |
| MUS | Medically Unexplained Symptoms<br>Persistent physical complaints for which medical examination does not reveal an obvious cause. |
| NICE | National Institute for Health and Care Excellence |
| Ofsted | Office for Standards in Education, Children's Services and Skills |
| PHE | Public Health England |
| PSHE | Personal, Social and Health Education<br>Programme of learning that aims to equip young people with the knowledge, understanding and skills they need to manage their lives healthily, safely, productively and responsibly. |
| SEND | Special Educational Needs and Disabilities |
| YIACS | Youth Information, Advice and Counselling and Services |

# Taskforce Membership

| Name | Job Title |
|---|---|
| Dr Martin McShane | Co-Chair & Director (Domain 2) Improving the quality of life for people with Long Term Conditions, NHS England. |
| Jon Rouse | Co-Chair & Director General for Social Care, Local Government & Care Partnerships, Department of Health. |
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| Dr Maggie Atkinson | Children's Commissioner for England. |
| Mick Atkinson | Head of Commissioning, Place2Be. |
| Prof Sue Bailey | Chair of Children & Young Peoples Mental Health Coalition. |
| Dr Laurence Baldwin | Royal College of Nursing. |
| Johnny Benjamin | Expert by Experience. |
| Sarah Brennan | Chief Executive, Young Minds. |
| Sally Burlington | Head of Programmes Local Government Association. |
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| Dr Ann York | Professional Adviser on CAMHS, Care Quality Commission. |

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# Improving mental health support for our children and young people

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## Expert Working Group co-chairs foreword

> There can be no keener revelation of a society’s soul than the way in which it treats its children.

Nelson Mandela’s statement from May 1995, spoken at the launch of the Mandela Children's Fund in Pretoria, still resonates with us more than two decades later. How we treat children, the sensitivity we show and the systems we put in place to address the needs of these children whose future is entrusted to us, is emblematic of our vision for society as a whole.

The mental health of children and young people has become a focus in our society as never before, and we welcome the commitment by government to achieve a system-wide transformation of the mental health care and support they receive by 2020. Many people have also come together, through the ‘Heads Together’ campaign, and talked publicly about their personal struggles in an overt effort to reduce stigma and bring mental health issues into the open.

It is our hope that as a society we will become more confident in expressing our compassion towards those with mental health needs, and that with this change the needs of children in care, who are among the most vulnerable in our society, will resonate in new ways: with government, with policymakers, and with local service commissioners and providers. However, to feel and express compassion is not enough. The feeling must act as a catalyst to galvanise those of us responsible for looked after children into making positive changes.

The Expert Working Group brought together a selection of the most committed experts in this field, who were determined and passionate to make a difference to the mental health and wellbeing of children and young people. We were fortunate to benefit from eloquent experts by experience, as well as a richness of oral testimony and evidence from local and national stakeholders. We concluded that the care system does not support the mental health and wellbeing of these vulnerable children and young people, and can sometimes cause them unintentional harm. This needs to stop now.

We were all motivated by a strong belief that we urgently need to transform the provision and improve support for children and young people's mental health and emotional wellbeing. We see a growing mental health crisis across all groups. Trends highlight an increase in mental illness among some groups of children and young people, particularly emotional problems such as anxiety and depression.[1, 2] Whatever the cause(s) of this increase, it is likely that the pressures on looked after children will increase with even fewer resources available to protect them.

There is also the societal cost of inaction. Given the prevalence and complexity of mental health problems among children in care, coupled with the knowledge that the best predictor of psychiatric disorders in adulthood is psychological disturbance or a psychiatric disorder in childhood or adolescence,[3] intervening early and sensitively in multiple contexts across the system can generate significant benefits.

Equally, we were concerned about significant external influences that can affect the mental health and wellbeing of all young people. For example, growing up in a digital age, increased societal inequality, austerity, and political conflict and instability in the world. One of the results of this upheaval is minors arriving unaccompanied on our shores.

There can be little doubt that children and young people are experiencing new and multiple pressures in a demanding and fast-moving digitally enabled world.
Online child sexual exploitation (CSE), where young people are groomed and abused online, increased by 135 per cent between 2015 and 2016.[4] The wider use of technology can increase young people's vulnerability to abuse, bullying and exploitation. Poverty also plays a critical role in child maltreatment.[5] During the recent period of austerity we have seen the number of children subject to child protection interventions, and who are taken into care, increase.[6] In the last 10 years there has been a 140 per cent increase in children and young people on child protection plans.

The Expert Working Group was also greatly concerned by the considerable delays in accessing vital mental health support in the first instance. Since 2012, mean maximum waiting times for access to child and adolescent mental health services (CAMHS)[7] have fallen.[8] However, these are still far too high, with some children and young people waiting a long time for assessment and then again for treatment. The Care Quality Commission (CQC) identifies access to timely care and support as a key area for improvement, with CQC inspections commonly finding that CAMHS services need to take action to improve waiting times for specialist community services.[9]

In any case, there is a significant human cost associated with long waiting times, and the difficulties in getting help after assessment are now generally appreciated. We also need to tackle the problem of inadequately coordinated services at the local level and the particular difficulties in the transition from children's to adults' services. There are notable gaps in provision between community and inpatient care.

So, while we have trained and passionately caring professionals, they are too often working within a system which acts as if it lacked compassion.

The ethical imperative to intervene early is overwhelming. The needs of looked after children are complex. Diagnoses of severe disorders such as autism and attention deficit hyperactivity disorder (ADHD) can be missed in the care population and the presence of trauma can overshadow other conditions.[10,11,12] All too often we can gain only a partial view of a child's health. By over-emphasising the distinct nature of each problem, the clinician is liable to miss important causal or situational considerations. For example, in relation to past or present attachment issues. While it is important to align symptoms with the correct diagnostic label, it is equally important that problems are viewed in the round, so that treatment can be based on a complete picture of the child's needs. This emphasis on a child-centred, needs-focused approach ran through almost all the considerations of the Expert Working Group.

In response to the need for a more flexible approach, there are useful parallels in how the needs of children and young people with special educational needs (SEN) are met. Mirroring the Education, Health and Care Plan (EHCP) approach, the co-chairs endorse the idea of a ‘graduated response’ to mental health and wellbeing. We have not recommended a special emotional wellbeing plan for children in care, but feel passionately that the inclusion of this dimension in existing care plans must be significantly strengthened.

We are also concerned that children are often overlooked in decisions that directly affect them, and that this reduced agency will not only have a negative impact on their sense of self, but their trust in the systems designed to assist them, leaving them with potential long-term problems of adaptation. We see a strong case for creating a small team of professionals, including their carers, who care about and understand the child and, importantly, are perceived as caring and understanding by them. There must be key individuals who, based on in-depth knowledge of the child, will have a trusting relationship and be able to guide others in how they can best help, ensuring that the child’s personal views on their care pathway are given full attention and consideration.

With significant and growing pressure on health and care budgets, there has often been no alternative to moving money out of non-statutory services (such as youth services) and into statutory child protection support. Disinvestment in one part of the system has often led to unplanned impact in another, leading to the unintended degradation of the ability of the system overall to respond well, particularly with early help.

Good commissioning and local system oversight is critical for success. Our report seeks to reinforce accountability and to emphasise the need for better professional leadership and high quality commissioning across local systems. Crucially we see this responsibility firmly within the corporate parenting role and call for better scrutiny and challenge on behalf of children in care. In our report we make specific recommendations to achieve improved collaboration and coordination of efforts at a national and local level, to move beyond organisational boundaries in a shared endeavour that is focused on the needs of children and young people. We are guided by a model of care that has the young person at its centre, recognising that if the system does not consistently enhance the child and young person's decision-making power and sense of agency, then it falls short as a corporate parent.

As a society we are clear that we are not prepared to tolerate abuse and maltreatment of children and we use our laws to intervene to protect and care for them. This places us under an ethical obligation to care well for those children for whom the state has assumed parental responsibility. This is expressed through our duty to act as corporate parents to them.

We want to end by emphasising that we found excellent practice in the field and very many dedicated and impressive individuals. We heard dozens of moving personal stories about how meaningful relationships with key remarkable individuals have turned around the lives of profoundly traumatised young people. And we were inspired by the resilience and personal resources of the young people we met, who reminded us why we must make sure everything is done to enable every person to reach their full potential.

We want this report to be used now as well as to inform policy, practice and commissioning decisions going forward. We sincerely hope that the report will fulfil the declared ambition of the Expert Working Group and that it will make a difference.

Professor Peter Fonagy OBE
Dame Christine Lenehan
Alison O'Sullivan

## Executive summary

In February 2016 the Department for Education (DfE) minister announced that an Expert Working Group would be created to ensure that the emotional and mental health needs of children and young people in care, adopted from care, under kinship care, under Special Guardianship Orders, as well as care leavers, would be better met. It was proposed that, by October 2017 the following would be developed:

- **care pathways**: focusing on the young person’s journey
- **models of care**: how services ensure appropriate interventions
- **quality principles**: measures that set out markers of high-quality care
- **implementation products**: to support those working in the field.

The charity Social Care Institute for Excellence (SCIE) was contracted by the Department of Health (DH) and the Department for Education to establish the Expert Working Group to support this work.

We believed that it was absolutely essential that our work was co-produced with children and young people, and over 80 contributed their experience and evidence to the project. We also heard from those looking after young people and approximately 100 professionals including looked after children nurses, doctors, birth parents, social workers, residential key workers, foster carers and adoptee parents. All of these groups attended our stakeholder event in April 2017.

The Expert Working Group gathered evidence from a review of literature about what the mental health needs of looked after children were, and held a Call for Evidence of good practice. The group also considered what a good system to support the health and wellbeing of looked after children would look like, and described its key features.

One of the key issues that we recognised was that good quality ongoing assessment must be the foundation of a comprehensive strategy of support and services. The feedback from young people, stakeholders and the Expert Working Group itself was that the Strengths and Difficulties Questionnaire (SDQ) by itself is not an effective way of measuring the mental health and emotional wellbeing of young people.

One of the strongest views of the Expert Working Group was that local areas need to be able to provide consistent care and support for a child, with an understanding that their diagnosis and therefore the type of support services they need can change. Therefore, assessment and services must be responsive and flexible. Mental health is a continuum and cannot be seen as a one-off diagnosis.

For one of our consultations we met 35 children and young people who had accessed provision from across health services including specialist in patient care ('Tier 4' provision). We asked them to create recommendations to include in our report, so that their voice was clear and strong. We present their 11 recommendations here, before our own, because their voice is the context in which our work should best be understood.

From the evidence base that we have assembled, the work of the Expert Working Group, the views of children and young people who are experts by experience, professionals and those looking after young people, we have:

- established 11 key findings, which are the drivers for change
- made recommendations that address those findings and will improve the mental health and wellbeing of looked after children
- developed seven quality statements that define the outcomes that our recommendations are intended to achieve.

Change needs to happen now, and it is our hope that this report provides a platform for that change and the necessary call for action.

We recommend that:

1. Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they need for their mental health and emotional wellbeing.
2. The Strengths and Difficulties Questionnaire should be supported by a broader set of measures which can trigger a comprehensive mental health assessment. There are a range of tools in use that could support the assessment depending on the need of the young person.
3. Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms. The young person, their caregivers, family (where appropriate) and professionals' viewpoints should be included. Young people should be able to share who they would like to accompany them to assessments, and where possible those wishes should be accommodated.
4. Caregivers should receive support for their own mental health and wellbeing.
5. Caregivers need to be informed of which statutory and non-statutory services are available when support is needed for the child or young person. This should be included in each area's local offer. It is crucial that services are funded to support caregivers' training and development.[13]
6. Everyone working directly with looked after children should receive training on children and young people's mental health so they are equipped with the appropriate skills.
7. A needs-based model is the best way to support and respond to young people. This model places the young person at the centre of decision-making and where appropriate lets them exercise choice as to how and what support they access. This allows appropriate support to be generated by need, rather than diagnosis.
8. Formal services should be more flexible in who they will allow to support the young person, acknowledging that support can come from a range of services and places. Health, education and social services need to work collaboratively to achieve this recommendation.

9. Ministers at the Department for Education and Department of Health should work together to ensure children in care and leaving care have access to services provided for their mental health and wellbeing.
10. Ofsted, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) should review their regulatory frameworks linked to registration to ensure that equal weight and attention is being given to mental and physical health needs.
11. The statutory review of a child's care plan by the independent reviewing officers (IROs) must include at each meeting a review of whether mental health needs have been met.
12. Every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are looked-after.[14]
13. Existing mechanisms for capturing direct views of young people should be integral to planning and commissioning arrangements. Local Health Watch services should monitor the effectiveness of mental health care arrangements for children and young people who are looked after, and report their findings to Health and Wellbeing Boards at least annually.
14. Self-help, peer mentoring and community initiatives should be considered (if a young person expresses this is their preference) before a referral to more formal child and adolescent mental health services.
15. Clinical Commissioning Groups should ensure commissioning is informed by a Joint Strategic Needs Assessment (JSNA) which addresses the mental health and wellbeing needs of looked after children and care leavers. This should be reflected in Local Transformation Plans.
16. The Local Safeguarding Children Board, Corporate Parent Board and Health and Wellbeing Board should give appropriate priority to ensuring that the mental health needs of children and young people in care and leaving care are met.

The Expert Working Group developed a new model which places the young person at the centre. The model is based on ‘I statements’ supported by enablers. The model highlights what good, holistic support for mental health and wellbeing looks like from the perspective of the young person, and what needs to be in place to make it happen.[15]

Alongside this model, one of the major findings from our evidence is that the journeys taken to access support are often not linear. For example, a child in care may have a social worker who has the statutory responsibility of referring to child and adolescent mental health services, but their trusted relationship may be with another professional or their main caregiver. In this instance, there would be benefit to the young person being able to utilise their trusted relationship to access support together.[16]

To support our findings, we then developed an ‘eco-map’, to be used in conjunction with the accompanying decision trees. The eco-map is a representation of the choices that should be available to the young person and/or primary caregiver to access the right support and resources.

The decision trees represent our recommendations for a responsive pathway that places the child or young person at the centre, and include those that know them in the decision-making, as appropriate.

At the core of both our model and pathway is the need for:

- timely intervention and support
- a system that can be activated by anyone within the child or young person’s network
- a recognition that mental health is a continuum
- support that is responsive to the young person’s needs.

Our decision trees together with the eco-map create the pathways for prevention and accessing support, the core components of which are:

- the people raising a concern
- who they raise the concern to
- how that person decides what the level of concern is
- what they do in response to this concern
- ongoing monitoring and responding to need.

The roles and responsibilities presented in Appendix 3 are those that the child or young person can expect to support them as they journey through the pathways.

## Introduction

As a society, we trust the state to provide the best possible care to all children who cannot be looked after by their birth families. In their journey through care, the meaning we can give to the life of the young person whose wellbeing rests in our collective hands, the speed with which we respond to the distress of children in care, and the resources we make available to support them in their time of need, all speak to our capacity as a society to safeguard the most marginalised.

The mental health of young people is a focus in our society as never before, and we welcome the government commitment that by 2020 there will be system-wide transformation of the local offer to children and young people. Work has begun with principles of service integration across health, education, justice and social care now feeding into sustainability and transformation partnerships (STPs) and Local Transformation Plans (LTPS) across the country

However, through our Expert Working Group meetings, stakeholder events and Call for Evidence we have learned that too often we are failing these children and young people. Multiple testimonies highlighted that some looked after children and young people are not accessing services when needed, or are being told that their mental health need does not meet service thresholds.

Other evidence in this report highlights that we must change our approach to children and young people's mental health and ensure that services are accessible, flexible and child-centred. The report also highlights the urgent need to transform how we commission, collaborate and work together in local areas to give children in care the same level of support, care and opportunity that we would wish for our own children. We need to build a community both around the child and those caring for them, to ensure that this group of young people are supported to reach their potential.

## Background to the project

In March 2015, the Department for Education and Department of Health published new statutory guidance on promoting the health and wellbeing of looked after children. The guidance acknowledged that almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs.[17]

Alongside the guidance, NHS England and the Department of Health published 'Future in mind',[18] which set out the need for appropriate care pathways and new models of evidence-based care to identify and meet the mental health needs of vulnerable children and young people. It was an expectation that the needs of children in care would be specifically addressed in the delivery of local services.

In September 2015, the House of Commons Education Committee announced its inquiry into the mental health and wellbeing of looked after children. In April 2016, the Committee published its report, including evidence and testimony highlighting the urgent need for action:

> Looked after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement.[19]

## The Expert Working Group

In February 2016, Ed Timpson, Minister of State for Vulnerable Children and Families, announced in evidence to the Education Committee that an Expert Working Group would be created.[19]

The aim was to ensure that the emotional and mental health needs of children and young people in care, adopted from care, under kinship care, or whose placement is formed by a Special Guardianship Orders or other formal legal orders, and those of care leavers, were better met by developing, by October 2017:

- **care pathways**: focusing on the young person’s journey
- **models of care**: how services ensure appropriate interventions
- **quality principles**: measures that set out markers of high-quality care
- **implementation products**: to support those working in the field.

The Expert Working Group has taken a definition of looked after children to include those living in foster homes, children's homes and residential special schools, along with those who have been adopted, are subject to Special Guardianship Orders, living within the secure care and criminal justice systems, asylum-seeking children and care leavers. Wherever we refer to ‘looked after children’ in this report, we mean all of these groups. We acknowledge that within this cohort, children and young people have a diverse range of needs.

Following consultation, Professor Peter Fonagy, Professor of Contemporary Psychoanalysis and Developmental Science, University College London, and Alison O’Sullivan, past President of the Association of Directors of Children’s Services, were appointed by ministers as co-chairs of the Expert Working Group. In April 2017, Alison O’Sullivan handed over her role to Dame Christine Lenehan, Director of the Council for Disabled Children.

The co-chairs were appointed to bring together the perspectives of health and social care, mirroring the close relationships that are needed to improve the mental health support that looked after children need.

The Social Care Institute for Excellence has supported the work of the Expert Working Group, including leading the co-production of this report and developing resources and training to support the project.

Appendix 1 sets out further detail on the membership and work of the group.

## Co-production

A fundamental principle of the project was that recommendations be based on proposals that were supported by the available research evidence, by those directly involved in looking after our most vulnerable young people, and by young people themselves. At the heart of our project were the young people who we talked to through the course of our work, to understand how they felt about mental health support and provision.

> I was told that I needed to talk to a therapist because I had ‘anger problems’. Wouldn’t you be angry if someone dumped you in a family you didn’t know? All I wanted was time to think about my feelings and space to breathe – to get my head around not living with mum anymore – but I was shoved in a room and told to talk to some random person. I wasn’t ready for that and it made things worse.[20]

As well as having young people as members of the Expert Working Group we held sessions with 80 children and young people. Young people contributed through attending the children’s reference group which met three times during the course of the project, or through a targeted group consultation.[21] In the course of this project, we asked young people: What would help when you are having a ‘bad’ day? What type of support do you need? What needs to change? Young people were always asked the same questions, but were given a choice of response methods to ensure that they could contribute in a manner which suited their emotional literacy.

Throughout the course of the project young people expressed their anger and despair at professionals assuming they did not have the capacity to contribute to decision-making. As a result they were often not kept informed about key decisions and presented with child and adolescent mental health services as the only solution. Over 75 per cent of the young people involved in the project cited time alone and having space to breathe, or access to community resources (youth centres, drama, art, sports etc.) as helping most on a ‘bad day’.[22] In order to promote young people’s messages, we have created a new digital platform which will host all of the art, video and creative content that they created during the course of the project.

We also heard from those looking after young people, with almost 100 professionals including foster carers, looked after children nurses, doctors, birth parents, social workers, residential key workers, independent reviewing officers and adoptee parents attending our stakeholder event in April 2017. A further consultation with 20 foster carers took place in May 2017 and with Adoption Together in October 2017.[23]

## What do we know about the mental health needs of children in care?

There are many drivers of poor mental health, including the early and ongoing experiences of many looked after children. This is true both of their experiences leading to them being taken into care and their experiences while in care.

> I used to think it was ironic, that the care system was called the 'care' system, because to me it looked like they should drop the care. The system failed to look after me well enough, which allowed my mental health and emotional wellbeing to not only be neglected, but actually directly making me unwell. Leaving me with my parents for far too long, witnessing extreme domestic violence and being diagnosed with PTSD symptoms aged 3 yet handing me straight back to my parents. To then being placed with a foster carer who never wanted me, both foster carers abusing alcohol and class A drugs, and spending 10 years bullied, controlled and hating my very existence ...[24]

As at 31 March 2017 there were 72,670 looked after children, an increase of 3 per cent on 2016.[25] We know that almost half of all looked after children have a diagnosable mental health disorder.[26] Data collected by the Children's Commissioner in 2015 suggests that while fewer than 0.1% of children in England are in care, 4% of children referred to specialist CAMHS services are in care.[27] We also know that 52 per cent of children in care have low subjective wellbeing compared to around 10 per cent of children in the general population. Additionally there is an increased risk of developmental disorders such as attention deficit hyperactivity disorder and autistic spectrum condition (ASC).[10] Given that the best predictor of psychiatric disorders in adulthood is a psychiatric disorder or disturbance in childhood or adolescence,[3] there is very strong obligation for early intervention with this high-risk group for their present needs and future wellbeing.

In addition to young people currently in care, every year 10,000 young people leave care. The government has acknowledged that:

> Those leaving care may struggle to cope with the transition to adulthood. They may experience social exclusion, unemployment, health problems or end up in custody. Care leavers have had these problems for a long time.[28]

Care leavers also face difficulties accessing child and adolescent mental health services, and they can face even more problems accessing support when they move from children's to adults' services.[28]

> Sometimes there is a disconnect between the social care and the health care system. Young people in care are treated as children up to 25 but for health services they are treated as adults from 18. Young people may not be able to navigate the complex pathways of the health system. They can find it difficult to access services and often have to go to the back of the queue as they don't meet adult services thresholds. Yet their health problems still remain.[29]

NHS England has introduced a nation-wide financial incentive in place from 2017-19 to improve the experiences of young people transitioning out of Children and Young People's Mental Health Services on the basis of their age.[30]

## Call for Evidence

The Expert Working Group also held a call for evidence across the country. A total of 68 practice examples were submitted with a further 14 submissions as proposals or policy responses. Respondents included NHS trusts, third sector organisations, local authorities, private providers, national bodies, university departments, and parents and carers.[31] The richness of oral testimony and evidence from local and national stakeholders enabled the Expert Working Group to consider what good mental health and emotional wellbeing should look like for children and young people. Each meeting looked at different functions and challenges of the system and discussions were supported with presentations by the Social Care Institute for Excellence research team.[32] Our model, pathways, recommendations and quality statements are based on the evidence we collected through the Call for Evidence, from children and young people, via stakeholder events and from in-depth discussions with the Expert Working Group.

Examples from the Call for Evidence that illustrate the principles of good practice as articulated in this report include the following.

### 1. Enhanced screening for younger children

**1a. Social-emotional Under 4's Screening and Intervention (SUSI) (Submission 9)**, was a clinical feasibility study based in Southwark, providing immediate access to assessment and, where indicated, intervention, for children under the age of 4 who become newly looked-after; children of parents referred to the parental mental health team; or children who are new to Child Protection Plans.

### 2. Multi-agency review and planning in relation to looked after children wellbeing

**2a. In North East Lincolnshire specialist child and adolescent mental health service, a monthly multi-agency clinic (Submission 72)** has been formed to review looked after children Strengths and Difficulties Questionnaire results. Where there are scores of concern, a multi-agency clinic decides how best to meet the needs of the person from a health, mental health, care and educational perspective. This differs from normal practice where a Strengths and Difficulties Questionnaire would be completed but there would be no opportunity to discuss or share the results with the agencies. The clinic has also been used to identify and escalate concerns about gaps in mental health provision. All looked after children living in the area, or placed out of area, or placed in the area by other local authorities, are included in the reviews.

**2b. ‘ATTACH’ (Submission 4)** is an assessment and intervention service for all looked after children, adopted and special guardianship order children in Oxfordshire, funded by the local authority and positioned within the department of Children, Education and Families. It offers interventions for carers and young people, working with families with a high level of need who may not meet CAMHS criteria; services also include monitoring high Strengths and Difficulties Questionnaire scores for looked after children in collaboration with the looked after children health team.

### 3. Different models of child and adolescent mental health services to facilitate early identification of need

**3a. Fast track North East London specialist child and adolescent mental health services drop-in (Submission 30)** is a fortnightly drop-in service for social workers to discuss concerns they have about looked after children, receive advice on actions and make referrals to the fast track looked after children child and adolescent mental health services team as appropriate.

### 4. Alternatives to (child and adolescent mental health services) therapeutic services

**4a. ‘No Wrong Door’ (Submission 7) is a multi-agency service model** based in North Yorkshire. Specialist roles are brought together under one roof, and each child or young person is given a key worker and can continue to access the service up to age 25 if needed. A ‘life coach’ (a clinical psychologist) carries out assessments and provides interventions. The model provides for more flexibility than traditional clinical psychology services offered by child and adolescent mental health services. Life coaches are also able to provide consultation, training and supervision to those caring for young people.

### 5. Child and adolescent mental health services delivered in an educational setting

**5a. Lewisham virtual school child and adolescent mental health services team (Submission 25)** is a joint venture between child and adolescent mental health services and the local authority’s virtual school. The team is described as being embedded within the virtual school and its aim is to incorporate a child and adolescent mental health services perspective into the work of the virtual school. This is seen as way of providing a flexible and responsive service to looked after children and young people placed both in and outside the borough.

## What should a good system look like?

As children and young people come into the system, and at key stages of their life, their caregivers and professionals need to demonstrate that they have a strong understanding of the child’s feelings, thoughts and wishes. This community of individuals around the child needs to share its understanding of the child on a regular basis.

Understanding the lens through which the young person sees life, and having a system that communicates and works together, provides a solid platform for the young person to have the resources and support they need to flourish.

Plans drawn up to meet the needs of each individual child should always include their emotional health and mental health needs, with details on how these will be best supported. This should be reflected for every child from the very first care plan submitted to court, through every review and into plans to support leaving care or transition to adult support. An understanding of mental health needs should be through a timely assessment that takes into consideration the key principles of good assessment that we raise in our report.

There was strong evidence throughout the project that caregivers[33] often felt they could not get the support they needed for their child or young person due to high thresholds or due to being excluded from key meetings. This is reflected in the recent report from the CQC which found that local variations in eligibility criteria for CAMHS and in the availability of other services meant that in some areas of England children and young people are unable to access the care and support that they need.[9]

Both the young person and the caregiver should be confident that they can access services from health, education and social care when they are needed. They should also be confident that these agencies will respond collaboratively and flexibly to meet their needs. This includes the caregiver being able to access support and advice for their own mental wellbeing.

There are existing services and support that should promote mental health and emotional wellbeing, but these can be highly dependent on the relationship between the professionals and young people. However, we know through talking to professionals and young people that relationships (e.g. between social worker and child), can be fragile, and that young people can find it difficult to sustain a relationship with social workers because of staff changes and workloads.

This view is supported by the Ofsted ‘Annual social care report 2016’ and the All Party Parliamentary Group for Children Inquiry into Social Care 2017:

> Stability is consistently undermined by staff shortages, high turnover of social workers and multiple care placements, with consequences for the quality of care. In some areas agency staff account for more than 40 per cent of social workers.[34]

## Commissioning and multi-agency collaboration

Good services need good commissioning. Every local authority has a Health and Wellbeing Board which is responsible for the Joint Strategic Needs Assessment;

clinical commissioning groups with responsibility for the sustainability and transformation partnerships; corporate parent committees who lead local arrangements and quality assure service delivery to looked-after young people and care leavers. However, we know that these systems are variable, and there is not consistent learning from the best practice of those who are delivering good care. There needs to be more transparency and accountability in each local area about how services are commissioned and quality assured for looked after children and young people.

The Expert Working Group were very concerned about the number of individuals and organisations that can be involved in a child's care, poor multi-agency collaboration and the capacity of the system to support young people with the most complex needs. There were several testimonies provided by Expert Working Group members of young people who needed inpatient care who could not access a bed and as an alternative were placed in a secure unit or children's home, or who had several placements before they accessed the right support.

The Expert Working Group's concern about insufficient capacity in the system was reflected in the comment made by Judge Munby, the president of the High Court's family division, in August this year. In his judgement on the case of a 17-year-old-girl who could not be provided with an appropriate mental health bed he stated

> If … we, the system, society, the State, are unable to provide X with the supportive and safe placement she so desperately needs, and if, in consequence, she is enabled to make another attempt on her life, then I can only say, with bleak emphasis: we will have blood on our hands.[35]

This supports evidence on the ground and information shared by Expert Working Group members that at the moment the system is not meeting the needs of all our young people with high-level needs who require specialist inpatient care ('Tier 4' provision). The CQC has also identified the availability of suitable inpatient services for children and young people in their local area as a key area for improvement.[9] There is a NHS England program across the country to improve crisis care and community services with an intended £1.4bn further investment.[36] We hope to see this translated into practice and suitably resourced to meet the needs of looked after children and young people

We know that there are some groups of looked after children who are particularly vulnerable to mental health problems. Critically, this includes children and young people with disabilities, who are over-represented in the care system and who can struggle to get mental health support which is tailored to their needs. When commissioning services, local areas must ensure that the needs of all looked after children and young people are met, including those who need more bespoke services.

## Virtual mental health lead

The Expert Working Group's concern that children and young people with complex mental health needs are not getting the mental health support they need led to one of our primary recommendations: the creation of a virtual mental health lead. This reflects the success of the creation of a virtual school head for looked after children, with the same principles of championing the needs of young people, monitoring progress in local areas (including young people out of borough), intervening where needed and promoting best practice, all with a focus on mental health and wellbeing. We see the two roles working closely together.

The virtual mental health lead would have responsibility for:

- system leadership; monitoring mental health and wellbeing plans that local areas have in place for looked after children
- collecting local data to help embed best practice nationally
- providing support and challenge where needed for individual young people
- developing strong multi-agency relationships in particular health, education and social care services

The Expert Working Group discussed at length where this post should be located and the overall consensus was that it should be a health role with the virtual mental health lead having sufficient mental health expertise and professional credibility to communicate with (and, where needed, challenge) other health professionals. However, to effectively deliver improvements, the post-holder must have the skills, credibility and authority to work across all local organisations.

## The corporate parent

The Expert Working Group discussed in detail the role of corporate parenting, which operates at many levels: through those carers who care for children on a day-to-day basis, through local authorities who carry the statutory responsibility to ensure children are well cared for on behalf of the state, and also through national and local agencies. The Expert Working Group were clear that the quality of support and placement stability that a child receives as they enter the system should not depend on where they have been placed.

Equally Expert Working Group members agreed that effective multi-agency collaboration is crucial in meeting the responsibility and duty of the corporate parent. The corporate parent has a dual responsibility, both as the 'parent' and as the provider of services for looked after children. The Expert Working Group is concerned that the latter role is too often given priority and wants to see the corporate parent putting their duty as parent first:

> The corporate parent should enhance a child's quality of life as well as simply keeping them safe. In order to raise ambition for looked after children, elected members and senior leaders must act like 'pushy parents', working hard to ensure the best for looked after children through asking the question, 'is this good enough for my child?[37]

One of the key principles in the Children and Social Work Act 2017 is that corporate parents must act 'in the best interests of and promote the health and wellbeing of children and young people in care'.[38] It is our hope that when the Act comes into effect in 2018 this increases local areas' commitment to children and young people's mental health and the consistency with which services are delivered.

## Child and adolescent mental health services provision

Improvements to mental health provision for our children and young people must be actioned on both a local and national level, building on existing guidance and reports, and on good practice already in place across the country, to deliver more responsive services.

While the government announcement of additional funding for child and adolescent mental health services is welcome, it is too soon to say whether this investment will deliver the significant improvements to services that we all want to see, with shorter waiting times and better, more tailored services. The imminent Green Paper on children and young people's mental health gives an opportunity for the government to set out how it plans to make further improvements for the mental health of all children and young people, including through prevention and access to services.

Increasing funding for child and adolescent mental health services will not deliver improvements to services if the new funding merely replaces funding which has been withdrawn. All parts of the system need to prioritise looked after children and support their mental health and wellbeing through a more coherent and properly funded response to their needs. It is also important to highlight that there is significant pressure on local authority budgets, and a huge knock-on effect on the quality of services available for children outside formal child and adolescent mental health services support – with councils facing a £2 billion funding gap by 2020.

## Stable placements and relationships

Young people themselves say that stability is the most important aspect of their experience of care. In the children's commissioner's latest report on vulnerable children and the stability index she says:

> When children in care have to change their placement, it can lead to relationships with trusted adults being broken. When children in care have to move schools, they can lose ties with friendship groups. Staff turnover in

> residential units and changes of allocated social worker can further unsettle children and young people. We estimate that around 50,000 children in care on the 31st March 2016 (71% of all children in care in England) experienced a change in their placement, school, or their social worker over a 12-month period … across England as a whole around 220 children experienced high instability ... That means they experienced multiple placement moves, a mid-year school move and multiple social worker changes, all within in the same 12-month period.[39]

Placement instability should be seen as both a cause of mental health conditions and an effect of the placement itself. A number of the children and young people we spoke to had experienced multiple placements. One young person said that this can make children in care feel unloved or too damaged to be cared for.

Another factor in placement instability is when carers are not properly supported to help the child or young person in their home. Examples were provided both by the Expert Working Group and through stakeholder consultations where caregivers received no support when living with young people with complex needs.

Caregivers need a supportive environment where their wellbeing is promoted and looked after, so in turn they are better equipped to support the complex needs of the young people they are caring for. Examples submitted through the Call for Evidence that promoted the caregivers’ wellbeing included the following.

- **AdOpt Parenting programme (Submission 44)**[41] is a group-based parenting programme, developed from the KEEP fostering programme, and specifically designed for adoptive parents to help facilitate parenting techniques. It address specific difficulties which adopted children may experience. AdOpt includes an adoptive parent as facilitator, and the programme targets parents and children post-legal order, a time when parents have historically received limited support and which is critical for future family cohesion, child development and wellbeing. The overall programme has been designed for adoptive parents to help facilitate parenting techniques and support that address specific difficulties which adopted children may experience.

- **Fostering Changes Programme National Adoption and Fostering Clinic (Submission 82)**[40] was developed at the Maudsley Hospital, South London, in conjunction with King's College London, in order to provide the practical support and training for foster carers. The approach seeks to train foster carers to maintain children and placements, address behavioural challenges and also to skill them up to thinking about how to collaborate and engage with young people about their mental health wellbeing and concerns.

## Assessment

Children and young people's needs and the support services they require evolve and change over time. The Expert Working Group was adamant that local areas need to be able to provide consistent care and support for the child, with the understanding that any diagnosis, if made, as well as specific needs, will change and adapt over time. Assessment and supporting services must therefore be responsive and flexible. Mental health need is a continuum and cannot be described by a one-off diagnosis. This echoes the findings of 'Future in mind':

> The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.[18]

## Strengths and Difficulties Questionnaire

Done correctly, assessment can be the foundation for providing a comprehensive strategy of support and services, developed in partnership with children and young people and their caregivers.

It was the view of the Expert Working Group, supported by feedback from young people and stakeholders, that the Strengths and Difficulties Questionnaire (SDQ) alone is not an effective way to measure the mental health and emotional wellbeing of young people. Additionally, members advised that it is unable to detect post-traumatic stress disorder (PTSD), attachment disorganisation[42] and developmental issues such as autistic spectrum condition. The Expert Working Group therefore recommend that the SDQ is used in conjunction with other assessment methods.

NSPCC research found that in four local areas surveyed, there was no routine assessment of mental health.[43] Similarly, although the completion of the SDQ for all looked after children has been a statutory requirement since 2009, there is a huge variation in completion rates across local authorities. Between 2014 and 2016 there was only a 75 per cent completion rate in England as a whole, with 15 local authorities completing SDQ for less than 50 per cent of their looked after children and young people, and three authorities failing to report a single use of the tool.[26]

The Expert Working Group spent considerable time discussing the way that need should be formally assessed. Our discussions recognised that looked after children have a range of needs beyond any diagnosis, and assessment should recognise their strengths as well as their challenges.[44]

Assessments should not be done once and then forgotten: they are inevitably a snapshot and as such need to be updated at regular intervals. Assessments should focus on the overall mental health and emotional wellbeing of a looked-after young person and lead to action. Their own, their caregivers', families' (where appropriate) and professionals' viewpoints should all be included.

Young people should be asked who they would like to accompany them to assessments and where possible those wishes should be met. At the end of an assessment, the young person should have an understanding of why the assessment took place, know that they were listened to and understood, and understand what will happen next. Effective assessments must see the young person in the context of the situation they are in, the support they need, the key people in their life and their own perspective on their life and situation. Assessments must also be kept under continuous review.

One of our sessions saw 35 young people from across the country who had accessed provision from early help to specialist inpatient care. In the session, the children and young people were unanimous in their belief that it did not matter who was completing the assessment, but rather how the assessment was done. One young person proposed (and others agreed) that anyone who asked you about your mental health should meet you first 'just to talk and get to know you'. One young person (unsurprisingly) added 'we need to know they care before we share our deepest and darkest feelings'.[45]

## Contemporary challenges

The number of people asking for help with mental health issues is increasing. The voluntary sector and health services report increasing demand for children and young people's mental health care and support.[9] Although increased awareness, improved screening and greater clinical recognition are factors, secular trend studies highlight a general increase in mental illness among children and young people, particularly emotional problems such as anxiety and depression.[2, 46] Whatever the cause(s) of this increase, it suggests that mental health challenges have become more complex and prevalent for all children and young people in recent years. The Expert Working Group was concerned about a number of external influences which can affect the mental health and wellbeing of all young people, including:

- growing up in a digital age
- increased societal inequality
- failure to develop coherent support for children's mental health.

## Children and young people’s recommendations

We asked the 35 children and young people who had accessed provision from early help to specialist inpatient care to create recommendations to include in our report so that their voice is clear and strong. It is right that these are presented before the key findings of the Expert Working Group’s work.

- **Young people need love and kindness**, and interventions should be tailored to this.
- **Not everything is an issue or problem** – sometimes a young person just needs help to take stock and to speak about things.
- **Don’t judge us**.
- **Don’t leave us waiting** for help or without information on decisions that affect us. We want to be involved in what’s happening in our lives.
- If someone gets told they have mental health problems, give them time and space to think about this alone, or process it with a friend/carer. **We need time**.
- Remember **we are still young people**.
- **Don’t treat us differently** because we are in care.
- **Remove barriers** to accessing mental health services. This includes access, location, waiting times and information about how the service can help.
- Let young people be **involved** in deciding what they want or how they receive help.
- **Social workers should be trained** in life story work, talking therapies and anger management.
- If a young person has more complex needs, they should have **access to more advanced therapy**, but if social workers were trained in (above) a lot of issues would be resolved.

## Summary of key findings

1. There was strong testimony from front-line professionals that a needs-based model is the best way to support and respond to young people. A needs-based model allows the child to be placed at the centre of decision-making and where appropriate to exercise choice as to what support they need.
2. Both young people and front-line professionals expressed a frustration at the conventional linear approach to describing care pathways, which over-emphasises reliance on a statutory relationship that may not be the most trusted relationship. A linear pathway also frequently fails to utilise the relationships that may be central to the child or young person. Young people's journeys are not linear and neither are their needs, so effective solutions cannot be solely linear either.
3. Initial and continuing assessment of mental health status is essential for monitoring and meeting needs. There are a range of tools in use that could support the assessment depending on the need of the child or young person. Strengths and Difficulties Questionnaires by themselves are not sufficient. Examples of different methods of assessment can be found in our Call for Evidence.
4. When we asked our young person's reference group who should complete the assessment, they consistently reported that **how** it was completed was more important than by whom. The group were eager to recommend that there is an initial meeting between the chosen professional and the young person before any assessment is done as 'trust and getting to know each other first before you share deep stuff' is crucial for young people. The Expert Working Group supports this recommendation.
5. Statutory services must ensure they allow those who have key relationships with the young person to **contribute** to decision-making. There was evidence offered during the course of the project that people with central current relationships with the child or young person, most commonly the main care-giver,[47] were excluded from decision-making.
6. Caregivers need to be fully aware and informed of what statutory and non-statutory services are available. Additionally, in order to properly support the

young people they care for, caregivers need support for their own mental health and wellbeing.[48]

7. Children and young people want choices outside of child and adolescent mental health services. The most commonly cited examples by children and young people when asked what helps on a bad day were having time out and space to breathe, followed by recreational activity. Self-help (including peer mentoring) and resources within the community should be seen as viable choices for supporting the young person.
8. The Expert Working Group strongly advocates the reframing of accountability for looked after children and young people’s mental health and emotional wellbeing. We believe that there need to be stronger mechanisms of accountability within existing systems which we highlight in our recommendations.
9. Building on the success of the virtual school head, the Expert Working Group believes that a similar oversight role of a virtual mental health lead is needed.
10. Statutory services are becoming much better at consulting children and young people. While this is a welcome step forward, it is only by **collaborating** with young people that we can move beyond services ‘done to’ to services ‘done with’. If young people are not involved effectively from the start, they will disengage with professionals and services and the commissioning of services will not be informed by those using the service.
11. In relation to mental health assessment, the Expert Working Group made key process recommendations that shift control back to the child and young person, including, where possible, a strengths-based approach focusing on enhancing resilience. This is detailed in our pathways and decision trees.

## Recommendations and quality statements

| Quality statement | Key risk | Recommendation |
|---|---|---|
| **Quality statement 1: Commissioning and accountability**<br>Young people's needs are met because there are systems and procedures in place to hold commissioners and providers to account. All those jointly responsible for commissioning have the knowledge and information to work together to make informed decisions that are responsive to children and young people's needs. | There is insufficient accountability in the current system. | 1. Clinical Commissioning Groups should ensure commissioning is informed by a Joint Strategic Needs Assessment (JSNA) which addresses the mental health and wellbeing needs of looked after children and care leavers. This should be reflected in Local Transformation Plans.<br>2. The Local Safeguarding Children Board, Corporate Parent Board and Health and Wellbeing Board should give appropriate priority to ensuring that the mental health needs of children and young people in care and leaving care are met.<br>3. Ofsted, the Care Quality Commission and Her Majesty's Inspectorate of Prisons should review their regulatory frameworks linked to registration to ensure that equal weight and attention is being given to mental and physical health needs.<br>4. The statutory review of the child's care plan by the independent reviewing officers must include at each meeting a review of whether mental health needs have been met. |

| Quality statement | Key risk | Recommendation |
|---|---|---|
| **Quality statement 2: Leadership**<br>Each locality has an accountable, independent virtual mental health lead whose primary responsibility is the mental health and emotional wellbeing of looked after children and young people.<br>This person provides leadership and oversight of the local system and ensures a holistic approach to care is in place, including ensuring that appropriate information is shared with everyone who is involved in the child or young person's care. | There is no consistent leadership for supporting, monitoring and championing young people's mental health. | 5. Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they needed for their emotional wellbeing and health.<br>6. Every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are looked-after.[49]<br>7. Ministers at the Department for Education and Department of Health should work together to ensure children in care and leaving care have access to services provided for their mental health and wellbeing. |
| **Quality statement 3: Workforce**<br>Everyone working directly with the children and young people, including those who are transitioning into adulthood, will have the knowledge, skills and competencies to recognise and respond to their mental health needs. This includes knowing when and how to access support from more specialist services if needed. | Caregivers are not sufficiently supported by the current system, either to access services for the young person they care for or to support their own mental health and wellbeing. | 8. Caregivers need to be informed of which statutory and non-statutory services are available when support is needed for the child or young person. This should be included in each area's local offer. It is crucial that services are funded to support caregivers' training and development.[50] |

| Quality statement | Key risk | Recommendation |
|---|---|---|
| **Quality statement 4: Workforce**<br>Foster carers, special guardians, kinship carers, adoptive parents and those providing first-line support in children's homes are recognised and valued as members of the workforce. They are provided with opportunities for training and development and are included in decision-making. They have access to support and advice from specialist mental health services for their own mental health and that of the child for whom they are caring. | Those working directly with young people do not always receive sufficient training to support complex mental health needs. | 9. Caregivers should receive support for their own mental health and wellbeing.<br>10. Everyone working directly with looked after children should receive training on children and young people's mental health so they are equipped with the appropriate skills. |
| **Quality statement 5: Voice**<br>Children and young people's right to be involved in decision-making that affects their lives is recognised and supported. They are listened to as experts in their own experience by being given opportunities to work with professionals in planning and reviewing their support, including involvement in their care plan and pathway plan. This should be consistent with their individual development, preferences and needs. | The current model of delivering care relies too much on diagnosis and not enough on need.<br>Children and young people are not consistently being offered the platform to contribute to decision-making that affects their lives. | 11. A needs-based model is the best way to support and respond to young people. This model places the young person at the centre of decision-making and where appropriate lets them exercise choice as to how and what support they access. This allows appropriate support to be generated by need, rather than diagnosis.<br>12. Existing mechanisms for capturing direct views of young people should be integral to planning and commissioning arrangements. Local Health Watch services should monitor the effectiveness of mental health care arrangements for children and young people who are looked after, and report their findings to Health and Wellbeing Boards at least annually. |

| Quality statement | Key risk | Recommendation |
|---|---|---|
| **Quality statement 5: Voice (cont)** | Children and young people want choices outside of child and adolescent mental health services. Their views must be listened to and responded to appropriately. Our consultations with children and young people highlighted that children often feel they are **not** given choices as to how to manage their own mental health and wellbeing. | 13. Self-help, peer mentoring and community initiatives should be considered (if a young person expresses this is their preference) before a referral to more formal child and adolescent mental health services. |
| **Quality statement 6: Pathway**<br>Children and young people know what services and support they are entitled to, and what those services provide. An informed and accountable workforce ensures that children and young people can access support that meets their individual needs and preferences, whatever their first point of contact. | A linear pathway can prevent a child or young person from sharing information essential for decision-making, as it places accountability on a statutory relationship that may not be their trusted relationship. | 14. Formal services should be more flexible in who they will allow to support the young person, acknowledging that support can come from a range of services and places. Health, education and social services need to work collaboratively to achieve this recommendation. |

| Quality statement | Key risk | Recommendation |
|---|---|---|
| **Quality statement 7: Assessment**<br>Universal health and wellbeing screening of all looked after children and young people are of a quality to act as an early warning system to identify support needs and prevent problems escalating. Young people and those supporting them meet to assess what the young person wants to achieve, and the help they need to achieve it. Assessments are not a 'one-off' exercise, but are ongoing, with flexibility in format and delivery, according to the individual needs and preferences of the young person. | Strengths and Difficulties Questionnaires (SDQ) by themselves do not capture the full range of emotional and wellbeing needs of a child or young person. Initial and continuing assessment of mental health status is essential for monitoring and meeting needs. | 15. The Strengths and Difficulties Questionnaire should be supported by a broader set of measures which can trigger a comprehensive mental health assessment. There are a range of tools in use that could support the assessment depending on the need of the young person.<br>16. Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms. The young person, their caregivers, family (where appropriate) and professionals' viewpoints should be included. Young people should be able to share who they would like to accompany them to assessments, and where possible those wishes should be accommodated. |

## Model

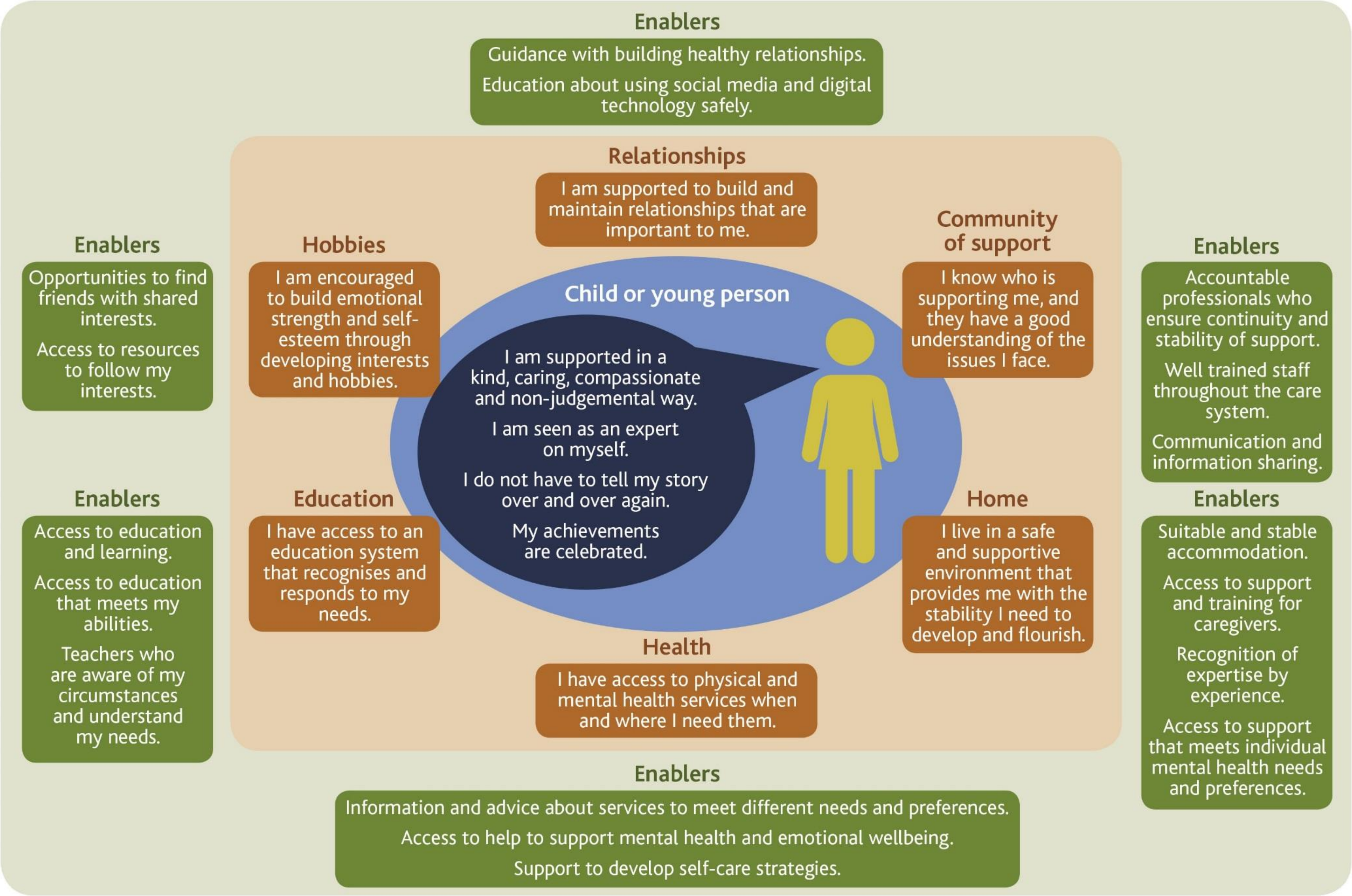
The development of a model that champions the mental health needs of the young person was a key task of the project. The Expert Working Group spent a considerable proportion of its meetings debating and evaluating what relationships and support were critical for a young person.

> A lot of my clinical work is with young people who are sick of being told what they are like, that they are traumatised or [have] attachment disorder or whatever the fashion is in local services, when their own priorities and self-understanding is very different from that of the professional system or carers who claim to know better than them. What is needed is open mindedness, truly collaborative practice and shared formulations.[51]

The group developed a model which places the young person at the centre. The model is based on ‘I statements’ supported by enablers: that is, what good, holistic support for mental health and wellbeing looks like from the perspective of the young person. The principles of the model were supported by evidence presented at the Expert Working Group, the Expert Working Group’s group work, the professionals’ stakeholder event and consultations with children and young people.

In conjunction with the model, a whole system framework of training that prepares and supports carers and professionals, respecting their roles in supporting young people, is crucial. This collaborative approach would both provide those at the front-line of supporting our young people with the resources to respond to and contain a range of behaviours and mental health needs, and ensure that everyone involved in their care is coming from the same understanding and knowledge base. There was a consistent request from stakeholders to have training that focused on how to manage behaviours and individual wellbeing.

## Expert Working Group model



**Enablers**

Guidance with building healthy relationships.

Education about using social media and digital technology safely.

**Relationships**

I am supported to build and maintain relationships that are important to me.

**Enablers**

Opportunities to find friends with shared interests.

Access to resources to follow my interests.

**Hobbies**

I am encouraged to build emotional strength and self-esteem through developing interests and hobbies.

**Child or young person**

I am supported in a kind, caring, compassionate and non-judgemental way.

I am seen as an expert on myself.

I do not have to tell my story over and over again.

My achievements are celebrated.

**Community of support**

I know who is supporting me, and they have a good understanding of the issues I face.

**Enablers**

Accountable professionals who ensure continuity and stability of support.

Well trained staff throughout the care system.

Communication and information sharing.

**Enablers**

Access to education and learning.

Access to education that meets my abilities.

Teachers who are aware of my circumstances and understand my needs.

**Education**

I have access to an education system that recognises and responds to my needs.

**Home**

I live in a safe and supportive environment that provides me with the stability I need to develop and flourish.

**Enablers**

Suitable and stable accommodation.

Access to support and training for caregivers.

Recognition of expertise by experience.

Access to support that meets individual mental health needs and preferences.

**Health**

I have access to physical and mental health services when and where I need them.

**Enablers**

Information and advice about services to meet different needs and preferences.

Access to help to support mental health and emotional wellbeing.

Support to develop self-care strategies.

## Pathways

One of the major findings from our evidence is that the journeys taken to access support are often not linear. For example, a child in care may have a social worker who has the statutory responsibility of referring to child and adolescent mental health services, but their trusted relationship may be with another professional or their main caregiver. In this instance, there would be benefit to the young person being able to utilise their trusted relationship to access support together.[52]

To support our finding, the Expert Working Group developed an eco-map, to be used in conjunction with the accompanying decision trees. The eco-map is a representation of the choices that should be available to the young person and/or primary caregiver to access the right support and resources. The decision trees represent our recommendations for a responsive pathway that places the young person at the centre, and includes those that know them in the decision-making, as appropriate.

At the core of both our model and pathway is the need for:

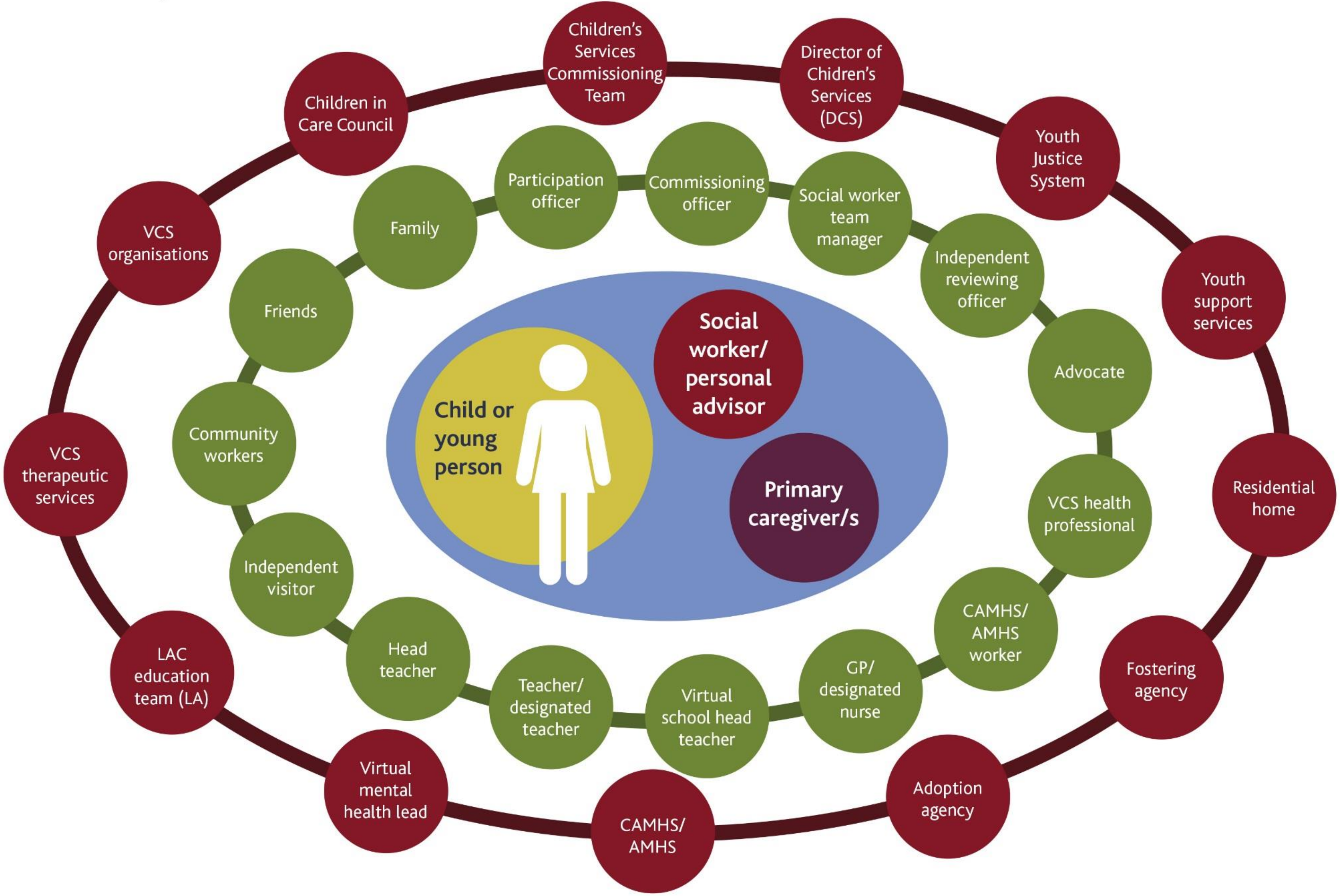
- timely intervention and support
- a system that can be activated by anyone within the child or young person's network
- a recognition that mental health is a continuum
- support that is responsive to the young person's needs.

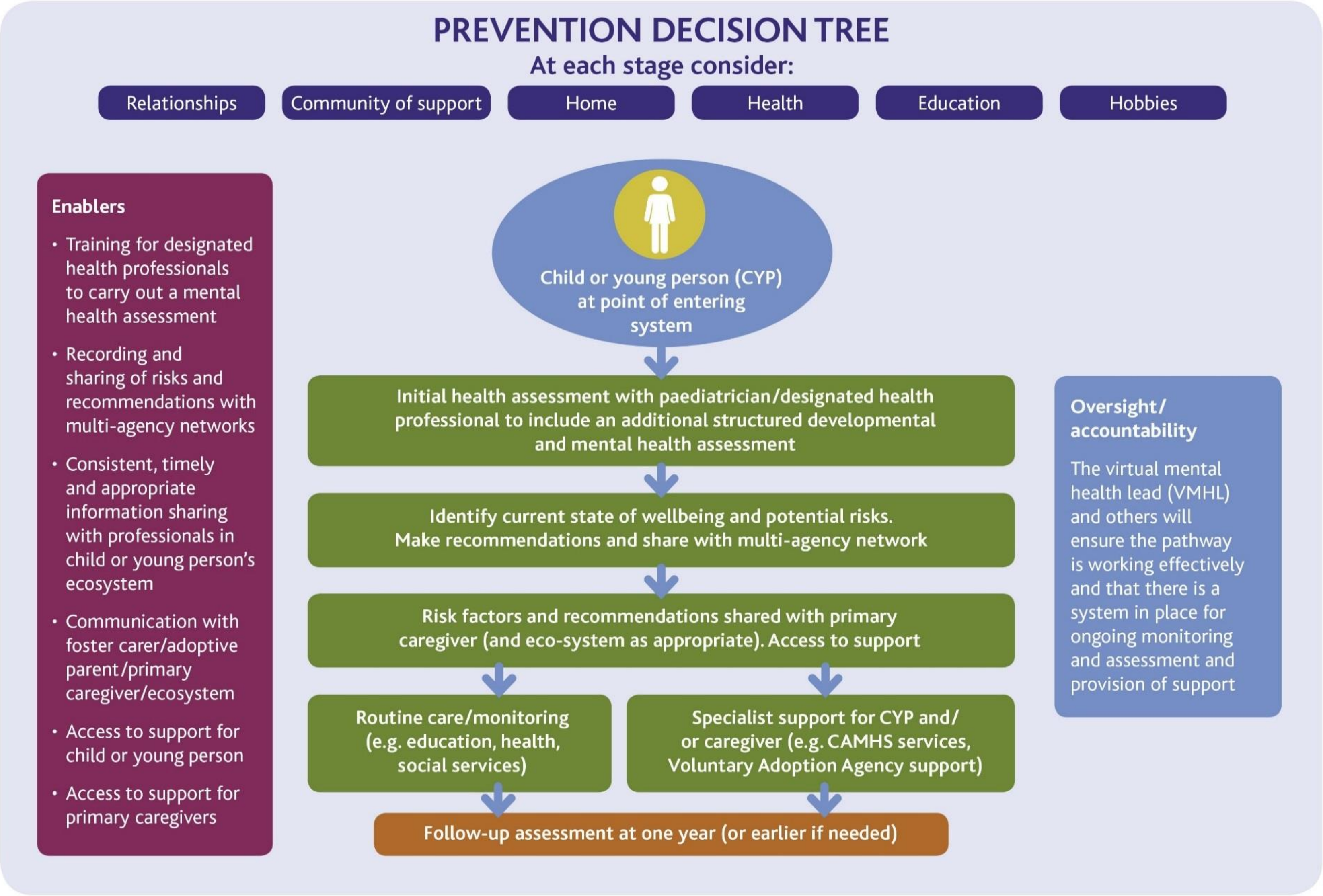
Our decision trees together with the eco-map create the pathways for prevention and accessing support, the core components of which are:

- the people raising a concern
- who they raise the concern to
- how that person decides what the level of concern is
- what they do in response to this concern
- ongoing monitoring and responding to need.

The roles and responsibilities presented in Appendix 3 are those that the child or young person can expect to support them as they journey through the pathways.

**General eco map**





## PREVENTION DECISION TREE

At each stage consider:

Relationships | Community of support | Home | Health | Education | Hobbies

**Enablers**

- Training for designated health professionals to carry out a mental health assessment
- Recording and sharing of risks and recommendations with multi-agency networks
- Consistent, timely and appropriate information sharing with professionals in child or young person's ecosystem
- Communication with foster carer/adoptive parent/primary caregiver/ecosystem
- Access to support for child or young person
- Access to support for primary caregivers

Child or young person (CYP) at point of entering system

Initial health assessment with paediatrician/designated health professional to include an additional structured developmental and mental health assessment

Identify current state of wellbeing and potential risks.
Make recommendations and share with multi-agency network

Risk factors and recommendations shared with primary caregiver (and eco-system as appropriate). Access to support

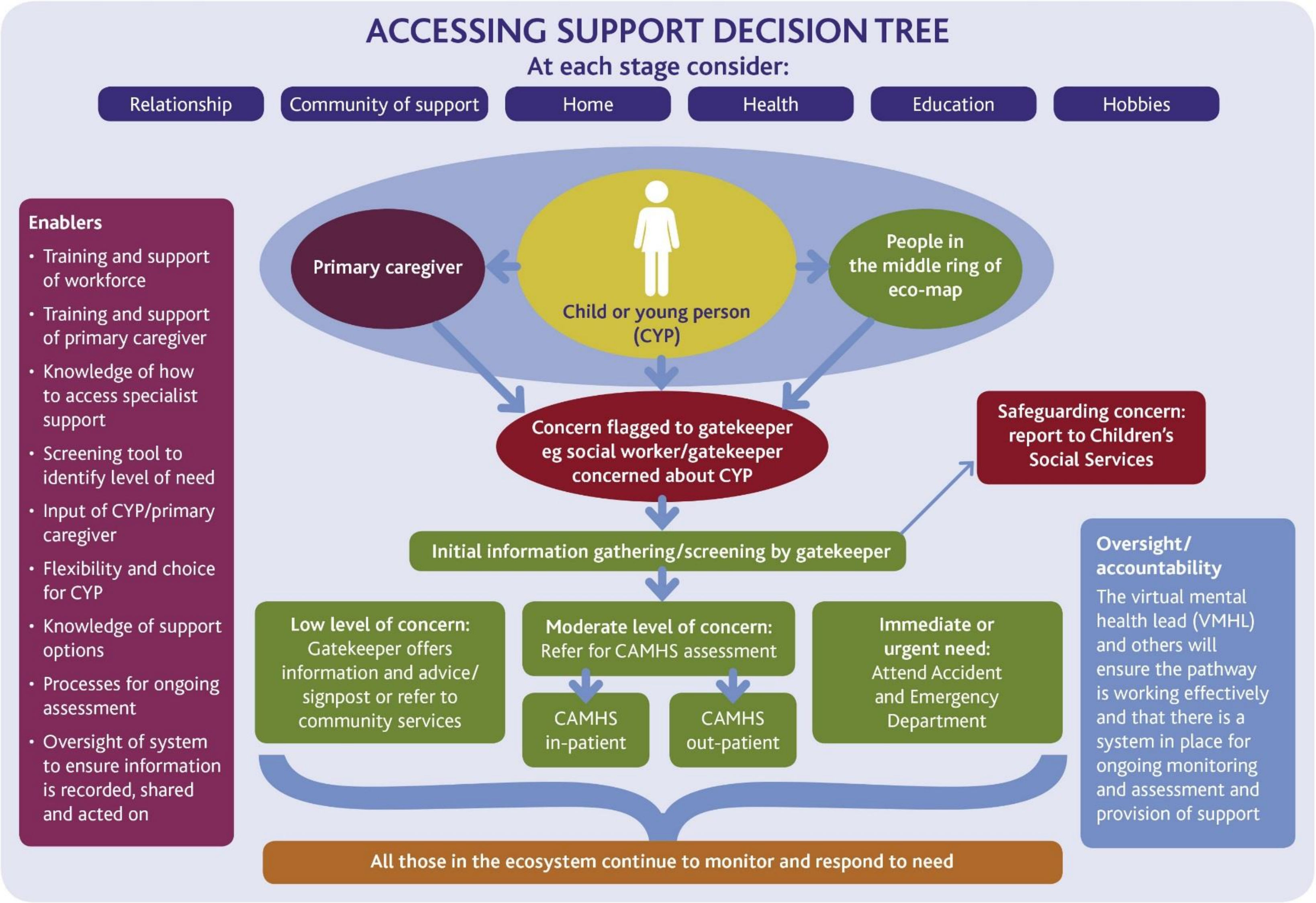
Routine care/monitoring (e.g. education, health, social services)

Specialist support for CYP and/or caregiver (e.g. CAMHS services, Voluntary Adoption Agency support)

Follow-up assessment at one year (or earlier if needed)

**Oversight/accountability**

The virtual mental health lead (VMHL) and others will ensure the pathway is working effectively and that there is a system in place for ongoing monitoring and assessment and provision of support



# ACCESSING SUPPORT DECISION TREE

## At each stage consider:

Relationship | Community of support | Home | Health | Education | Hobbies

**Enablers**

- Training and support of workforce
- Training and support of primary caregiver
- Knowledge of how to access specialist support
- Screening tool to identify level of need
- Input of CYP/primary caregiver
- Flexibility and choice for CYP
- Knowledge of support options
- Processes for ongoing assessment
- Oversight of system to ensure information is recorded, shared and acted on

**Primary caregiver**

**Child or young person (CYP)**

**People in the middle ring of eco-map**

**Concern flagged to gatekeeper eg social worker/gatekeeper concerned about CYP**

**Safeguarding concern: report to Children's Social Services**

**Initial information gathering/screening by gatekeeper**

**Low level of concern:** Gatekeeper offers information and advice/ signpost or refer to community services

**Moderate level of concern:** Refer for CAMHS assessment

CAMHS in-patient

CAMHS out-patient

**Immediate or urgent need:** Attend Accident and Emergency Department

**Oversight/ accountability**
The virtual mental health lead (VMHL) and others will ensure the pathway is working effectively and that there is a system in place for ongoing monitoring and assessment and provision of support

**All those in the ecosystem continue to monitor and respond to need**

## Conclusion

The Expert Working Group’s strength was the wide range of skills and experiences of its individual members. Drawn from across the health, education and social care sectors, its members were committed to transforming the care that looked after children receive. All Group members unanimously agreed that the current system is failing these young people – and at its worst is causing unintentional harm.

Our Call for Evidence found pockets of excellence across the country, however there is not a consistently good offer for the mental health support and provision of looked after children in all local areas. Too many young people are not receiving the support they need, which in turn is having a detrimental effect on their wellbeing. Equally, we are not sufficiently supporting those that are caring for young people, some of whom can have very complex mental health needs.

There has been a consistent message from front-line staff, caregivers, local and national stakeholders and young people themselves that there is an urgent need to transform current service provision and provide a systematic approach across local areas that meets the needs of all children and young people.

Both provision and policy need to be developed alongside the young people that need the service, in a genuinely collaborative way. Local areas cannot develop services for young people without ensuring they are at the heart of informing how those services are commissioned and developed. Likewise, care plans should robustly demonstrate how they are supporting the mental health and wellbeing of individuals while ensuring the young people themselves have been given an appropriate platform to contribute to the decision-making that affects their lives and wellbeing. There are still too many young people who feel they are watching from the side lines rather than being active participants in their own care.

We strongly believe services that view mental health and physical health equally, a coordinated mental health offer from local areas, and a virtual mental health lead to champion quality services, could transform the current system. Our recommendations not only provide a route to change in local areas and commissioning services, but provide a model and pathways to help individuals and service providers navigate through the system.

We have the choice of whether we want our young people to become active citizens that contribute to society or ones that continue to need the support of the state. The system at present creates the latter, with a significant financial burden at a local and national level and the wasted potential of some remarkable young people. Change needs to happen now, and it is our hope that this report provides a platform for the change needed and the necessary call for action.

# Appendix 1: Members of the Expert Working Group

### Expert Working Group co-chairs

Professor Peter Fonagy OBE

Dame Christine Lenehan (April 2017 – November 2017)

Alison O’Sullivan (April 2016 – April 2017)

### Expert Working Group members

Polly Ashmore
Linda Briheim-Crookall
Tony Clifford
Saffron Cuts
Sally Donovan OBE
Richard Field
Councillor Gillian Ford
Sharon Goldman
David Graham
Professor Jonathan Green
Dr Renu Jainer
Cathy James
Chloe Juliette
Matt Langsford
Glynis Marsh
Carol McCauley
Eamon McCrory
Phillip McGill
Steve Miley
Gwyneth Nightingale
Dr Sheila Redfern
Filmon Russom
Dr Miriam Silver
Doug Simkiss
Dr Oliver Sindall
Jan Slater
Billy Smallwood
Jack Smith
Sue Sylvester
Kevin Williams
Dr Matt Woolgar
Linda Wright

### Representatives from the Department for Education

Andrew Baxter
Helen White
Akosua Wireko

**Representatives from the Department of Health**

| | |
|---|---|
| Ellie Isaacs | Shain Wells |

**Members of SCIE staff**

Beth Anderson
Ted Barker
Dr Susanne Gibson
Stephen Goulder
Michaela Gray
Florence Lindsay-Walters
Lucy Milich
Hannah Roscoe

# Appendix 2: The Expert Working Group process

## Establishing the Expert Working Group

The overall aims agreed with the Social Care Institute for Excellence as the contracted social care charity supporting the Expert Working Group, was to ensure that the emotional and mental health needs of children and young people in care, adopted from care, in kinship care, those with Special Guardianship Orders and care leavers were better met. That in the future, children and young people who are looked after would have access to high quality services, from a range of informed professionals and based on a clear assessment of need. To do this the project would develop, by October 2017:

- care pathways – focusing on the journey that a child or young person in need of support might make
- models of care – the organisation and configuration of services to ensure the provision of appropriate evidence-based interventions
- quality principles – clear statements and measures that set out an achievable marker of high-quality and effective care
- implementation plans and products to support the use of the care pathways, models of care and quality principles.

## Membership of the Expert Working Group

The Social Care Institute for Excellence led a nationwide recruitment process for the membership of the Group, who met eight times over the course of the project and provided feedback between meetings. Members of the Group included directors of children's services, foster carers, social workers, designated doctors and nurses, children's home managers, consultant clinical psychologists and psychiatrists**,** local councillors, adoptee parents and care leavers.[53]

> I joined because we all hold a responsibility to continue improving our looked after children's services and I wanted to learn, think and contribute to the development of joined up services. Change can only happen when we all work together.[54]

> As a care leaver I joined the Expert Working Group, because I know it's not just me that has been let down by the care system. I am fed up of hearing speech after speech, announcement after announcement about how things need to change and they don't, by getting involved, I can feel like we're making a difference, hold the top dogs to account and to contribute to improving the care system so that it focuses on what matters most – care.[55]

Our members played a crucial part in our hearing professionals' and young people's voices and considering the best available evidence to assist us in developing a new model of care, pathways and quality statements.

## Project scope

The Expert Working Group's aim was to include the mental health and emotional wellbeing support for looked after children and young people, those adopted, living in kinship arrangements and under Special Guardianship Orders, and for care leavers.

The Group acknowledge that there are both parallels and key differences for each cohort within the population of children and young people described above. For example, there are the children and young people who are living in kinship arrangements with relatives or family friends who are not (or are no longer) looked-after, and whose placement is not formed by a special guardianship or other formal legal order. These children are placed with their relatives and friends often as a result of hardship or trauma, and social services may have been involved with the family.

Within this cohort of young people are asylum-seeking children who have a unique set of challenges that come about from the nature of how they entered the country, what they may have witnessed in their life before this point, and because their support networks of family and friends have been left behind.

Another example is care leavers who can leave care as young as 16, with the expectation of being prepared to live independently, while statistics show that within the general population there are now 3.3 million 20–34-year-olds still living with parents and this number is expected to increase.[56]

There are now 26,340 care leavers aged 19–21. Unfortunately, on average, these young people are far less likely than others to achieve positive outcomes as they reach adulthood. They are far more likely not to be in education, employment or training (NEET), to have poor physical and mental health, to experience abuse and neglect, and to be involved in the criminal justice system.[40]

We fully acknowledge the diverse nature of this cohort of young people. For the purpose of the report, we have referred to the population within scope as looked after children or young people, unless referencing a specific group within that population.

## Stakeholder events and consultations

| Title | Date | Location |
|---|---|---|
| Expert Working Group | 11 July 2016 | Kinnaird House, London |
| Expert Working Group | 12 October 2016 | Kinnaird House, London |
| Expert Working Group | 15 November 2016 | Kinnaird House, London |
| Call for Evidence | 1 January-1 April 2017 | Online |
| Expert Working Group | 26 January 2017 | Kinnaird House, London |
| Children & Young People's Steering Group | 15 February 2017 | Kinnaird House, London |
| Expert Working Group | 7 March 2017 | Kinnaird House, London |
| Professionals' stakeholder event | 13 March 2017 | Friends House, London |
| Children & Young People stakeholder event | 11 April 2017 | St Luke's Community Centre, London |
| Expert Working Group | 26 April 2017 | Kinnaird House, London |
| SCIE Mental Health Support Focus Group – Foster Carers | 24 May 2017 | St Luke's Community Centre, London |
| Expert Working Group | 12 June 2017 | Kinnaird House, London |
| Children & Young People stakeholder event | 14 June 2017 | Location withheld |
| Expert Working Group | 13 July 2017 | Kinnaird House, London |
| Children & Young People's Steering Group | 7 August 2017 | Kinnaird House, London |
| SCIE Focus Group – Adoption Together | 4 October 2017 | Kinnaird House, London |

## Appendix 3: Roles and responsibilities

### Children's Services

Children's Services are ultimately accountable to the Director of Children Services who will be accountable to the Chief Executive and the Lead Member for Children and Young People. These are the only statutory accountable roles aimed at improving outcomes for our children and young people.

**Care Leaver Personal Advisor:** They take over care planning from social worker when the young person is over 16 or a care leaver. They should help with education, training and employment opportunities, as well as advice on housing, money, and health and wellbeing. Accountable to the Team Manager, who is in turn accountable to Director of Children's Services.

**Child Participation Development Officer:** This role can vary but they predominantly sit in the Quality Assurance team and try to encourage children and young people to have a voice and/or hold children's services to account. They will also work with the Children in Care Council and children and young people to ascertain views on services are represented. They are accountable to Quality Assurance Unit.

**Commissioning Officer:** Commissioners in local authorities are responsible for making decisions about which services to buy in, and assure the quality of the service. For children's social care, this would involve decisions about which independent fostering agencies, children's homes, and specialist services to support looked after children, Children's Services should use. Commissioners would also be responsible for negotiating favourable deals and rates with particular providers, in return for using their service a particular amount of time. They are accountable to the Children's Service Commissioning Team. Commissioning of some services may be undertaken jointly with the NHS Clinical Commissioning Group.

**Independent Advocate:** This is a statutory role to ensure that the child or young person is able to express their views, including making a complaint. Local Authorities should provide information about children's rights and arrangements for advocacy services to every child or young person in their care. The Independent Advocate is also responsible for providing information about advocacy services. They are accountable to their Advocacy service.

**Independent Reviewing Officer:** Chairs the Looked After Children Review meetings. This role ensures children and young people's views, wishes and feelings are heard at the meeting. They have oversight of the care plan and can act on behalf of the child in challenging the local authority. They are employed by and accountable to the Local Authority. However the nature of their responsibilities means that they also hold the local authority to account and they must be independent from the immediate line-management of the professionals working with the child or young person.

**Independent Visitor:** This is a voluntary role, independent of the local authority, who visits the child or young person regularly in a befriending and listening role, and will provide a consistency of support. Accountable to the relevant Independent Visitor service that abides by Department for Education guidance.

**Social Worker:** Each looked after child and young person must have a named social worker who is responsible for their care. The social worker will manage the care plan, make decisions about placements, and may make or approve referrals to other agencies. They are accountable to the Social Worker Team Manager, Service Directors and Director of Children's Services.

**Social Worker Team Manager:** They manage a team of social workers and allocate cases to the social worker/personal advisor, and monitor outcome of decisions, whilst giving advice, support and supervision to the team. Accountable to the Director of Children's Services.

## Health Services

**Designated Doctor and Nurse for looked after children:** The Designated Doctor/Nurse has specific roles and responsibilities for safeguarding children and young people. They are a source of expertise for partner agencies and provide strategic advice and guidance to service planners and commissioning organisations. They ensure that a timely and appropriate holistic assessment and health care plan identifies needs of looked after children. Children over five years will receive an annual health review by a Designated Nurse. GPs and primary health staff will also be involved in supporting children and young people with their mental health: as primary care they are often the first point of contact for children and young people having problems with their mental health, after which they may make a referral to local Mental Health services and will be a steady point of contact for young people in their area. They are accountable to their NHS Trust.

**Health Visitor:** Children under five years will receive a six monthly review health assessment by a Health Visitor. They are accountable to the Nursing and Midwifery Council and their NHS Trust.

**Mental Health Worker (children and young people's and adults'):** Children and young people's mental health services (CYPMHS) cover a range of different support offers and professionals. Examples of services could be drop-in centres or self-help support, or more targeted support provided by multi-disciplinary teams that work with children and young people and those who care for them, to support their emotional or behavioural wellbeing (commonly known as 'CAMHS'). Similarly, Adult Mental Health Services (AMHS) will provide support for care leavers with a mental health problem. Some areas offer services for young people between the ages of 16 and 25, or from 0-25, as part of an alternative service model that bridges a number of life transitions such as starting work or going into higher education. There may be a wide range of professionals involved, but service workers often include psychiatrists, clinical psychologists, psychotherapists, social workers, family therapists and mental health nurses and support workers. Children and young people and adult service workers are accountable to their service manager and to their professional bodies; service providers are accountable to commissioners (be it the Clinical Commissioning Group (CCG), NHS England or other commissioners like local authorities) and to NHS Improvement; CCGs are responsible for commissioning services in their area and are accountable to the Health Secretary through NHS England; finally NHS England is responsible for commissioning some specialist services such as inpatient beds and is also accountable to the Health Secretary.

**School Nurse:** Play an important role bridging the gap between health and education, and have a safeguarding responsibility. They are alert to signs of neglect and abuse, and report any concerns they may have. They are accountable to the Nursing and Midwifery Council and their NHS Trust.

## Voluntary and Community Sector

**Community Workers:** This is intended to refer to all those who are in a position to support a child or young person's mental health through voluntary activities such as clubs (sport, drama, music). These activities are in themselves supportive of mental health and emotional wellbeing; at the same time, community workers may be in a position to identify and respond to the individual needs of children and young people. People working in the voluntary sector are accountable to their organisations, which should provide guidance and training on safeguarding.

**Voluntary and Community Health Professional:** Some therapeutic services which are supporting children and young people, and caregiver's mental health and wellbeing are provided by voluntary and community sector. Health professionals employed in the voluntary and community sector are accountable to their organisations, and to their commissioning bodies.

# Education

**Teacher/Designated Teacher:** All maintained schools and academies must have a designated teacher for looked after children. The designated teacher should have lead responsibility for helping school staff understand the barriers and trauma which might affect how children and young people learn and achieve. The designated teacher should have lead responsibility for helping school staff understand how being in care might affect how children and young people learn and achieve. The designated teacher should: promote a culture of high expectations and aspirations; be a source of advice for staff about differentiated teaching strategies appropriate for individual children; make sure looked after children are prioritised in one-to-one tuition arrangements; make sure that carers understand the importance of supporting learning at home, and a voice in setting learning targets; and have lead responsibility for the development and implementation of the child's personal education plan (PEP) within the school; and monitoring the child's progress to ensure the child/young person gets the support needed to achieve their full potential. They are accountable to the school's Head Teacher.

**Head Teacher:** As leader of the school, has greatest responsibility for educational provision and is responsible for ensuring appropriate safeguarding measures are in place in maintained schools and academies, and arrangements for liaising with other agencies where necessary.

**Virtual School Head Teacher:** The lead officer in the local authority responsible for discharging the local authority's duty to promote the educational achievement of its looked-after children, wherever they live or are educated. Virtual school heads are likely to work closely with local authorities' education services, schools and colleges to support the educational achievement of all their authority's looked after children as if they all attended a single school. Accountable to the Local Authority.

# Youth Justice and Youth Support Services

**Youth Justice Board:** The Youth Justice Board seeks to prevent children and young people under 18 from offending or re-offending, and addresses the causes of children's offending behaviour. They ensure custody is safe and secure which adhere to applicable regulations, and oversee youth justice services.

**Youth Support Services (YSS):** These are locally dependent but many of the teams are based in local youth centres to offer accessible local responses and services, and provide Youth Information Advice and Counselling Services. Youth Support Services staff work with partners including health professionals, schools and colleges, the police and voluntary organisations so that support can be tailored to each individual.

## Appendix 4: Case studies

**Please note that these case studies are meant as illustrative examples and do not represent any person/s.**

### Case Study 1: Nathan coming into care

**Prevention**

**Background:** Nathan, aged 11, was placed in the care of the local authority because of ongoing sexual abuse from his father and uncle. He is currently in foster care. Nathan is close to his maternal grandmother and he has told his social worker on several occasions that he would like to live with her. Presently, the social worker is assessing the suitability of Nathan being placed with his grandmother on a Special Guardianship Order (SGO).

**Stage 1: Initial health assessment**

Nathan attends the initial health assessment for all children entering care of the local authority, conducted by a pediatrician or designated health professional. This includes a structured developmental and mental health assessment, with input from Nathan's school, social worker, Grandmother and foster carers.

**Stage 2: Identify current state of wellbeing and potential risks**

The initial health assessment identifies that Nathan has complex trauma and the recommendation is a referral to CAMHS for further assessment and support. Additionally, the assessment identifies the importance of Nathan's grandmother as part of his support network and recommends that Nathan and his grandmother are supported to continue contact.

**Stage 3: Risk factors and recommendations shared**

The assessment and risk factors are shared with professionals working with Nathan including social worker, foster carers and grandmother.

**Stage 4: (4a) Routine care and monitoring (4b) Access to specialist support**

Nathan's social worker is responsible for ensuring he has access to specialist support **(4b)**

- Nathan has a CAMHS assessment and is offered weekly counselling with a psychologist
- Nathan's foster carers are able to contact the CAMHS team for advice and support.
- Nathan's social worker arranges for Nathan to visit his grandmother and informs the grandmother of developments in the assessment and decision-making process regarding the SGO. The grandmother is given information, advice and support to help understand the impact of Nathan's experiences.

**Stage 5: All those in eco-system monitor and respond to need. There will be a follow up assessment at year 1 (earlier if need changes)**

Nathan's **social worker** has case responsibility of recording his care plan, and ensuring information is shared appropriately with the **foster carers, grandmother** and **CAMHS workers.** The **social worker** organises the looked after children's review meetings which is chaired by the **Independent Reviewing Officer (IRO)** who ensures Nathan's voice is heard, and that the care plan is put into action. The **Children's Services team manager** has oversight of ensuring that Nathan's social worker is working effectively. Nathan's **CAMHS Psychologist** should share information appropriately about Nathan's progress.

# Case Study 2: Charlotte in Foster Care Placement

**Background:** Three months ago, Charlotte, aged 12, was initially removed from her family under Section 20 due to neglect. The local authority successfully applied for a care order but Charlotte is struggling to come to terms with her removal from her family. Her two siblings were also placed in care but she has not seen them since she was separated. Charlotte's social worker referred her to CAMHS but Charlotte has not been seen yet. She has recently started a new school. At school, Charlotte is quiet and engaged in art classes. During one of the classes Charlotte rolls back her sleeve to avoid getting it dirty, and her friend James notices that she has self-harm marks on her arm. Charlotte quickly rolls back her sleeve when she sees James looking, but he is very concerned about his friend and speaks to the art teacher after class.

### Stage 1 and 2: Who is involved and appropriate concern flagged

Professionals in the middle of the eco-map who are accountable – The art teacher reports what James has said to the Designated Teacher, and the advice is to have a conversation with Charlotte and talk to her about what will happen next. Her art teacher talks with Charlotte and explains that the information will be shared with her social worker, foster carers and Looked After Children Nurse. Concern flagged to gatekeeper, Charlotte's Social Worker because Charlotte is under 18.

### Stage 3: Initial information gathering/screening

Charlotte's social worker conducts an assessment to identify Charlotte's level of need. This includes inviting Charlotte and her foster carers to a meeting to discuss the options to address her mental health and wellbeing needs. Charlotte is encouraged to talk about the kind of support she would like. Her foster carers do not have any previous experience of self-harm and feel that they need to be supported in order to sustain the placement.

### Stage 4: Referral and concern level

Charlotte's social worker records a moderate level of concern **(4b)** and contacts CAMHS to make an appointment:

- Charlotte is able to access Tier 3 CAMHS. She meets with a CAMHS mental health worker and is offered counselling, which she refuses.
- CAMHS offers her a community run art based therapeutic intervention, which she agrees to attend if her aunt can take her to the first session.
- Foster carers are able to consult with the CAMHS team for ongoing support.
- Foster carers undertake training in mental health first aid course with their Fostering Agencies. The Agency also arranges the foster carers to join a peer support group.
- The teacher is able to work with the designated teacher to develop Charlotte's Personal Education Plan to ensure that Charlotte has access to the right support.

### Stage 5: All those in eco-system monitor and respond to need

Charlotte's **social worker** has case responsibility of recording her care plan, and shares information appropriately. The **social worker** organises the Looked After Children review meetings. This is chaired by the **Independent Reviewing Officer (IRO)** who ensures Charlotte's voice is heard. The Children's Services **team manager** has oversight of ensuring that Charlotte's social worker is working effectively. Charlotte's **teacher and designated teacher** shares the Personal Education Plan in Looked After Children review meetings, and they are aware of the escalation process if Charlotte's self-harm increases. The **teacher** updates everyone on the extra tuition sessions. Charlotte's **community mental health worker** has agreed that she will keep in touch with social worker and foster carer to ensure that Charlotte keeps attending the art based intervention. It is understood that if the art therapy is not successful another alternative will need to be identified. **CAMHS mental health Worker** records and updates all on Charlotte's progress.

## Notes

[1] Hussey, J.M., Chang, J.J. and Kotch, J.B. (2006) ‘Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences’, Pediatrics, vol 118, no 3, pp 933–942.

[2] Fink, E., Patalay, P., Sharpe, H. et al. (2015) ‘Mental health difficulties in early adolescence: a comparison of two cross-sectional studies in England from 2009 to 2014’, Journal of Adolescent Health, vol 56, no 5, pp 502–507.

3 Fryers, T. and Brugha, T. (2013) ‘Childhood determinants of adult psychiatric disorder’, Clinical Practice & Epidemiology in Mental Health, vol 9, pp 1–50.

4 Metropolitan Police (2017) Figures released ahead of National Child Sexual Exploitation Awareness Day. Available at **http://news.met.police.uk/news/figures-released-ahead-of-national-child-sexual-exploitation-awareness-day-227196**

5 Hussey, J.M., Chang, J.J. and Kotch, J.B. (2006) ‘Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences’, Pediatrics, vol 118, no 3, pp 933–942.

6 Department for Education (2017) Children looked after in England including adoption: 2015 to 2016, London: DfE.

7 Throughout the report we refer to CAMHS as this was the term most commonly used by frontline staff and members of the EWG. However, we recognise that during the consultation for Future in Mind, the decision was made based on evidence from children and young people to replace the term with Children and Young People’s Mental Health Service (CYPMHS). This term is intended to be more inclusive of the full spectrum of mental health services for children and young people.

8 Frith, E. (2017) Access and waiting times in children and young people’s mental health services, London: Education Policy Institute. Average maximum waiting times to assessment decreased from 508 days (2012-2013) to 266 days (2016-2017); average maximum waiting times to treatment decreased from 761 days (2012-2013) to 490 days (2016-2017).

9 Care Quality Commission (2017) Review of children and young people’s mental health services, Newcastle-upon-Tyne: CQC

10 Green J, Leadbitter K, Kay C, Sharma K. (2016) Autism Spectrum Disorder in Children Adopted After Early Care Breakdown. Journal of Autism and Developmental Disorders, vol 46, no 4, pp 1392 – 1402

11 Kay C, Green J. (2013) Reactive attachment disorder following early maltreatment: Systematic evidence beyond the institution. Journal of Abnormal Child Psychology, vol 41, no 4, pp 571-581.

12 Woolgar, M. and Baldock, E. (2015), Attachment disorders versus more common problems in looked after and adopted children: comparing community and expert assessments, Child and Adolescent Mental Health, vol 20, no 1, pp 34–40.

13 Both at our stakeholder event and foster carer event, main caregivers highlighted not knowing what services were available and/or not being able to access support from those services.

14 We welcome the current consultation on DfE guidance on increased responsibility for mental health and wellbeing for the virtual school head and designated teacher. This is a direct outcome of Children and Social Work Act legislation.

15 This is in line with current person-centred policy initiatives, for example the Integrated Personal Commissioning programme, which includes children and young

people with complex needs in its cohorts. **https://www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/**

16 The scope of the EWG covers children and young people with a range of legal statuses. The above example is used to illustrate how the pathway could work for a child in care, however we have produced a range of eco pathways and a decision tree to suit the wide cohort of children and young people the project was asked to consider.

17 Department for Education and Department of Health (2015) Promoting the health and Wellbeing of looked after children, London: DfE/DH.

18 Department of Health, NHS England (2015) ‘Future in mind: promoting, protecting and improving our children and young people’s mental health and wellbeing’, London: DH, NHSE.

19 House of Commons Education Committee **(2016) Mental health and well-being of looked after children, HC 481**, Paragraph 11, London: HCEC.

**20** Fifteen-year-old girl in foster care, SCIE Children and Young People’s group February 2017.

21 An individual consultation was held for unaccompanied asylum-seeking children.

22 Young Person’s Stakeholder event, 11 April 2017. All media created by young people is available at **https://www.scie.org.uk/children/care/mental-health/young-peoples-views/young-peoples-artwork**

23 All information from consultations is available at **https://www.scie.org.uk/children/care/mental-health/findings**

24 ‘Expert by experience’ written testimony to SCIE, 28 July 2017.

25 Department of Education, (2017) Children looked after in England, year ending 31 March, London: DfE Available at **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/647852/SFR50_2017-Children_looked_after_in_England.pdf**

26 Channa, K. (2017) A healthy state of mind, London: LOCALIS. Forty-two per cent of 5–10-year-olds compared to 7.7 per cent of that age group overall, and 49 per cent of 11–16-year-olds compared to 11.5 per cent of the comparable overall population.

27 Children's Commissioner (2016) Lightning review: access to child and mental health services, London: Children's Commissioner for England

28 National Audit Office (2015) Care leavers' transition to adulthood Available at **https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf**.

29 David Graham, national director of the Care leavers Association.

30 Age-based Transitions out of CCG-commissioned CYPMHS has been included as one of 13 mandatory national indications in the Commissioning for Quality and Innovation (CQUIN) payments framework in 2017-19. This sets out a framework for joint-agency transition planning with young people at its heart, to enable better transition experiences for young people. It will apply to all transitions out of CCG-commissioned CYPMH services, whether to adult mental health services, to other relevant CCG-commissioned local services (such as a service for young people with a learning disability), or discharge.  A national data collection is taking place in 2018/19 to review the scheme.

31 The full findings of our Call for Evidence can be found at: **http://www.scie.org.uk/children/care/mental-health/findings/call-evidence-findings**.

32 All minutes of the EWG can be found at: **http://www.scie.org.uk/children/care/mental-health/about-the-project/expert-working-group**.

33 For the purpose of the report, caregiver refers to those directly caring for the child or young person. This includes foster carers, kinship carers, special guardianship orders, adopted parents and residential key workers.

34 All Party Parliamentary Group for Children (2017) No good options: report of the inquiry into children's social care in England, London: National Children's Bureau

35 Munby, J. (2017) In the matter of X (A Child) (no.3) EWHC 2036 (Fam) **https://www.judiciary.gov.uk/wp-content/uploads/2017/08/x-a-child-no-3-2017-ewhc-2036-fam-20170803.pdf**

36 NHS England is part way through a programme to improve access to mental health services for children and young people. This includes the opening 150-180 new in-patient beds, rebalancing bed distribution across the country, and improving crisis and community care. NHS England has committed to eliminating inappropriate admissions for children and young people by 2020/21. The programme is explained by a short animation available at **https://www.england.nhs.uk/mental-health/cyp/children-and-adolescent-mental-health-service-inpatient-services/**

37 Ofsted (2016) 'Annual social care report', Manchester: Ofsted

38 Children and Social Work Act 2017 **http://www.legislation.gov.uk/ukpga/2017/16/pdfs/ukpga_20170016_en.pdf**

39 Children's Commissioner (2017) 'A rapid review of sources of evidence on the views, experiences and perceptions of children in care and care leavers', London: Children's Commissioner for England

40 For further information, see Call for Evidence, p 18

41 For further information, see Call for Evidence, p. 35

42 Tarren-Sweeney, M. (2007) ‘The Assessment Checklist for Children – ACC: a behavioural rating scale for children in foster, kinship and residential care’, Child and Youth Services Review, vol 29, no 5, pp 672–691.

43 Bazalgette, L., Rahilly, T. and Trevelyan, G. (2015) ‘Achieving emotional wellbeing for looked after children: a whole system approach’, London: NSPCC

44 McCrory, E.J., Gerin, M.I. and Viding, E. (2017) ‘Annual research review: childhood maltreatment, latent vulnerability and the shift to preventative psychiatry – the contribution of functional brain imaging’, Journal of Child Psychology and Psychiatry, vol 58, no 4, pp 338-357

45 Children and Young People’s Event, 11 April 2017.

46 Collishaw, S.  (2015) ‘Annual research review: secular trends in child and adolescent mental health’, Journal of Child Psychology & Psychiatry, vol 56, no 3, pp 370–393.

47 The project acknowledges that the legal status and contact allowed with birth families can vary significantly from child to child. Our evidence was primarily focused on main care-givers including residential staff in children’s homes, however we recognise that there are birth families that can and should contribute to the process, where legally appropriate.

48 Both at our stakeholder event and foster carer event, main caregivers highlighted not knowing what services were available and/or not being able to access support from those services.

49 We welcome the current consultation on DfE guidance on increased responsibility for mental health and wellbeing for the virtual school head and designated teacher. This is a direct outcome of Children and Social Work Act legislation.

50 Both at our stakeholder event and foster carer event, main care-givers highlighted not knowing what services were available and/or not being able to access support from those services.

51 Member of EWG, written submission to SCIE July 2017

52 The scope of the EWG covers children and young people with a range of legal statuses. The above example is used to illustrate how the pathway could work for a child in care, however we have produced a range of eco pathways and a decision tree to suit the wide cohort of children and young people the project was asked to consider.

53 The membership of the EWG can be found here: **http://www.scie.org.uk/children/care/mental-health/expert-group/**.

54 Steve Miley, director of children's services, EWG member.

55 'Expert by experience' written Testimony to SCIE, 28 July 2017.

56 Office for National Statistics (2016) 'Why are more young people living with their parents?' **https://visual.ons.gov.uk/living-with-parents/**

# Improving mental health support for our children and young people

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Sandwell and West Birmingham
Clinical Commissioning Group

Sandwell
Metropolitan Borough Council

healthcare
without boundaries

# Sandwell CAMHS Transformation Plan REFRESH 2017 & beyond

**Diane Osborne**

**SWB CCG**

**10/30/2017**

# Contents

## Version Control

| Date | Comments |
|---|---|
| 16.10.2017 | Initial draft V.01 |
| 19.10.2017 | Amended following brief consultation V.02 |
| 20.10.2017 | Final draft submitted to NHSE V.03 |
| 30.10.2017 | Final Doc, following full assurance from NHSE V.04 |
| | |

## Forward

I was very pleased to be asked to write the foreword for this transformation plan-refresh for SWB CCG. As one of the mental health leads, I consider children and young people's (CYP) mental health services are absolutely critical. Mental illness destroys lives. 50% of all lifetime cases of mental illness begin by age 14, 75% by age 24; approximately 50% of students age 14 and older with a mental illness drop out of high school and even more critically suicide is the third leading cause of death in youth ages 10 - 24.1

Implementing the Five Year Forward View for Mental Health lays out a blueprint for the delivery of the recommendations over the coming years to 2020/21.2 Aims include a significant expansion in access to high-quality mental health care for children and young people, developing new and innovative alternatives to in-patient admissions and developing new services for children and young people for a range of conditions which have previously been underfunded- if mental health services are the "Cinderella service" of our NHS, Child and Adolescent Mental Health Services (CAMHS) are the Cinderella Service of Cinderella Services.3

One distinct benefit of the transformation plans is the need for different services, organisations and professionals including the NHS, public health, children's social care, education and youth justice, children and young people and their families to work together and co-produce the best possible services. This refresh document is a update on our progress to provide transformed child and adolescent mental health services in Sandwell. We know that Sandwell is a vibrant area and welcomes new arrivals from the EU and beyond. We must be alert to this though and ensure that as demographics change our services are able to adapt and be flexible enough to provide equitable provision and reduce health inequalities.

We have been working hard to improve access for children and young people to specialist mental health services and to reduce waiting times and increasing numbers of staff are now being trained to provide psychological therapies or children and young people. Key areas that are supporting this are the development of the single point of access which offers children and young people rapid access to a range of professionals including third sector workers too. Sandwell is highly innovative in having a comprehensive 'tier 2' service which provides psychological therapies and support, reducing the need for referrals to speciality CAMHS.

Whilst this is taking place, there is a change in the wider landscape of commissioning with the implementation of STPs (Strategic Transformation Plans), which aim to develop services that are consistent in their approach, have the same outcomes and to reduce variation; improve access, choice, quality and efficiency; and develop new highly specialised services in the Black Country e.g. Children's Tier 4, secure services Conditions that benefit from a strategic approach to planning and

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[1] Merikangas KR.et al. 2010. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study. Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. Oct;49(10):980-989.

[2] Implementing the mental health forward view. NHS England, 2017

[3] Reforming young people's mental health services is a crucial mission for us in delivering a fairer society. https://www.libdems.org.uk/reforming_young_people_s_mental_health_services_is_a_crucial_mission_for_us_in_delivering_a_fairer_society

development include Eating disorders and crisis care home treatment and we are very pleased to announce that we now have a fully compliant eating disorder service which is a big step forward in treating this condition.

We hope that this refreshed plan will show that we are moving closer to the service envisaged by children and young people in one of the initial engagement events which offer choice, access and personalised care as their key components. By building capacity and capability across the system and investing in comprehensive services we are making measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes.

Dr Liz England
SWB CCG Mental Health Clinical Lead
RCGP Mental Health Clinical and Commissioning Lead

# Sandwell CAMHS 'Refreshed' Transformation Plan

## Introduction

Following the publication of "Future in Mind" – promoting, protecting and improving our children and young people's mental health and wellbeing (report of the government's Children and Young People's Mental Health Taskforce in 2015), Sandwell & West Birmingham Clinical Commissioning Group worked with partners to develop its 'Sandwell' Local Transformation Plan for Children and Young People's Mental Health and Wellbeing for the period 2015 -2020.

The CCG submitted its Transformation Plan (see appendix 1) in October 2015 and it was fully assured with an **88%** assurance rating from NHSE.

Links to the original Transformation Plan can be found here
http://sandwellandwestbhamccg.nhs.uk/publications/policies

Our LTP set out the local areas joint response to Future in Mind, including the use of new resources. CCGs received a total of £149M in 2016-17 and will receive £170m in 2017-18.

The requirement to produce a further refresh, of LTPs was set out in the Planning Guidance, for implementing the Five Year Forward View for Mental Health. **NHSE expect that refreshed plans will document and represent significant progress from the initial submission in 2015.**

The aim of this refresh is to confirm that there is, and has been transparent commitment and local engagement in 2017/18 to deliver existing planning commitments for CYP MH&WB and to make the necessary preparations for future years.

Following submission of this refresh (October 2017) which includes information requested via the KLOE (appendix 2) and assurance from NHSE. We should be able to confidently confirm that intentions/plans are progressing and are backed by a substantive and transparent commitment with system-wide partners which is reflected in demonstrable progress towards the building of improved access, capacity and capability since the first LTP in 2015.

Sandwell's LTP is a 'living' document. The joint work to improve outcomes set out in the initial plan, requires continued commitment to working together to ensure success. Sandwell's plan has now been in place for over 2 years, this refresh will reflect local progress, showcase impact/outcomes to date and inform on further ambitions.

## Sustainability & Transformation Plan (STP)

The Five Year Forward View for Mental Health (2016), the CCG Improvement and Assessment Framework (2016/17) and Implementing the Five Year Forward View for Mental Health (2017) describe NHS England's detailed improvement blueprint for mental health to 2020 which has been developed in partnership with patient groups, clinicians and NHS organisations.

Achieving 'mental health parity of esteem' includes a focus on the performance management of CCGs regarding equity of access to evidence based care and treatment, equity of status in the measurement of mental health outcomes (i.e. including the April 2017 MHSDS) and equity of funding in terms of the CCG Mental Health Investment Standard but also with release of NHS England targeted investment funding. NHS England mandated mental health transformation programme presents challenges but also great opportunities for the Black Country & West Birmingham STP (BC&WB STP) CCGs with key improvements and benefits for our registered populations.

The 'Working as One Commissioner' work programme will collaboratively commission a set of services to strengthen and energise the CCGs delivery of the improvement blue print for Mental Health both in terms of the delivery of transformed service models and CCG targets.  The set of services that commissioners have agreed to collaboratively commission from providers are as follows:

- Early Intervention in Psychosis (EIP)
- Perinatal services
- Eating Disorders (all age)
- Personality Disorder
- Criminal Justice
- Core 24 psych liaison
- 136 suite
- Memory Clinics and Dementia front end (i.e. diagnosis and assessment)
- Neuro-Developmental services
- LD service (Community assessment and treatment)
- **CAMHS**
  1. **Eating disorders**
  2. **'Core' CAMHS**
  3. **Crisis**

Across the Black Country & West Birmingham STP, gaps have been identified across: Crisis & Intensive Community Support, Paediatric Liaison, 24/7 coverage 365, Capacity to offer intensive support in the community and in-reach into CAMHS TIER 4 Units and tri-partite funded packages to facilitate repatriation / discharge to community settings.
In addition there is evidence that there are difficulties associated with:

- Delayed discharges
- Long hospital stays
- High rates of hospital re-admissions
- Admissions to Paediatric Wards and Departments with lengthy waits for Tier 4 admission or gatekeeping and / or development of the appropriate care plan

Our collective experience as CAMHS commissioners is that the needs and requirements of our CAMHS population has changed, in a manner which requires response on a footprint that can deliver locally whilst benefitting from sub-regional collaboration. We are aiming to bridge hospital and community services to deliver a dynamic CAMHS 'Whole System' to build upon and develop local and sub-regional capacity and capability and utilise a set of standardised care pathways that are NICE compliant utilising the framework of the Care Programme Approach as the overarching delivery model, building on our successes i.e. reductions in admissions to TIER 4 in 2016/17 across our footprint.

This will ensure improved responsiveness and access across the system, with a focus upon integration, early intervention and prevention and reducing the impact on the Acute and Community Trusts. In essence we aim to align our processes, systems and care pathways across our STP working with NHS England to develop TIER 3PLUS Services to impact upon:

- Delayed discharges
- Long hospital stays
- High rates of hospital re-admissions
- Large numbers of patients (30%) placed outside the West Midlands
- Large numbers of referral into Tier 3
- Large numbers of admissions and referrals to paediatric wards/A&E
- Lengthy waits for Tier 4 admission or gatekeeping and / or development of the appropriate care plan.

We will unify our systems, reporting and recording across our Mental Health and Acute & Community Trust for all patient records and all HRG, ICD 10 and other recorded data to provide better information at patient, service and system level. We will work with providers to ensure they meet the requirements of the transformation agenda including the: Mental Health SDS, national KPIs, waiting and access standards.

Each CAMHS commissioner across the STP footprint has agreed to lead on a work-stream. T&F meetings have commenced to ensure that service specifications are drafted by October 2017.

In addition to the above planned activity, partners have also agreed to develop a 'suite' of ROMs for all CAMHS provision across the STP footprint. ROMs will be initially piloted in both the ED & Crisis service. The ultimate vision for the CAMHS provision across the STP is that we will only commission for outcomes, and that the ROMs used will be pathway focused!!

Link to STP
http://sandwellandwestbhamccg.nhs.uk/images/161020_Black_Country_STP_-_October_Submission_V0_8_clean.pdf

## Transparency & Governance

The CAMHS Transformation Board (Executive Director Level) oversees the delivery of the local transformation plan. The Transformation board reports into the Health and Wellbeing Board and the Childrens Joint commissioning Board. The programme of work is managed by the Children and Young People's Emotional Wellbeing and Mental Health Group (EWMHG) (Operational Management Leads). Working groups (Teams/Service Managers) reporting to the EWMHG are responsible for informing and implementing specific areas of work that are developed as part of the plan.
The CAMHS transformation board is represented by:

- ✓ Accountable Officer for CCG
- ✓ Director of Public Health
- ✓ Director of Children's Services
- ✓ Schools Head teachers
- ✓ CAMHS Clinical Director
- ✓ GP Clinical Leads
- ✓ Voluntary sector
- ✓ NHSE
- ✓ Provider clinical lead
- ✓ Engagement lead (Brook)

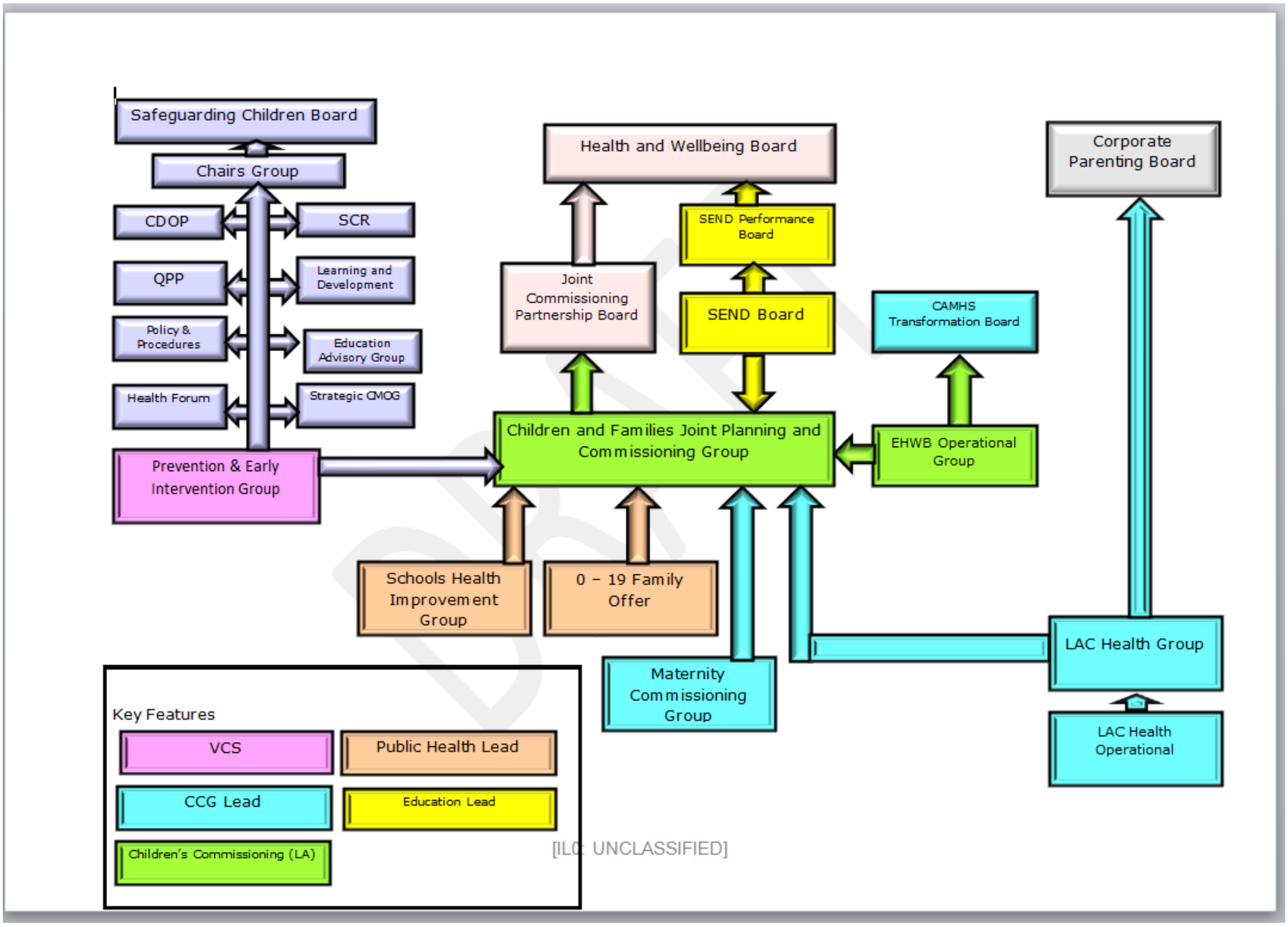
The Board oversees the delivery of the plan and ensures that risks are managed appropriately. Sandwell's Governance arrangements reflect individual's accountabilities whilst also creating a basis for collective action. They are inclusive, and as such ensure that those involved in delivering and receiving services are meaningfully involved in decision-making, and able to co-ordinate the range of activities necessary to meet the plans ambitious objectives

The governance arrangements allow leaders to work collaboratively, using a system leadership approach, based on negotiation and influence, and importantly underpinned by clinical leadership and the engagement of frontline clinical staff. This ensures that Sandwell is able to deliver on changes needed.

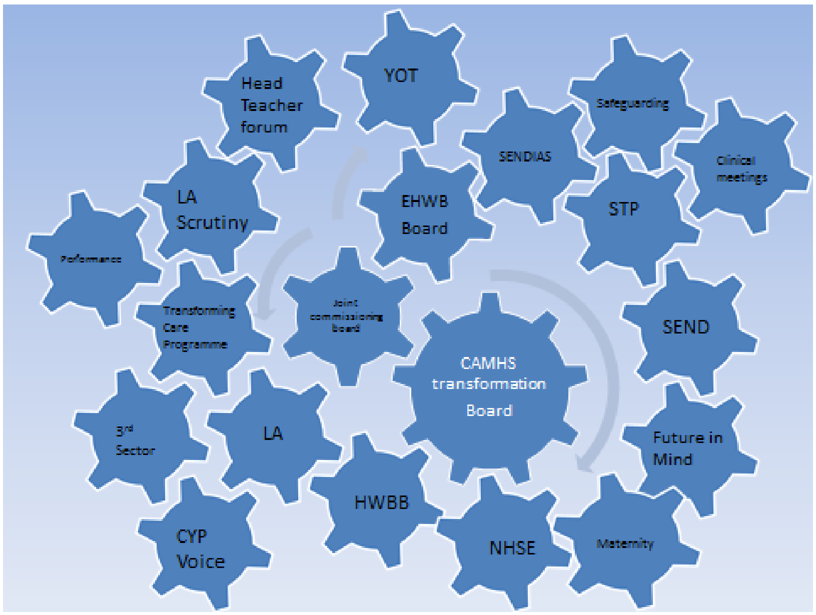
The board is well established, and conflicts are resolved by utilising informal mechanisms, the board recognises conflict as a healthy reflection of the state of our collaborative working and our ability to disagree and move on. Members are clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system.

The CAMHS board is also part of a wider partnership structure across the local health, social care and education economy, ensuring that those that can influence positively are able to do so

**Governance Arrangements for Sandwell Transformation Plans**



## CAMHS in Partnership



## Finance

Creating a sustainable finance model for CAMHS has not been simple and continues to require commissioners and providers to work together.

Local partners have had to agree the collective resources available to meet the objectives of LTP. In practice, this has resulted in the commissioners and local authority working together to pool their budgets and commission services jointly.

The challenge for the CAMHS LTP Board, has been in developing a sustainable finance model, whist managing the growing imbalance between providers' incomes and spending.

In Sandwell we have actually spent considerably more than the allocation (+increase) that we have received into our baseline e.g. in 2016-17 for Sandwell we spent **£632 more** than the allocation and in 2017-18 our spend is **£660k more than** the allocations in our baseline.

Going forward, we need to consider innovative ways to utilise the existing investments to fund any identified unmet needs.

| | ***2015-16*** | ***2016-17*** | ***2017-18*** |
|---|---|---|---|
| ***Allocations*** | ***£000's*** | ***£000's*** | ***£000's*** |
| Eating Disorders | 289 | 300 | 300 |
| CYP - Indicative | 723 | 1,192 | 1,402 |
| **Total in Baseline** | **1,012** | **1,492** | **1,702** |
| ***Expenditure*** | ***£000's*** | ***£000's*** | ***£000's*** |
| West Birmingham | 418 | 606 | 732 |
| Sandwell | 1,070 | 1,518 | 1,630 |
| ***Sandwell & West Birmingham Total*** | **1,488** | **2,124** | **2,362** |
| ***Spend above allocation*** | **476** | **632** | **660** |

## Risks & Mitigation

There are six key barriers that could hinder the process of transforming CAMHS in Sandwell, these are:

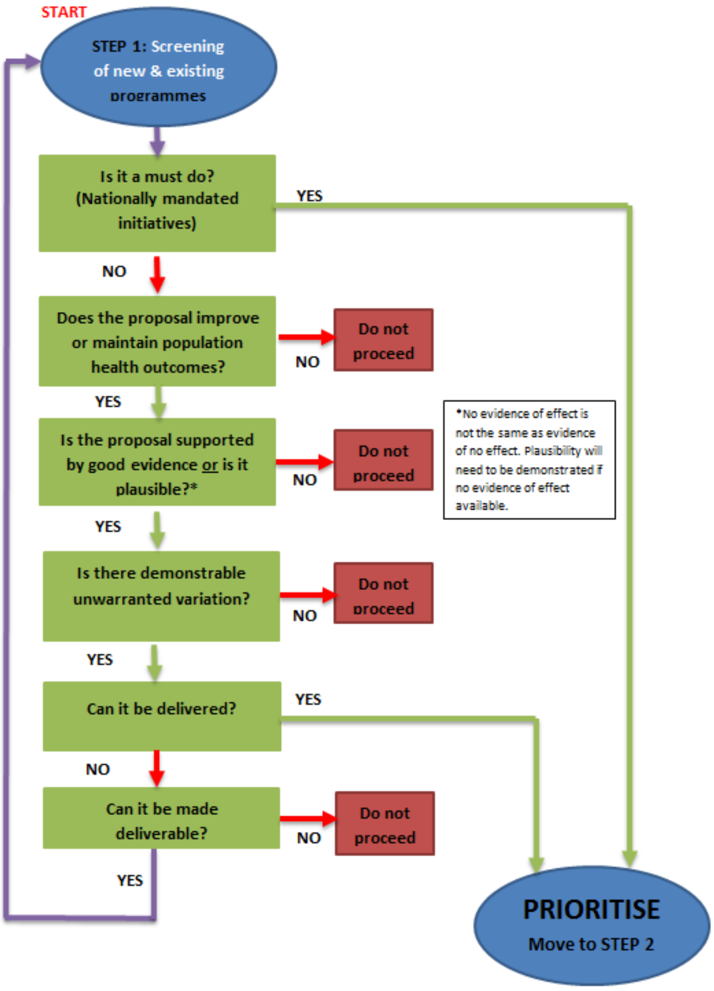
- Workforce
- Funding
- Commissioning
- Data
- Fragmentation
- Intervening too late

## Workforce

A comprehensive CAMHS service requires a diverse range of interventions and skills to be available and this requires professionals with a range of competencies. Limitations are often evident due to who providers can appoint to a post because of the way that professionals are regulated by the Health and Care Professions Council. Increased access to training will strengthen the skills in the workforce locally. The planned skills/training needs audit will enable us to understand better where the gaps are, and enable us to proactively seek solutions

## Funding

Children's mental health services have been historically underfunded. In 2012-13 £704m was spent on CAMHS43, the equivalent of about 6 per cent of the total mental health budget, or around 0.7 per cent of the total NHS budget. The majority of our CAMHS services are funded via block contracts, and investment hasn't always kept pace with demand. Locally, we are aiming to move to outcome based commissioning, giving us the autonomy to decide on the most appropriate payments. We are also ensuring that we are fully informed/aware of services commissioned with 'Short term budgets' and how we will ensure that future funding is available to enable us to plan effectively over the long term. Services are being robustly reviewed to ensure that they are fit for purpose, and achieving the desired outcomes. Prioritisation tools are being utilised to support difficult decisions (see diagram below)



## Data

Child and adolescent mental health services have been described as working in a 'fog' due to the lack of up to date and reliable data. However from March 2016, new data began to flow from the Health and Social Care Information Centre's minimum dataset, this will eventually include information on everything from referral rates to waiting times and outcomes of treatment. Additionally data on CYP MH prevalence is being updated and will be available in 2018. The partnership in Sandwell is committed to improving local data collection, necessary to inform on both success and gaps. Transformation funds exceeding 300k were provided in 2015-16 for investment in improving IT capability locally

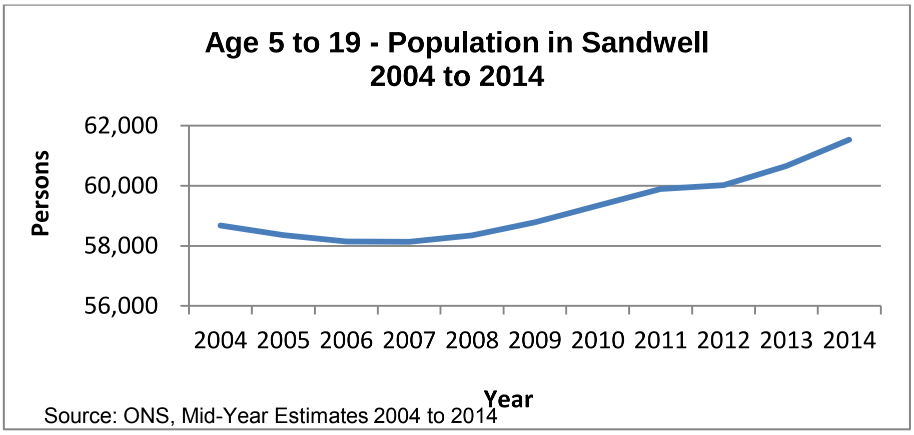
## Mitigation

An undertaking of this magnitude is not without its risks. A number have been discussed in previous chapters, strategies can be used to mitigate against these risks (examples blow). However prior planning and anticipation is crucial, in order to increase our chance of successful transformation.

| Risk | Mitigation |
|---|---|
| Failure of providers to implement agreed changes | Use contractual levers, with the possibility of considering an open tender process if providers fail to deliver the necessary changes. |
| Skill mix of CAMHs staff not appropriate to meet intervention requirements of the new model | Use contractual levers, with the possibility of considering an open tender process if providers fail to deliver the necessary changes. |
| Insufficient resources, to meet the demands of place based care – assumption is that over time, referrals to Specialist CAMHS will reduce. | Using population and service utilisation data, a robust model needs to be developed. Using parity of esteem and other levers, the CCG and partners may need to review the level of services that can be delivered. |
| Failure of organisations to work together due to structural/contracting impediments and/or conflicting priorities | Escalate to STP senior executives. Use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes. |

## Understanding Local Need

In 2014 Sandwell had an estimated population of 316,719 people, with 19.4%, (61,530) aged 5 to 19 years old. Over the last decade Sandwell has seen an increase in the numbers of younger residents with 5-19 year olds increasing by 4.9% (2,853 persons), since 2004.

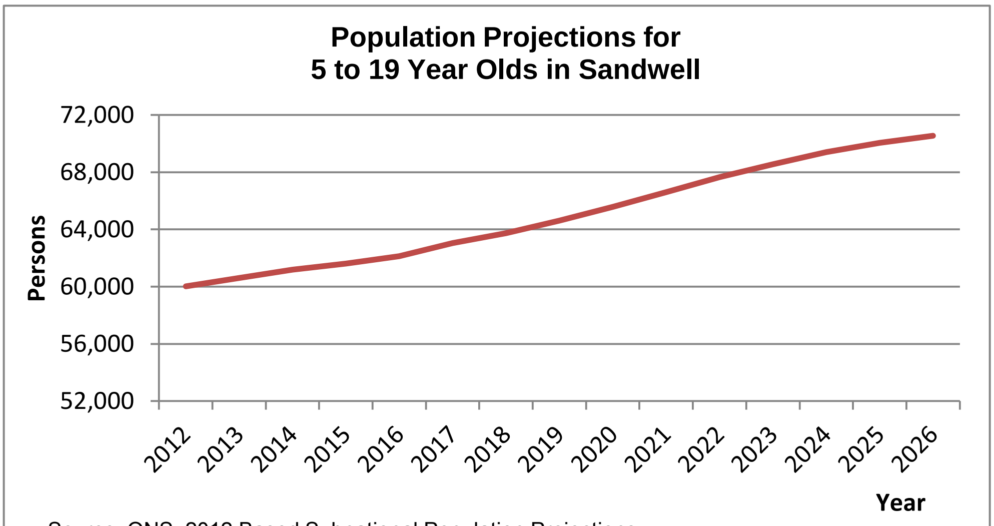


Source: ONS, Mid-Year Estimates 2004 to 2014

Changes over this period show marked differences in the younger sub-age groups, with 5-9 year olds increasing by 18.9%, 10-14 decreasing by -3.9% and 15-19 remaining fairly static, increasing by just 0.3%. There was also a 27.8% growth in the numbers of 0-4 year olds. These changes compare to a 9.7% increase for the whole population (all ages) in Sandwell, for the same period.

There are higher proportions of 5 to 19 year olds in Sandwell (19.4%), than in England (17.0%) and only Birmingham (21.0%) in the West Midlands has a greater proportion of this age group.

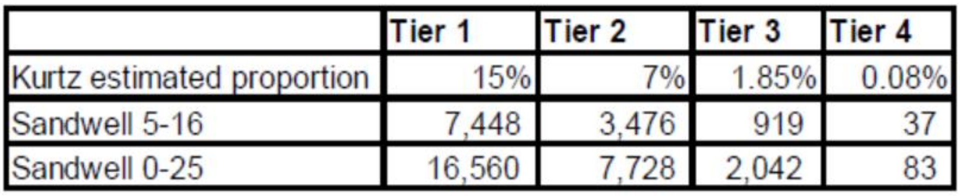
Over the next decade to 2026 the 5 to 19 population in Sandwell is projected to increase by 15.3% to 70,546 persons. The greatest increase being 24.5% within the 10-14 year age band, followed by increases of 11.6% and 10.6% in the 15-19 and 5-9 year groups.



Source: ONS, 2012 Based Subnational Population Projections

The 2015 initial CAMHS LTP included estimates of 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 (provided by Kurtz;1996). The figures were applied to the Sandwell population based on the 5-16 year age group and the 0-25 year age group.

Table 5 - Estimated number of children and young people requiring CAMHS by Tier



| | Tier 1 | Tier 2 | Tier 3 | Tier 4 |
|---|---|---|---|---|
| Kurtz estimated proportion | 15% | 7% | 1.85% | 0.08% |
| Sandwell 5-16 | 7,448 | 3,476 | 919 | 37 |
| Sandwell 0-25 | 16,560 | 7,728 | 2,042 | 83 |

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report)

## Point of access data/informing on need

The Point of Access (POA) is a collaborative venture between Sandwell Metropolitan Borough Council, Sandwell and West Birmingham Clinical Commissioning Group, Black Country Partnership NHS Foundation Trust and the EHWB collaborative (Childrens society, KOOTH, Kaleidoscope). The POA allows us to monitor referrals across the whole of the EHWB/CAMHS provision

The development of the POA for all children's emotional wellbeing and mental health referrals was agreed as part of the LTP vision (Operating Guidance: appendix 6), and following the identification of concerns regarding timeliness of response and duplication of referrals that resulted in an ineffective system causing delays to access of the right support, at the first time and promptly. The aim of POA is to reduce duplication of referrals, simplify the referral processes and offer a reduction in waiting times for assessment and intervention/treatment.

The POA became operational in September 2015, a comprehensive review was undertaken in 2016, the data used for the review was from the period 1st October 2015 - 31st March 2016 (3rd and 4th Quarter). There were **1446 referrals made to POA between October 2015 and March 2016** of those, 703 referrals were for females and 743 referrals for males.

The majority of referrals were from the health sector; with GPs and other Primary Care sources making 678 referrals equating to 47% of all referrals. Schools were the second highest referrers at 415 referrals (29%). Specialist CAMHS received 20% of the overall referrals, It must be noted that referrals for Looked after Children and Children with a Learning Disability do not come via POA.

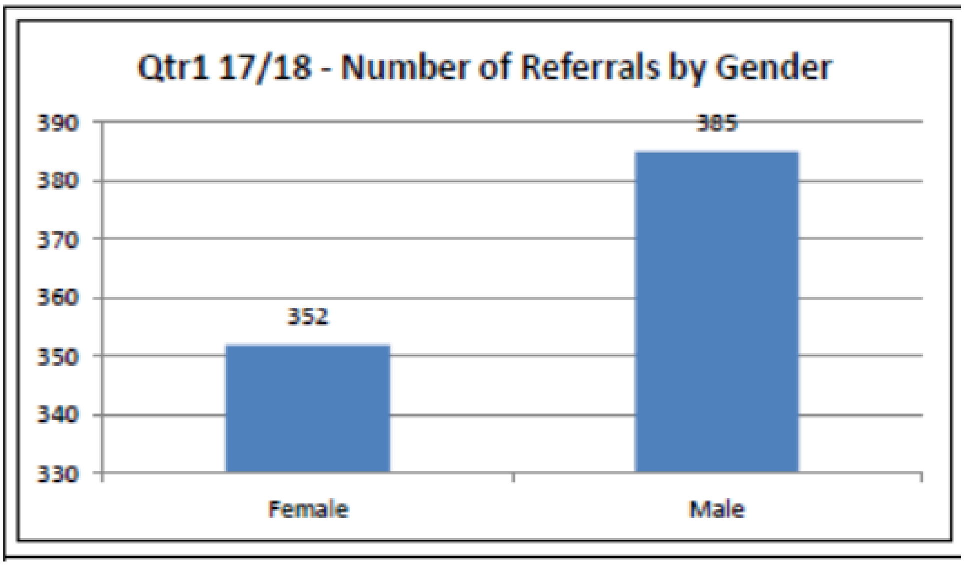
The above data has enabled us to react proactively, and plan engagements with both GP's and Schools. A dedicated PLT session with general practitioners is planned for January 2018.

The Sandwell POA activity, is monitored by the CAMHS Board, the increasing demand has identified that there is scope for improving outcomes even further. Improvements are planned and will be done in line with best practice guidance, so that the children and young people of Sandwell will have a gold standard service and have the best available opportunity to reach their full potential. Improvements currently under consideration are:

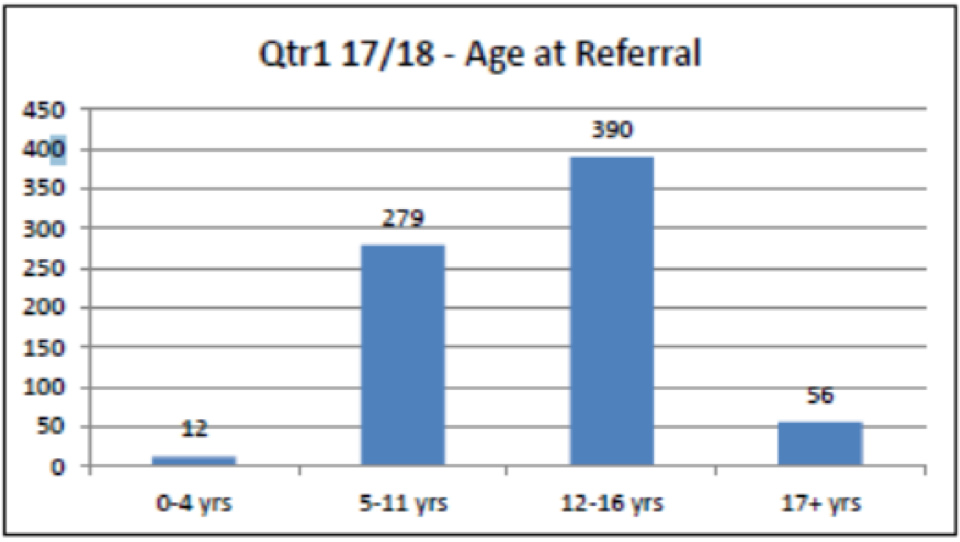
- Increase capacity within the POA i.e. create a team leader post
- Align the POA to the MASH
- Accept self-referrals

Current POA data: Qtr. 1 2017-18 continues to demonstrate demand for services:

**Referrals by gender**



**Referrals by age**



## LTP Ambition

Sandwell is committed to moving away from the traditional tiered system for CAMHS and aims to embrace the concepts of the 'Thrive Model'. The original LTP used this approach to outline future plans: Coping, Getting Help, Getting More Help and Getting Risk Support.
Key objectives of the additional funding, embraced by the partnership in Sandwell are:

- Build capacity and capability across the system so that we make measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes by 2020;
- Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT)
- Develop evidence based community Eating Disorder services for children and young people with capacity in general teams released to improve self-harm and crisis services;
- Improve perinatal care. There is a strong link between parental (particularly maternal) mental health and children's mental health.

Our ambition is to ensure that a systematic approach to commissioning and working with current and new providers will ensure integrated services where provision is delivered seamlessly. Our ethos was and still is to remove the barriers that have previously hindered access to reduce the numbers of children and young people falling through the gaps of service access criteria's. Our plan is based on a systemic approach that links universal services to targeted and specialist services, by:

- Promoting resilience through self-management
- Early Intervention
- The provision of outreach mental health services
- Training and advice support for universal services
- The delivery of a full range of psycho social therapeutic interventions based on the young person's need
- Community based services that include school based interventions
- Timely access
- Holistic provision- all services under one pathway from the point of triage

These principles will continue to be used to transform local services for young people, it is widely accepted that the onset of mental ill health occurs before the age of 18, highlighting the need for robust pathways and services for young people that experience issues with their emotional wellbeing and or mental health.
Our plan is system wide; however there is a greater emphasis on vulnerable groups that have previously been neglected, especially LAC, SEND, CSE and YOS. To date additional resource for LAC includes:

- Dedicated Primary Mental Health Worker (PMHW) for LAC
- Additional commissioning support for LAC/CAMHS. The post holder is currently: ensuring that panels are comprehensive and 'fit for purpose'/ reviewing the CETR process to ensure it is explicit and fit for purpose/ ensuring that risk registers are up to date
- Additional PMHW capacity for unaccompanied asylum seeking children & young people

Additional resources for SEND include:

- 2 new posts: EHCP planning officer (appendix 3), ensuring that input from health professionals is outcome focused, and Early Years Psychologist to support early identification of ASD, and input into the MAA process

The CAMHS landscape in Sandwell looks significantly different to how it did in 2015; by 2020 the partnership aims to fulfil its original ambition, which includes a commitment to ensure that provision in in line with expectations outlined within the Five Year Forward View.

Sustainability of the work stream beyond 2020 is under discussion. The partnership is committed to ensuring that provision is maintained, and robustly monitored to ensure that capacity issues are addressed.

The ambition beyond 2020 is to ensure that funding is aligned to areas where impact will be greatest and outcomes evident. Government policy has called for a shift in focus of services from crisis intervention to one of early intervention and prevention. A key principle is that **all** professionals working with and on behalf of children, young people and their families accept their full responsibility for ensuring that everything possible is done to prevent the unnecessary escalation of issues and difficulties and that a positive focus is maintained on ensuring the best outcomes.

Sandwell's plan has recognised that it is important that children and young people, however they first present with difficulties, are supported by professionals to receive appropriate help and support as soon as possible, hence the increased investment into the EHWB provision.

Our model is already demonstrating a reduction in the number of referrals into specialist CAMHS, and this trend should continue as services 'up-stream ' enable young people to be resilient, develop coping strategies and manage their emotional health and wellbeing without the need for specialist intervention. Clear national evidence is available to demonstrate that early intervention is cheap, effective and cost-saving. The cost of providing mental health support is estimated as:

- £5.08 per student – the cost of delivering emotional resilience program in school
- £229 per child – the cost of delivering six counselling or group CBT sessions in a school
- £2,338 – the average cost of a referral to a community CAMHS service
- £61,000 - the average cost of an admission to an in-patient CAMHS unit

Not only is provision much cheaper if delivered earlier, it is also more (cost) effective: Public Health England estimates that every £1 invested in emotional resilience programs in schools has a £5 benefit realised over 3 years.

## 2018/19

| **Outcome/Objective** | **Proposed works** | **Measurement/Links** |
|---|---|---|
| Increase access for CYP and reduce waiting times | *Formerly review the current POA<br>*secure further investment if capacity is an issue<br>* expand POA provision to include self-referral | *Review recommendations<br>*budget decisions<br>*self-referral pathway |

| | | |
|---|---|---|
| **Strategic Direction**<br>Implement the year on year trajectories for workforce and access as outlined in FYFV and FiM | * Continue to support the IAPT collaborative<br>Develop further training programmes, based on intelligence from audits, identify backfill where required<br>* Ensure all courses are formerly evaluated (Gather data on courses attended, skills gained measured against NICE Concordat) | * Numbers trained<br>* Number of pathways fully compliant to deliver against NICE recommendations<br>*Formal evaluations completed |
| **In patient Care**<br>Reduce LOS, by extending the choice of treatments to support patients remaining in community treatment, as close to home as possible including the development of appropriate day care | *Build relationships with NHSE Case workers<br>* Model/cost day care options<br>* Align TCP and FiM agenda a for recovery centre approach | * pilot day care approaches<br>* develop day care service specification |
| **CYP Mental Health**<br>Continue to explore and understand the EHWB needs of CYP in Sandwell as demographics change (new arrivals, asylum seekers etc.) and adapt services to provide equitable provision and reduce health inequalities | * Data interrogation and analysis<br>*fully utilise the **MHSDS**<br>* Joint Strategic Needs Assessment<br>*Co-production<br>* Schools Charter mark<br>* consider rolling out the STEER programme | * Joint Strategic Needs Assessment<br>*improved outcomes for CYP, including educational attainment |
| Maintain co-production arrangements and joint working | * Agreed Memorandum of understanding<br>*Robust TOR<br>* accurate reporting<br>* Agreed pooled budget | * Pooled budget published<br>*meeting minutes |
| **STP**<br>Continue to work collaboratively across the STP footprint, to achieve the 1 commissioner model | *Develop single service spec's<br>* plan implementation<br>* support providers with new model of working<br>* set timeframe for formal review | *service Spec, fully implemented<br>*service fully functioning |
| **CYP IAPT**<br>Continue to roll out training across all tiers.<br>Agree suite of ROMs across all provision | *training numbers increase<br>*access to IAPT increases<br>* Outcome focused ROMs captured | |

## 2019/2020

| Outcome/Objective | Proposed works | Measurement/Links |
|---|---|---|
| To have a fully compliant CAMHS service, that meets all core standards and where possible NICE guidance | * Review baseline against current activity<br>* Develop robust business cases for assured long term/recurrent investment<br>* Develop contractual documentation including Service Specs & KPI's<br>* Ensure transition is addressed | * Service fully compliant across all provision<br>* Linked to MERIT<br>* linked to STP |
| Reduce health inequalities through better systems:<br>Co-production &<br>Joint commissioning of emotional wellbeing services | * Develop emotional wellbeing and mental health strategy for 0 to 25<br>* Develop formal documentation for service contracts (Specifications, quality metrics and KPI's)<br>* Continue engagement/consultation process | * Service Specs in place and included in contracts<br>*Quality metrics agreed<br>* KPI's agreed |
| Mental health workforce are skilled to support the needs of all CYP in Sandwell | * Develop a long term Workforce/training strategy agreed across all partners | See previous plans |

# Workforce

Future in Mind through the transformation funding has supported both the expansion and development of specialist CAMHS workforce. The development of a capable and competent workforce is essential to the continued modernisation and expansion of evidence-based services across the whole CAMHS pathway.

Sandwell CAMHS has worked with the Midlands C&YP IAPT collaborative, Health Education England and local partners to identify workforce needs and commence plans.

Sandwell and West Birmingham CCG have invested transformational monies into the provider trust, to build the workforce within specialist areas of CAMHS; this has allowed the specialist CAMHS workforce to develop a new model of care delivery by removing some of the specialist provisions around vulnerable children and young people from core CAMHS into the dedicated provisions of Crisis Intervention and Home Treatment and Eating Disorders. This will hopefully support core CAMHS in delivering on the increase in access to mental health services, and has also supported the identification and delivery of specific training to meet local skills gaps.

The new model of care ensures evidence based treatment interventions and a pathways approach and has allowed further consideration to be given for consideration of skill mix.

Expansion in the workforce has been within specific elements of the service; further financial support to expand and change the model of care offered: CAMHS Crisis Intervention/Home Treatment provision, Eating Disorder provisions and work in partnership with early years by providing specialist psychological support for the under 5 year old with specific learning disabilities.

Other new partnership workforce development posts include having CCG commissioned posts working as Primary Mental Health workers with the local authority. The Primary Mental Health workforce delivers mental health interventions within Sandwell COG's (community operational groups). As well as other specialist mental health arenas such as for children who experience sexual exploitation and those that are LAC.

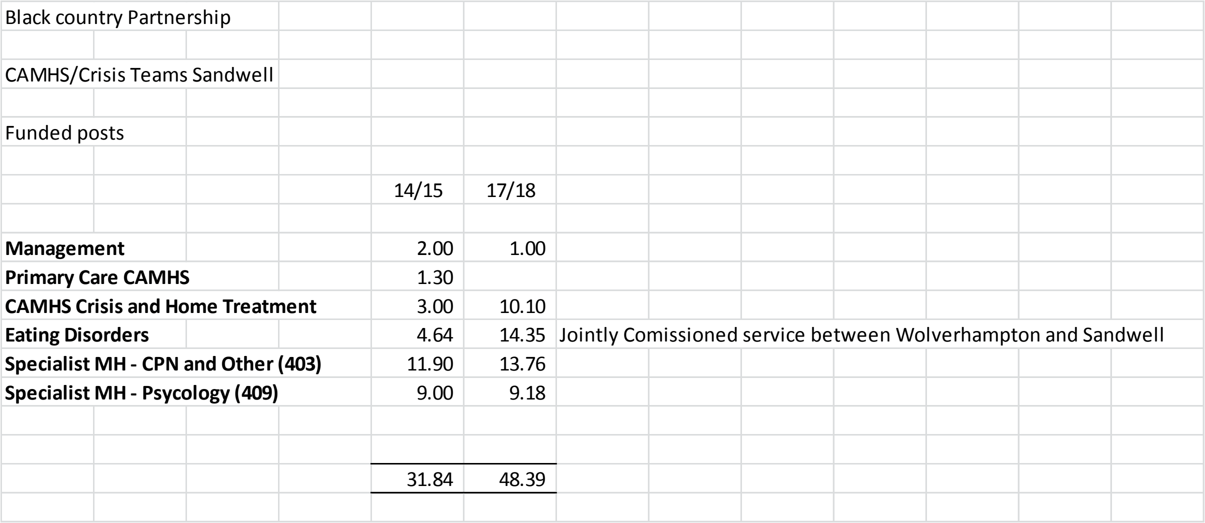
The approaches locally to addressing the workforce training needs across all of these areas have included:

- Engagement in a Sandwell local partnership to join the Midlands C&YP IAPT collaborative and attend leadership and clinical training modules and clinical supervision
- Ensuring our leadership team undertake the C&YP IAPT Leadership and Transformation training
- Accessing the C&YP IAPT outreach training sessions
- Exploring skills and competencies gaps within specialist CAMHS and providing locally based competencies training to meet local skills gaps for particular evidence-based treatments or diagnostic categories
- Accessing the national Eating Disorder training days

Specialist CAMHS have also supported universal provisions through training in schools and have ran specific group parenting sessions that have a psychoeducational element to supporting parents and foster parents in the care and management of children and young people. The workforce has been enabled by providing further IT support with training and some equipment. Local young people that have engaged with specialist CAMHS have developed the CAMHS web site that has further information and self-help support for all.

Lodge Road (specialist CAMHS venue) in Sandwell has been upgraded with IT equipment and refurbished through transformational funding; young people were involved in the decor and design of the building to ensure that it is an environment suitable to meet the needs of children and young people.

Sandwell and West Birmingham CCG specialist CAMHs workforce investment through LTP



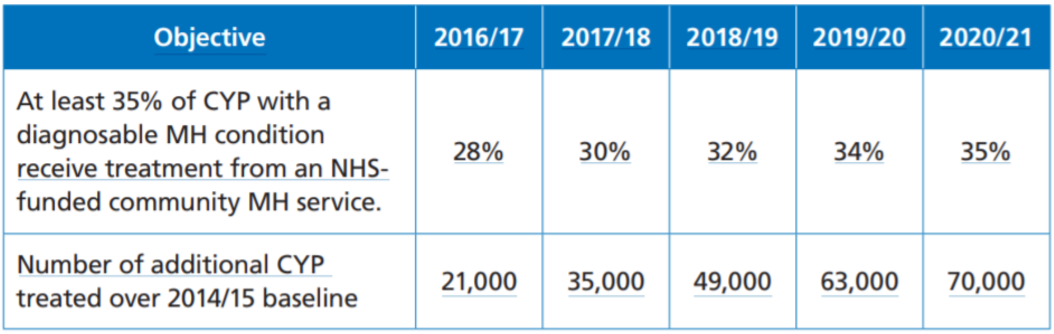
| | | | |
|---|---|---|---|
| Black country Partnership | | | |
| CAMHS/Crisis Teams Sandwell | | | |
| Funded posts | | | |
| | 14/15 | 17/18 | |
| **Management** | 2.00 | 1.00 | |
| **Primary Care CAMHS** | 1.30 | | |
| **CAMHS Crisis and Home Treatment** | 3.00 | 10.10 | |
| **Eating Disorders** | 4.64 | 14.35 | Jointly Comissioned service between Wolverhampton and Sandwell |
| **Specialist MH - CPN and Other (403)** | 11.90 | 13.76 | |
| **Specialist MH - Psycology (409)** | 9.00 | 9.18 | |
| | 31.84 | 48.39 | |

In July 2017, NHSE published a mental health workforce plan: **Stepping forward to 2020/21**. The plan focuses on the health workforce to 2021, whilst acknowledging that social care, housing, community and the third sector all provide invaluable services which need to be thought about in the context of cross-cutting themes.

The workforce plan was agreed by a number of partners across many systems and is based on the most comprehensive and robust study of the mental health workforce nationally to date. To deliver the improvements locally will require a concerted action and focus from everyone working in Sandwell across the children & young people's health and social care system. .

**CYP ACCESS:**

The table below sets out an indicative NHS England trajectory for increased access based on existing data on prevalence of mental health problems in children and young people. It will hopefully be reviewed in 2018 following publication of new national prevalence data



| Objective | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service. | 28% | 30% | 32% | 34% | 35% |
| Number of additional CYP treated over 2014/15 baseline | 21,000 | 35,000 | 49,000 | 63,000 | 70,000 |

By 2020/21, at least 1,700 more therapists and supervisors will need to be employed to meet the additional demand. By 2018, all services should be working within the CYP IAPT programme, leading to at least 3,400 current staff being trained by 2020/21 in addition to the additional therapists above.

Transformation funding to date has impacted on the CAMHS workforce across all tiers, as demonstrated in the table below, funded post have almost doubled since 2014:

| | Funded posts | | | |
|---|---|---|---|---|
| **Service Area** | **2014 - 15** | **2015 - 16** | **2016 - 17** | **2017+** |
| **Commissioning (CCG)** | 1WTE | 1WTE | 1WTE | |
| **Commissioning (panel representative)** | 0 | 0.1WTE | 0.1WTE | |
| **Management CAMHS** | 2WTE | 2WTE | 3WTE | |
| **Point of Access** | 0 | 2WTE | 2WTE | |
| **Core CAMHS** | 21.5WTE | 21.5WTE | 22.67WTE | |
| **Crisis/Home treatment** | 5WTE | 9.1WTE | 9.1WTE | |
| **Eating Disorders** | 4.64WTE | 4.64WTE | 14.35WTE –Sandwell and Wton | |
| **Early Years (0-5)** | 0 | 0.6WTE | 0.6WTE | |
| **EHWB Service** | | | | |
| **KOOTH** | | | | |
| **Primary Mental Health Workers** | 0 | 10 WTE | 10 WTE | |
| **CAMHS waiting list initiative** | 0 | 0 | 2WTE | |
| **136 suite** | 0 | 1WTE | 1WTE | |
| **TOTAL** | **34.14** | **51.84** | **65.82** | |

FUTURE WORKFORCE PLANS POST 2018

Partners in Sandwell recognise that further changes are needed to the local workforce within Child and Adolescent Mental Health services, including the creation of new/innovative roles that will support increasing access to services at a much lower level. Preventing children & young people becoming so ill that they require significant specialist intervention.

The partnership is committed to:

- Identifying funding to ensure that annually local practitioners have access to the CYP IAPT training
- Ensuring capacity for crisis provision 24/7
- Identifying and utilising a Workforce audit Tool, to inform on future needs
- Adopting best practice in respect of CAMHS workforce initiatives

## Collaborative & Place based Commissioning

NHS England has listened to patients' experiences of mental health services. Feedback has advised that care pathways are often disjointed, particularly where the commissioning responsibility for services changes, leading to gaps in provision and poor sharing of data, resulting in poor outcomes for children and young people.

CCG's have been encouraged to develop a more collaborative approach to commissioning, making it easier for commissioners to work together to better align pathways, and service models across all systems, resulting in a more holistic and integrated approach to improve healthcare for the diverse local populations served, and improve outcomes.

**Definition-collaborative commissioning**

> *the ability to plan effectively in a coherent way to provide the highest quality healthcare, to reduce any inequalities in access to services and to improve outcomes. For providers, collaborative commissioning will mean the opportunity to have one conversation about all the services they provide.*

**Aims of collaborative commissioning:**

- Improve pathway integrity for service users, helping to ensure that care is commissioned as part of a single pathway;
- Enable better allocation or investment decisions, giving CCGs and their partners the ability to invest in prevention or more effective services;
- Improve financial incentives over the longer term, reducing demand, where appropriate, and unwarranted variation, and increasing value for money
- Ensure providers can be effectively held to account, ensuring clearer links between services, commissioners, referrers and providers.
- A better patient experience through more joined up services;
- Improved equitable access to high quality sustainable services.

Locally 'Place-based Commissioning' ensures that providers of services are working together to improve health care for children & young people in Sandwell. Our partnership working arrangements advocate that all partner organisations collaborate to manage the common resources available to them rather than each organisation adopting a 'fortress mentality' and acts to secure its own future and funds regardless of the impact on others.

Sandwell's Local Transformation Plan (LTP) enabled all partners to have a shared vision and shared aims & objectives, tailored to the needs of the population, reflecting the challenges that exist and the level of ambition necessary. The plan built on work done previously by commissioners and the health and wellbeing board in understanding the needs of the local population, as well as providers' knowledge of local services.

Collaborative and place based commissioning is a key feature of Sandwell's LTP.

### Collaboration with NHSE

SWB CCG was party to a joint funding bid to pilot a 'New Care Model' (NCM) to manage in-patient provision. The bid submitted reflected the overall vision that children and young people should be treated as close to home as is possible, and were suitable enable them to stay in the community accessing specialist inpatient care. Unfortunately the joint bid was unsuccessful and funding/management remained with NHSE.

Following the unsuccessful bid, Sandwell's partners have strengthened the links with NHSE case managers to ensure processes are in place to enable young people to access in-patient provision in a timely/coordinated manner. Aligning systems is still 'work in progress', but together we are aiming to ensure that the planning will always consist of a joined up approach across the whole care pathway, as indicated in the original Transformation Plan, including content agreed with and signed off by a representative of the local Specialised Commissioning Team.

In addition the local CAMHS STP (Black Country & West Birmingham) leads are working closely with NHSE case managers to scope the possibility of developing a virtual 'NCM' for tier 3+ and tier 4 provisions across the STP footprint.

## Collaboration with LA/Youth Offending

The LTP recognised the need to identify specific resources to support young offenders. Working collaboratively has resulted in the following provision:

- A full time dedicated 'Primary Mental Health worker' co-located with the YOT. Co-location with the YOT has supported the efforts of a variety of criminal justice partner organisations in building stronger community links to preventing crime and anti-social behaviour.
- Dedicated support from a SALT practitioner (2 days per week) to identify communication issues, especially in relation to undiagnosed ASD, resulting in timely intervention from specialist CAMHS. Involvement of SALT in a recent case led to a young person being diagnosed with a rare form of ASD, this in turn resulted in the YP receiving a much reduced custodial sentence.

## Collaboration with LA/ SEND

Sandwell have a well-established SEND Partnership board, the CAMHS Commissioner, and CAMHS providers are present. Board membership also includes representation from the 'people's parliament' (mental health service users). The board has a detailed delivery plan that includes actions across the partnership to ensure that all partners are fully compliant with the SEND code of practice.

However the recent (January 2017) Ofsted/CQC SEND joint inspection raised some concerns in respect of CAMHS provision and its statutory obligations in respect of the SEND agenda. The formal feedback included the following statement:

*The child and adolescent mental health service (CAMHS) is not fulfilling its statutory role in cooperating with the local authority to integrate provision that would promote the well-being of children and young people who have special educational needs and/or disabilities. For example, as frontline practitioners are not fully aware of their responsibilities with regard to education, health and care (EHC) plans, they are not contributing consistently to the process. This is limiting the local area's ability to work in partnership with children, young people and their families towards positive outcomes.*

A collaborative approach to addressing the concerns raised has resulted in both Ofsted/CQC reporting that they are fully assured with the progress made. Specialist CAMHS practitioners have now embraced the SEND agenda and to date completed actions have included:

- Revised staff induction process, that incorporates the SEND code of practice
- SEND has been incorporated within clinical and business team meetings as a standing agenda item
- The provider Trust has published the CAMHs contribution to the Local Offer, CAMHS eligibility criteria has also been added, CAMHS website link has been added to the Local Offer
- Refresher training to be provided to all CAMHs staff as part of an overarching CPD programme (commenced June 2017).
- CAMHs staffs have received training in relation to developing outcome focused EHC Pians
- CAMHS have developed an Exemplar template to support the completion of  Statutory Advice, and ensure that EHCP information is outcome focused

In addition the CCG have commissioned a post within the Statutory SEND Team: **Health EHC Planning Officer for Special Educational Needs and Disability (SEND)** this will ensure high quality reports are received from Health colleagues within 6 weeks. The post is very innovative, and NHSE are keen to see the impact the post has, and to share the concept with other areas (Post details added as an appendix)

## Collaboration with Liaison and Diversion

Research in the UK and internationally demonstrated that prison populations have significantly higher psychiatric morbidity than the general population. The Institute of Mental Health on behalf of the Offender Health Collaborative, part of the National Liaison and Diversion Development Programme (Kane et al, 2012), found evidence to support the following:

- Diversion should happen at the earliest possible point on the pathway.
- Defendants in the police station/court should be screened face-to-face for mental illness.
- Individuals and their behaviours should not be inappropriately pathologised, creating stigma,
- A clear and boundaried definition of the service should be provided with multiagency commitment
- Availability of a service infrastructure into which individuals can be diverted
- Diversion and liaison services are most effective when commissioned on the basis of joint funding from mental health and criminal justice agencies.

Why are L&D services needed?

NHS England

2004/5 found that nearly half (47%) of the offender population had misused alcohol in the past, 32% had violent behaviour related to their alcohol use and 38% were found to have a criminogenic need relating to alcohol misuse, potentially linked to their risk of reconviction.

People in contact with the criminal justice system are also known to be one of the groups of people known to be at higher risk of suicide than the general population.

Almost 50% of adult prisoners suffer from anxiety and/or depression compared with 15% of the general population

31% of young people (aged 13-18) who offended (including young people in custody and in the community) were identified as having a mental health need.

Based on the study by Harrington & Bailey (2005), Chitsabesan et al. (2006) found that 20% of young offenders had a learning disability

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Collaboration has led to the commission of a Black Country Liaison and Diversion service; it is located within the police and courts to divert those most at risk away from the criminal justice system and into local health and care services. The service is provided by the Black Country NHS Partnership

Trust, Dudley and Walsall Mental Health Partnership NHS Trust, delivering a single service across the Black Country consisting of Dudley, Sandwell, Walsall and Wolverhampton, working closely with existing Criminal Justice Teams (CJT).

The service comprises of an outreach function designed to ensure those at risk are offered appointments with providers and are supported in engaging with other providers and increasing the uptake of services. The service is agile and makes use of information technology, capturing data electronically at the point of contact, enabling teams to view mental health records across the area through improving access to existing systems.

Youth Justice Liaison and Diversion workers have access to young people in custody although their interventions will primarily take place outside Criminal Justice settings including Mental Health clinics, schools and outpatient buildings. Screening will assist in the early identification of unmet mental health needs, speech and communication needs, and learning difficulties of children and young people. In addition the CCG fund a full time PMHW who is based with the YOT, and working closely with colleagues in Youth justice. Primary Mental Health Workers (PMHWs) work with children and young people, families and carers and professionals providing support where there are emotional or mental health concerns.  PMHWs come from a range of professional backgrounds having specialist training and experience in helping children, young people and their families and carers when there are emotional or mental health concerns.

Their skills include but are not exclusive of:
- Counselling
- Cognitive Behaviour Therapy (CBT)
- Play Therapy
- Art Therapy
- Transactional Analysis
- Solution Focussed
- Humanistic Approaches
- Trauma and Attachment
- Family Functioning

The PMHW increases the capacity of mental health services for children and young people (CYP) who have been in contact with NHS England Health & Justice directly commissioned services and assists in improving their journey through the full clinical pathway, providing a better link into mainstream/community services and ultimately achieving improved outcomes for CYP families and carers who access the service. Referrals come via the YOI/YOS, the Diversion Service, the single POA and potentially SARCs. Interventions are available for CYP/families/carers where the CYP is in custody pending release to Sandwell. Referrals are also taken from staff engaging with CYP and families and carers both in a general capacity e.g. Officers who note a concern with emotional wellbeing or CAMHS in custody who wish to refer to a transitional service into the community.

Essentially we know that CYP in detention and/or the adult carers in the community may require some support in relation to emotional and mental health needs and this support can be accessed by the service. Our service focuses on supporting good emotional and mental health and wellbeing, the prevention of escalation of bad emotional or mental health and wellbeing, ensuring seamless access of services pre and during the transition from custody to community.

Sandwell partners are committed to supporting NHSE Clinical networks Children and Young People's Mental Health & Wellbeing team, in their quest to map current provision, and will also seek to secure additional national funding to pilot new models or strengthen existing models

## Collaboration with Public Health/Education

Public Health colleagues have invested in the LTP, they are committed to the model, and keen to ensure that children and young people locally are supported to become resilient, and have improved Emotional health & Wellbeing.

**The Charter Mark for Schools- is a** universal programme designed to promote emotional and mental health through a whole-school approach. It is a three-year programme now entering the third year. It was extended recently to include secondary schools. As of August 2017, 66 schools were involved at various stages of the process with a new cohort starting in September 2017.

Schools are awarded the Sandwell Wellbeing Charter Mark if they can demonstrate that they take a whole-school approach to emotional health and wellbeing through a process of audit, action planning and review. Educational Psychologist undertake a baseline audit looking at 8 criteria:

1. Leadership
2. Ethos and Environment
3. Curriculum, Teaching and Learning
4. Student Voice
5. Staff Development/wellbeing
6. Identifying Needs and Monitoring Impact
7. Working with parents/carers
8. Targeted support and appropriate referral

Research psychologists gather data i.e. exclusion rate, staff sickness etc; undertake a staff questionnaire, conduct parent focus groups and child focussed activities.

Findings are collated into a baseline report and Schools then develop an action plan to address areas of improvement, which is reviewed in order to reach a judgment about whether the criteria have been met. A measurement tool has also been developed and standardised that maps against the outcomes of the programme.

Both the CCG CAMHS commissioner and the PH 0-19 Commissioner are keen to collaborate to ensure that all opportunities to improve outcomes locally are identified. As such we are keen to secure investment to participate in the **Mental Health Services and Schools Link Programme**, which will be running with funding from the Department for Education.

### Mental Health Services and Schools Link Programme

The Anna Freud Centre for Children and Families (AFCCF) and the Department for Education are inviting partners to take part in a ground-breaking initiative to help CCGs and LAs work together with schools and colleges to provide timely mental health support to children and young people.

Following a successful pilot across 27 CCGs and 255 schools in England, AFCCF are now recruiting 20 further areas for 2017/18. Participating areas will receive two workshops for CCG leads, LA leaders, school staff, NHS CYPMHS providers and community organisations working with CYP. The workshops take a blended learning approach, drawing on evidence-based approaches to training and system transformation.

Participating in the programme will:

- Develop a shared view of strengths and limitations and capabilities and capacities of education and mental health professionals
- Increase knowledge of resources to support the mental health of children and young people
- Ensure more effective use of existing resources
- Improve joint working between education and mental health professionals

# CYP Improving Access to Psychological Therapies

The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a change programme delivered by NHS England in partnership with Health Education England. Sandwell's commitment to success and proactive approach resulted in us joining the programme in 'Wave 1'. The programme aims to:

- work with existing services that deliver mental health care for children and young people (provided by NHS, Local Authority, Voluntary Sector, Youth Justice)
- create, across staff and services, a culture of full collaboration between child, young person and/or their parents or carers by:
- using regular feedback and outcome monitoring to guide therapy in the room, using a mixture of goals and symptom measures suitable for all child, young person and/or family/carer – Child Outcomes Research Consortium (CORC); CHIMAT; PHE Fingertip tools; Mental Health Services Data Set
- improving young people's participation in treatment, service design and delivery – Young Minds Amplified and GIFT MYAPT – improving access through self-referral
- improving the efficiency of services by training managers and service leads in change, demand and capacity management
- improving access to evidence-based therapies by training existing CYP MHS staff in in an agreed, standardised curriculum of NICE approved and best evidence-based therapies.

The ambition over the next five years is to build effective, evidence-based, outcome focussed Child and Adolescent Mental Health Services for the future, in collaboration with children, young people and families. This includes delivering improved access and waiting times, reduced numbers of children requiring inpatient care, development of a fully trained and competent workforce, and self-referral across the system. Services should utilise technology to achieve accountability to all stakeholders, including children, young people and families, commissioners, and the services themselves

CAMHS partnerships were requested to select a collaborative they wished to join, creating a network of partnerships. Sandwell bid to join the Midlands Collaborative in 2016, enabling us to shape the development of course content, learn from others, encourage good practice and avoid pitfalls as the CYP IAPT programme developed.

The Midlands collaborative currently comprises the following CAMHS partnerships across the East and West Midlands:

- Leicester, Leicestershire and Rutland
- North Derbyshire
- Lincolnshire and North East Lincolnshire
- **Sandwell**
- Solihull
- Wolverhampton
- South Derbyshire
- South Staffordshire
- Dudley
- Walsall

Sandwell CCG entered into an agreement with NHSE, with a clear understanding that as a partnership we would: honour, observe and perform the obligations agreed by parties following the successful bid to join to Children and Young People's Improving Access to Psychological Therapies

(CYP IAPT) Programme. Table 1 demonstrates the initial funding agreed for the Sandwell partnership.

Table 1

| **FUNDS** | | **INSTALMENTS** | |
|---|---|---|---|
| **Training** | **Firm Price** | | |
| | | | |
| 18 CBT + 3 SFP therapists (@ £30k each) | £630,000 | **July 2016** | £111,250 |
| 4 supervisors<br>(@ £20k each) | £80,000 | **February 2016** | £111,250 |
| 20 Enhanced Evidence Based Practice trainees<br>(@ £5k each) | £100,000 | **July 2017** | £293,750 |
| | | **October 2017** | £293,750 |
| **Total Price** | **£810,000** | | |

Specialist CAMHS and C&YP IAPT

Training has commenced for modules on CBT and SFP eating disorders and 5 clinicians from Sandwell CAMHS are in the final stages of completing these courses; two for CBT and three for the SFP training, clinicians are based either within the CAMHS Crisis Intervention Home treatment provision or within the all aged eating disorder provision working with the under 18 year olds. One core CAMHS clinician is just completing the EEBP module.

Clinicians are also completing the Transformational Leadership module and a range of clinical supervision training inclusive of PWP, CBT and SFP clinical supervision.
Specialist CAMHS have been completing routine outcomes manually during the training process and have just had their first workshop on ROM's and will be working towards a whole service electronic reporting of CAMHS ROM's.

The vision for 2020 is that across the STP footprint, there will be an agreement in respect of the most appropriate ROMs to use. It is anticipated that a whole of suite of ROMs will be agreed/available for all partners in the Black Country by March 2018.
The current EHWB provision in Sandwell is assessed in respect of effectiveness by the use of **Outcome star,** however this provision will be able to utilise ROMs from those agreed.

| **Service** | **Name** | **Course Attended** | **Supervision Requirements** |
|---|---|---|---|
| CAMHS | Sarah Hogan | Transformational Leadership | External |
| CIHTT | Melissa Beckford | CBT | Ruth Stevens or Sarah Simpson |
| CIHTT | Elizabeth Shaw | CBT | Ruth Stevens or Sarah Simpson |

| | | | |
|---|---|---|---|
| CIHTT | Rachel Buckley | SFP - Eating Disorder | Simon Thompson |
| Eating Disorder | Clare Dupree | SFP - Eating Disorder | Simon Thompson |
| Eating Disorder | Sultana Begum | SFP - Eating Disorder | Simon Thompson |
| Core CAMHS | Megan Gwilt | EEBP | TBA |
| Core CAMHS | Simon Thompson | SFT Clinical S/V | Not applicable |
| Core CAMHS | Ruth Stevens | Clinical Supervisor CBT | TBA |
| Core CAMHS | Sarah Simpson | Clinical Supervisor PWP | TBA |

In order to continue to train the whole of our specialist CAMHS workforce an application has been completed for further training: the award will secure:

4 CBT modules and 1 EEBP module; these modules are being distributed between specialist CAMHS and our partnership.

## Eating disorders

Sandwell did not have a discrete eating disorder service as outlined in national guidance. There was a dedicated adults Eating Disorder service and some identified resource within the CAMHS provision, however, this did not provide a discrete eating disorder service for children and young people. CAMHS offered a core service for patients with eating disorders that did not meet the thresholds for inpatient admission. The service provided a multi-disciplinary approach to eating disorders but lacked some of the specialisms as outlined in the guidance such as dietetic support.
The initial 2015 transformation plan, detailed a number of commitments in respect of delivering a comprehensive eating disorder service, including:

- Developing an eating disorder service, aligned to national guidance that ensures cyp get help, before requiring more help
- Intervention in Psychosis 14 to 35 year olds and Eating Disorders
- Develop and implement waiting time standards for Eating Disorder services
- Accessible service available that increases access for people with eating disorders

In 2016, NHS England outlined a clear commitment to driving a more equal response across mental and physical health. A key element of this is ensuring timely access to evidence-based and effective treatment, a vision outlined in Achieving Better Access for Mental Health Services by 2020. An Access and Waiting Time standard was implemented, stating that children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case. The standard includes all children and young people up to the age of 19 years in whatever setting (community or inpatients) the young person is receiving care

**Standards**

**% within 1 week**
The percentage of CYP Eating Disorder **urgent** cases started within 1 week of referral.
**% within 4 weeks**
The percentage of CYP Eating Disorder **routine** cases started within 4 weeks of referral.

**Progress to date:**

Sandwell now has a comprehensive all aged specialist eating disorder provision, ensuring that all people referred with Eating Disorders have access to effective dedicated eating disorder interventions from a dedicated committed and experienced multi-disciplinary workforce, resulting in improved outcomes. (ED pathway aged 5-18: appendix 5)

Service users are at the centre of the continued evolution of the service and their experiences are being improved through the elimination of transition from CAMHS to AMHS, despite robust transition protocols young people and their families have often found themselves in limbo as thresholds and philosophies of care differ.

The services recovery philosophy has ensured that people with Eating Disorders are involved and instrumental in every stage of their journey through the stepped model of care.

Our ‘stepped model’ recognises that the sooner someone with an eating disorder starts an evidence-based NICE concordant treatment the better the outcomes:

- Early intervention and prevention
- Specialist dedicated eating disorder out-patient provisions, and
- Non-admitted community care through our home treatment and day centre teams.

- The Eating Disorder Service adheres to set standards that drive and monitor the performance, these are:
- Working in partnership will both primary and secondary services to ensure that care team can identify, assess and when appropriate treat people with Eating Disorders and are fully coherent with the referral pathway to the specialist provision.
- Working in partnership with a range of acute and general medical treatments and services to ensure that physical health needs are addressed and information is shared on treatment and diagnosis.
- Working in partnership with inpatient provisions for children, young people and adults to ensure both timely access and discharge, with adequate follow up as recommended by NICE guidance.
- In line with influencing strategies and current evidence base the all age eating disorder service will work to develop a high quality, safe and therapeutic continuum of assessment, treatment and care for all ages across all tiers of service.

Interventions offered by our comprehensive provision include

- Cognitive Behaviour Therapy (CBT)
- Family Based Therapy (FBT)
- Interpersonal Psychotherapy (IPT)
- Dialectical Behaviour Therapy (DBT)
- Nutritional Counselling
- Cognitive Analytic Therapy (CAT)
- Psychiatric Interventions

**During 2016-17: Feedback from CYP**

**Service user 1**: *It's like having the weight of the world lifted off your shoulders. I feel as though I have bounced back and recovered finally from an awful condition I never expected any respite from*.

**Service user 2**: *I have learnt so many new skills from you to help me deal with and process all sorts of challenges in my life; without my eating or health being affected, and for the first time in a long time as a result I feel very confident going forward*.

**Service user 3**: *People like me wouldn't have a light at the end of the tunnel without people like you*

# Data

## POA Referral Intelligence

There was a 7.9% increase in the number of referrals between Qtr. 4 15/16 and Qtr. 1 16/17, with 57% for males and 43% for females. 52.6% of all referrals between September 2015 and the end of Qtr. 1 16/17 were for young people in the 12-16 year age group, whilst 40.5% of all the referrals were for young people in the 5-11 year age group.

**In total there were 737 referrals in Qtr1 17/18.**

- This quarter (QTR 1 2017-18) saw a decrease in the percentage of referrals received from Schools.
- Referrals from health colleagues saw a 10% increase this quarter (76%) compared to Qtr4 16/17 (66%)
- The rate of decisions made within 5 working days was greatly improved for this quarter, Qtr1 17/18 (42%), Qtr4 16/17 (26%)

Data demonstrated that 51% (377) of referrals had the Level of Need as 'Targeted' demonstrating a 7% increase on the last quarter. Those needing specialist intervention (Tier 3 CAMHS) equates to 28% (207) of all referrals. There have been no referrals from Children's Centres or external local authorities this quarter, and the number of referrals received from schools decreased again by 7%, the majority of these referrals continue to be identified as a Targeted Level of Need.

The wealth of data provided by the POA enables us to:

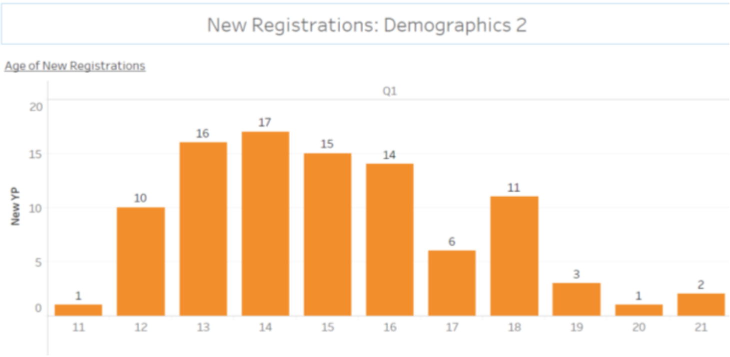
- monitor performance/progress of the POA in respect of capacity
- identity gaps, including capacity issues with service provision and the impact on the timeliness of interventions
- Identify trends

Sandwell & West Birmingham CCG and Sandwell Council have commissioned XenZone, a pioneer of online counselling services, to give children and young people (CYP) access to professional mental health counsellors through its online Kooth service, including provision 'out of hours'.

As with the POA, data is provided quarterly, this enables the CAMHS Board (and other partners) to better understand local need, and respond proactively.

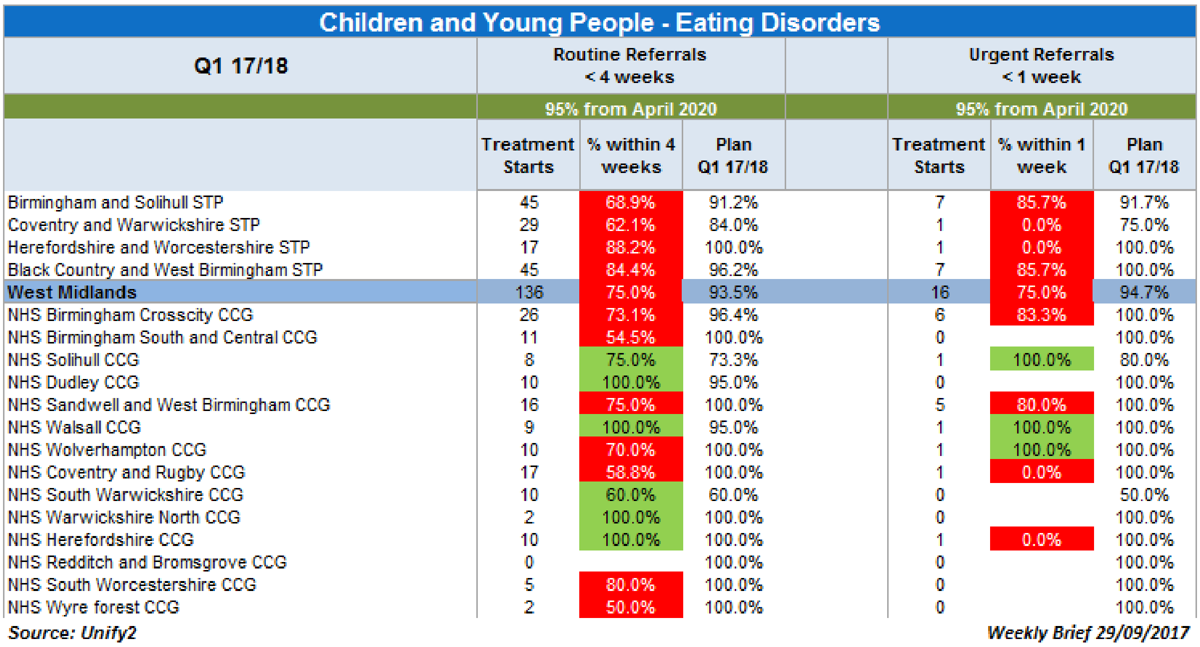
In Qtr. 1 2017-18 there were 1,078 logins and 96 new registrations. 64% of the logins were made out of hours

**New registrations by age**



## Eating disorder Service

**Qtr 1 2017 data: National target: 95%...............Local (aspirational target) 100%**



Children and Young People - Eating Disorders

| Q1 17/18 | Routine Referrals < 4 weeks | | | | Urgent Referrals < 1 week | | |
|---|---|---|---|---|---|---|---|
| | 95% from April 2020 | | | | 95% from April 2020 | | |
| | Treatment Starts | % within 4 weeks | Plan Q1 17/18 | | Treatment Starts | % within 1 week | Plan Q1 17/18 |
| Birmingham and Solihull STP | 45 | 68.9% | 91.2% | | 7 | 85.7% | 91.7% |
| Coventry and Warwickshire STP | 29 | 62.1% | 84.0% | | 1 | 0.0% | 75.0% |
| Herefordshire and Worcestershire STP | 17 | 88.2% | 100.0% | | 1 | 0.0% | 100.0% |
| Black Country and West Birmingham STP | 45 | 84.4% | 96.2% | | 7 | 85.7% | 100.0% |
| **West Midlands** | 136 | 75.0% | 93.5% | | 16 | 75.0% | 94.7% |
| NHS Birmingham Crosscity CCG | 26 | 73.1% | 96.4% | | 6 | 83.3% | 100.0% |
| NHS Birmingham South and Central CCG | 11 | 54.5% | 100.0% | | 0 | | 100.0% |
| NHS Solihull CCG | 8 | 75.0% | 73.3% | | 1 | 100.0% | 80.0% |
| NHS Dudley CCG | 10 | 100.0% | 95.0% | | 0 | | 100.0% |
| NHS Sandwell and West Birmingham CCG | 16 | 75.0% | 100.0% | | 5 | 80.0% | 100.0% |
| NHS Walsall CCG | 9 | 100.0% | 95.0% | | 1 | 100.0% | 100.0% |
| NHS Wolverhampton CCG | 10 | 70.0% | 100.0% | | 1 | 100.0% | 100.0% |
| NHS Coventry and Rugby CCG | 17 | 58.8% | 100.0% | | 1 | 0.0% | 100.0% |
| NHS South Warwickshire CCG | 10 | 60.0% | 60.0% | | 0 | | 50.0% |
| NHS Warwickshire North CCG | 2 | 100.0% | 100.0% | | 0 | | 100.0% |
| NHS Herefordshire CCG | 10 | 100.0% | 100.0% | | 1 | 0.0% | 100.0% |
| NHS Redditch and Bromsgrove CCG | 0 | | 100.0% | | 0 | | 100.0% |
| NHS South Worcestershire CCG | 5 | 80.0% | 100.0% | | 0 | | 100.0% |
| NHS Wyre forest CCG | 2 | 50.0% | 100.0% | | 0 | | 100.0% |

*Source: Unify2*

*Weekly Brief 29/09/2017*

### Exception reporting revealed the following

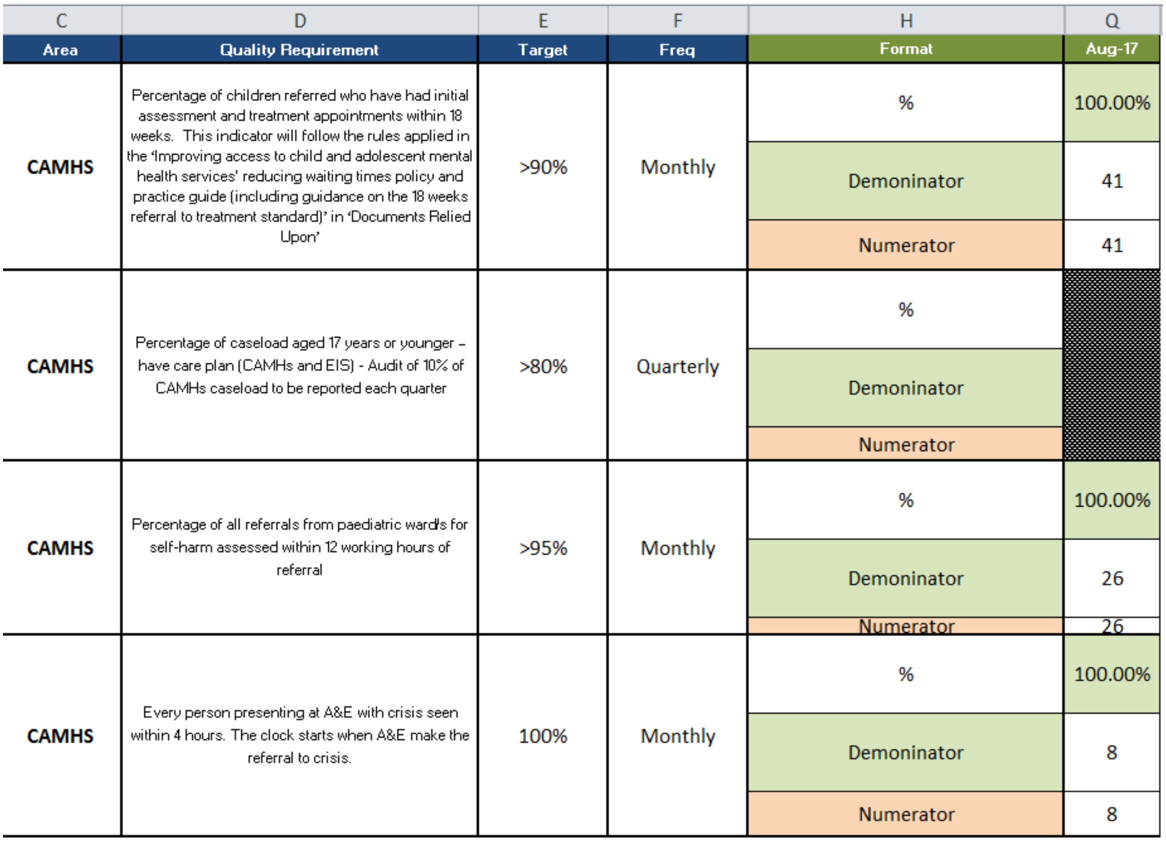
**Client 1** - offered two appointments and did not attend - offered a third appointment and attended but this was out of the waiting time standard for routine waits
**Client 2** - demand on service increased and capacity not available to offer within the agreed time frame
**Client 3** - client was seen prior to the routine appointment time by CAMHS Crisis team and admitted for inpatient episode, the appointment was not cancelled on the system

### Specialist CAMHS

There are four key KPIs (excluding those relating to Eating disorders) that are included in the current contract with the provider trust.

1. Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks.
2. Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS) - Audit of 10% of CAMHs caseload to be reported each quarter
3. Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral
4. Every young person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis.

The provider trust is currently meeting all four performance targets (see below)



| C | D | E | F | H | Q |
|---|---|---|---|---|---|
| **Area** | **Quality Requirement** | **Target** | **Freq** | **Format** | **Aug-17** |
| **CAMHS** | Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'Improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard)' in 'Documents Relied Upon' | >90% | Monthly | % | 100.00% |
| | | | | Demoninator | 41 |
| | | | | Numerator | 41 |
| **CAMHS** | Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS) - Audit of 10% of CAMHs caseload to be reported each quarter | >80% | Quarterly | % | ▨ |
| | | | | Demoninator | |
| | | | | Numerator | |
| **CAMHS** | Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral | >95% | Monthly | % | 100.00% |
| | | | | Demoninator | 26 |
| | | | | Numerator | 26 |
| **CAMHS** | Every person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis. | 100% | Monthly | % | 100.00% |
| | | | | Demoninator | 8 |
| | | | | Numerator | 8 |

## Urgent & emergency crisis Care

### Crisis Intervention and Home Treatment Team

Future in Mind document stated that the 'litmus test of any local mental health system is how it responds in a crisis'. (FiM, DoH 2016) our local transformation plan has further invested in provision to support the development of a comprehensive care model to support young people in a mental health crisis.

Our model supports crisis presentations at the acute hospital and within the community and accepts the out of hours care for young people who are attending specialist core CAMHS. The team also provides home treatment for those presenting with greatest risk or who are unable to attend other services. Home treatment is also provided to young people who present with eating disorders and support for any young person requiring mental health act assessment in a place of safety. These provisions ensure that there is a swift and comprehensive assessment of the nature of the crisis.

Our model is driven by a value base that ensures:

- Crisis management is a process of working through a crisis until it is resolved.
- Successful service user engagement is paramount.
- The achievement of a therapeutic alliance with the service user and already involved CAMHS Clinician or referrer is essential before any intervention can be successful.
- The team takes a systemic approach, looking at all the factors involved in the crisis, including biological, psychological and social issues and the context in which that young person lives, using a range of interventions to address these.
- Crisis staff will approach work with service users from a "strengths" rather than an "illness" model, and draw on the innate strengths of service users in order to support them. Communication and engagement processes are of specific importance when dealing with service users with disabilities or whose preferred language is not English.
- Providing crisis management and educating service users and carers to acquire coping skills will form a significant part of the crisis work. The team will assist the service user and their carers to acquire/learn behaviours to improve maintain their mental health. The approach should be one of collaboration with the service user and/or their family by "doing work with them", so as to promote their "ownership" of the crisis.
- As far as is reasonably practicable, the team will work in a way that demonstrates regard for the present, past wishes and feelings of the person receiving services and their cares and/or legal guardian.
- Standards of care will reflect evidence based practice and fit within the CIHTT referral pathway.

CIHTT staff fully exercise their duties in respect of safeguarding adults and children by working with partner agencies to protect vulnerable persons from abuse. This is achieved through cooperating in discussions, meetings and investigations with relevant agencies whenever abuse is suspected or reported.

The current objectives of the service are:

- To provide emergency (Same Day Assessments)
- Provide an extended level of support in conjunction with Core CAMHS/CAMHS ED to support young people at home and avoid hospital admission.
- Provide urgent assessment and intervention to young people who are not known to CAMHS.
- Assess young people in Crisis develop their care plan and ascertain if there is a need for hospital admission and co-ordinate the admission.
- Support young people with stepping down from a hospital admission back into the community.

- Advice and signposting to other agencies regarding appropriate responses and pathways into services.
- Managing and responding to CAMHS 136 suite.
- Gatekeeping of inpatient beds with CAMHS Consultant psychiatrists.

**Current Crisis Intervention & Home Treatment Team**

| | | |
|---|---|---|
| Admin & Clerical | Band 3 | 2.00 WTE |
| Sandwell Consultant | | 0.20 WTE |
| Qualified Nurse | Band 5 | 1.00 WTE |
| Qualified Nurse | Band 6 | 4.00 WTE |
| Qualified Nurse | Band 7 | 3.00 WTE |
| Qualified Nurse | Band 8A | 1.00 WTE |
| Sandwell Specialist Doctor | | 1.00 WTE |

Sandwell's increased investment in the above provision has resulted in the development and delivery of a very comprehensive model, capable of supporting children & young people whom are experiencing a mental health crisis. The Crisis intervention & home treatment team's services have been extended beyond the typical core hours of: 9:00 – 17:00 Monday to Friday to now offering a comprehensive service 7 days a week from 08.00 - 20.00. In addition there is access to a CAMHS psychiatrist on call outside of the core hours to ensure support 24/7 if necessary, for any children or young people who is experiencing a crisis, and has been transported or transferred to an acute hospital setting.

In addition work is progressing via the STP work stream across the Black Country to increase the service, to ensure provision is available 24 hours a day, 7 days a week across the Black Country. Collectively a bid has been submitted to NHSE, to secure funding for **Mental Health Crisis, Intensive Community Support and Paediatric Liaison Service for Children and Young People.** The bid includes additional capacity to ensure delivery 24/7 365, and access to:

- Care and support for patients with high levels of and / or acute need
- In- reach into Acute and Paediatric Wards and Accident and Emergency and Urgent Care Centres and CAMHS TIER 4 units to provide timely assessment and intervention at times of crisis and timely discharge
- Intensive Support to prevent avoidable admissions (including medical, psychological and social models of support / intervention including Family Therapy and DBT), including for those with Complex Needs and / or High Volume Service Users
- Robust care packages for patients with high levels of need including patient reviews, early discharge and repatriation

Should the NHSE bid be unsuccessful, CAMHS commissioners across the STP footprint are committed to delivering a 24/7 service model, and will continue to identify funding opportunities locally and nationally to assist with the transformation of crisis provision.

In addition to the above Sandwell has access to a dedicated 'place of safety' (136 suite). Partners are working collaboratively to agree plans, and offer assurance to NHSE, that when the regulations change the provision is ccompliant with the legislation, regarding the detention of adults and Under 18s under section 136 of the Mental Health Act (MHA).

## Triage Car

The availability of a ‘the triage car’ further enhances the crisis provision locally. It is mostly called by 999 to assist in an emergency, data demonstrates that there are a number of younger adults and children accessing this service which aims to prevent hospital admissions (unless the child requires inpatient care)  A number of case studies shared have evidenced that this type of support has and will continue to save lives given the fast response (mostly under one hour, the police powers to access property, the paramedic with the skills to provide essential first aid and the CPN providing the psychiatric support.

# Integration/Transition

Sandwell's LTP is working towards **integration** across the whole CAMHS pathway to ensure that Sandwell C&YP are seen by the right people, in the right time and at the right place. Our EHWB provision for young people accessing help is a partnership consortium currently led by the Children's Society in partnership with other local voluntary sector providers, woman's aid and BCPFT.

**All** referrals for mental health and wellbeing enter these services via the jointly managed Point of Access as previously described. The POA clinicians not only triage referrals and ascertain further information from referrers but they also facilitate transition of cases up and down the CAMHS pathway should a need be identified.

**Transition**

Sandwell's specialist CAMHS provider has committed to implementing the Transitions CQUIN: Age-based Transitions out of Children and Young People's Mental Health Services.

The CQUIN: consists of three components;

1. a case note audit in order to assess the extent of Joint-Agency Transition Planning; and
2. a survey of young people's transition experiences ahead of the point of transition (Pre-Transition / Discharge Readiness); and
3. a survey of young people's transition experiences after the point of transition (Post-Transition Experience).

The following principals have been adopted in the local CAMHS transition CQUIN plan, and have been developed in line with the following national guidance recommendations; Quality Criteria for young people friendly health services; Your Welcome (DoH, 2011), Closing the Gap (DoH, 2014), Future in Mind, (DoH, 2015), Five Year Forward View (NHS England, 2014) From the pond into the sea Children's transition to adult health services (CQC 2014), Transition from children's to adults' services for young people using health or social care services (NICE NG43 2016)

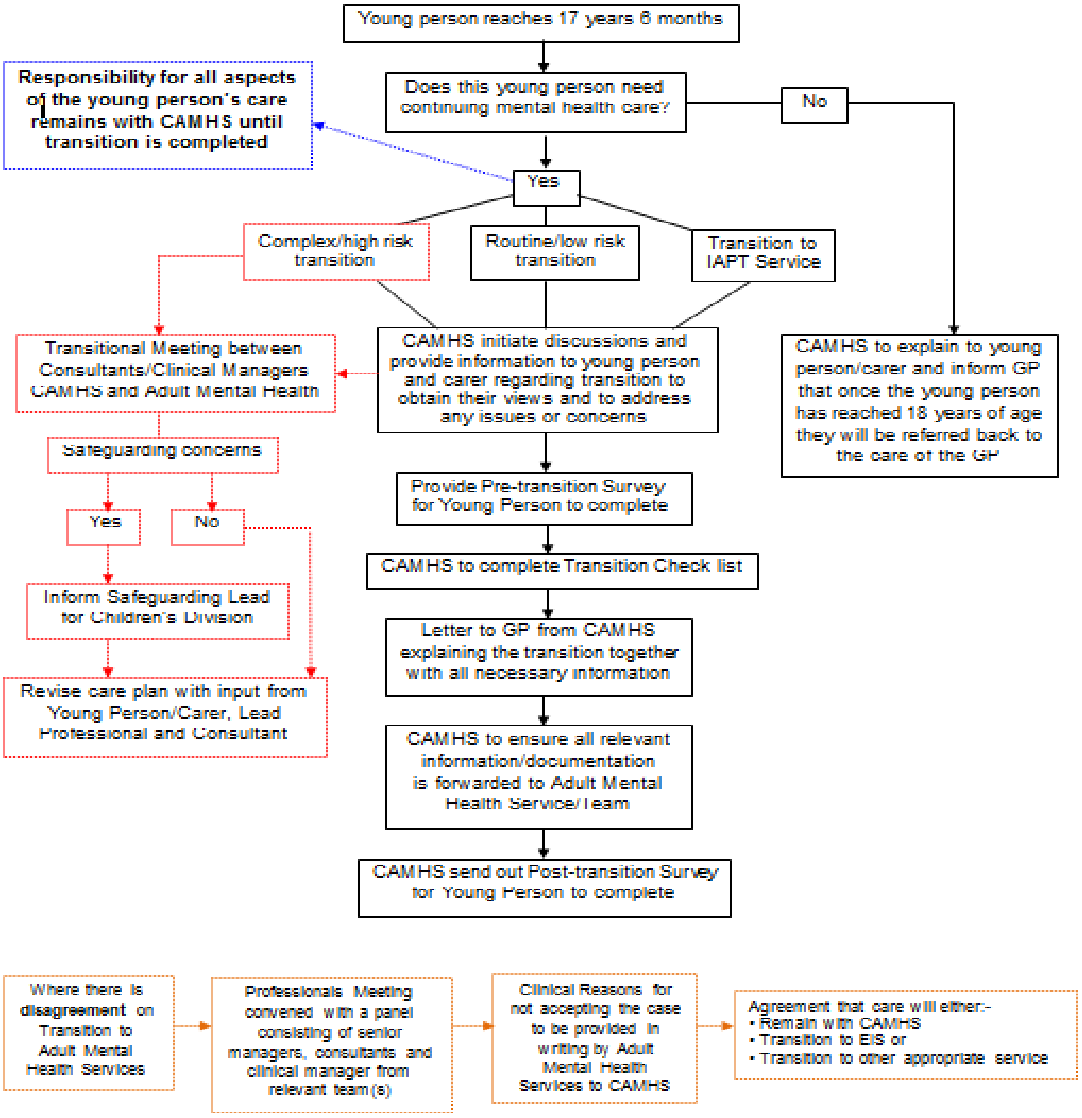
All young people will have access to age-appropriate services that are responsive to their specific needs as they grow into adulthood. All transition processes are planned and focused around preparation of the young person. Young people and their families are actively involved in transition planning. Plans for young people are developed between agencies as appropriate, and ensure that:-

- ✓ Young people are not transferred fully to adult services until the supports are in place to enable them to function in an adult service;
- ✓ Individual disciplines have clear good practice protocols for the management of young people's health during transfer to adult care.
- ✓ General Practitioners are kept informed; and
- ✓ Joint audit of local transitional arrangements is undertaken

The trust has developed their Engagement Implementation Plan for Qtr 1, (appendix 4) in line with both the CCG, and NHSE expectations. The plan includes a very comprehensive transition pathway (below)

### 4.0 Transition Pathway

**Young Person from CAMHS to Adult Mental Health Services**



In addition to the CQIUN work, the SEND DMO is leading on the development of a comprehensive joint transition policy, this will include provision across schools, primary care, early help etc.
The DMO will be adopting a co-production approach to ensure young people are engaged in the process. A time limited task & finish group is about to be established locally to develop a joint policy that will suit the needs of CYP, including those that are vulnerable (SEND) and encompasses current best practice. Progress of this work will be monitored as part of the 'Written Statement of Action' used to inform DfE/CQC following the recent joint SEND inspection

## Early Intervention in Psychosis

Sandwell commission the Black Country Partnership NHS Foundation Trust (BCPFT) to provide community Early Intervention (EI) Services, support for young people and adults aged between 14-65 who are going through their first episode of psychosis, or who seem at risk of going through psychosis.

The specialist approach that this service offers, aims to improve recovery outcomes for patients by reducing relapse and readmission rates. This enhances the likelihood of a patient returning to or remaining in employment, education or training. Evidence based research into Early Intervention Services has highlighted the significant positive impact it has on patient outcomes.

The dedicated team consists of Psychiatric Nurses, a Psychologist, Specialist Doctor, Occupational Therapist, Consultant Psychiatrist and a Medical Secretary. The dedicated Consultant is able to support both physical and mental health issues, ensuring continuity of care. The team link into staff within Primary Care GP practices, providing information/education to support the reduction of the duration of undiagnosed psychosis (DUP). This improves the likelihood of the young person/adult receiving the treatment they require at the right time, by the right person, with the right skill.

***Sandwell EI Service model***

Early engagement /assertive engagement/reduce stigma

Early Intervention/early assessment

Reduction of DUP

Recovery approach/3 years

Vocational rehabilitation

Small caseload -15 clients

Relapse plan

Crisis plan

Physical Health Monitoring

Enhanced MDT with dedicated Medic

Psychological Interventions

The model provided fits the national agenda for EI services. Various publications -Mental Health Crisis Concordat (Feb 2014), Practical Mental Health Commissioning (joint commissioning panel for Mental Health) and the Mental Health Five Year Forward View- have been released indicating the need for better links between Primary and Secondary Care to provide a more dynamic mental health service. The importance of EI services in providing this link has been highlighted nationally.

The Department of Health and National Institute for Health and Care Excellence (NICE) indicate that EI Services can improve patient outcomes allowing them to have a better quality of life and has the potential to save the NHS £44 million per year (Department of Health, October 2014, Achieving Better Access to Mental Health Services by 2020).

In February 2011, the Mental Health Strategy 'No Health without Mental Health' indicated six objectives to improve mental health outcomes. Key priorities highlighted in this document include

- **Prioritising EI services across all age groups.**
- Tackling health inequalities.
- Supporting people who experience mental health issues to recover meaningful lives.

The model outlined above provides an extended service running from 8am-8pm, including dedicated link workers that liaise with various external agencies; providing additional support, education and training to assist with the earlier referral of patients and helping patients sustain a good quality of life.

The 8-8 service is flexible and responsive to community needs; Sandwell EI also supports those Primary Care centres which offer extended hours to patients. Appointments are offered outside of usual office hours increasing the contacts the service can provide. The joint working with employment agencies has been significant in supporting those patients seeking to return to employment, further support, assistance, enhancement of skills and confidence building has also been possible by linking in with recovery colleges and other partnership agencies.

Sandwell EI services have clinical pathways which lead into CAMHS and Adult Mental Health Services, supporting safe and effective transition. The service is integral to the mental health community services that BCPFT deliver.

The Early Intervention team's promotion and education of Psychosis within Primary Care and Local Communities has encouraged early contact with the service, thereby reducing the duration of undiagnosed psychosis in patients and potentially reducing the risk of future relapse and hospital admission.

The flexibility of the service allows it to respond to community needs, links have been made with external agencies that can assist with the quality of life experienced by the patient, enabling some to remain in employment and assist those dealing with substance misuse. Early Intervention clients have often presented with comorbid substance misuse as an integral part of their complexity, and the interface with these services has been crucial, the EI consultant has a training specialist endorsement in substance misuse which is proving beneficial during clinical reviews; risk assessment and the treatment requirement of this client group.

Sandwell EI services are also committed to providing a comprehensive physical health evaluation for all new referrals and for ongoing cases as they are often on anti-psychotic medication, this is also maintained for all new referrals into the service.

## Impact & Outcomes

Previous chapters provide comprehensive information in respect of the ‘transformation’ road map to date. This refresh demonstrates the progress made locally, and the services/initiatives/projects locally that are innovative and key enablers to the transformation.

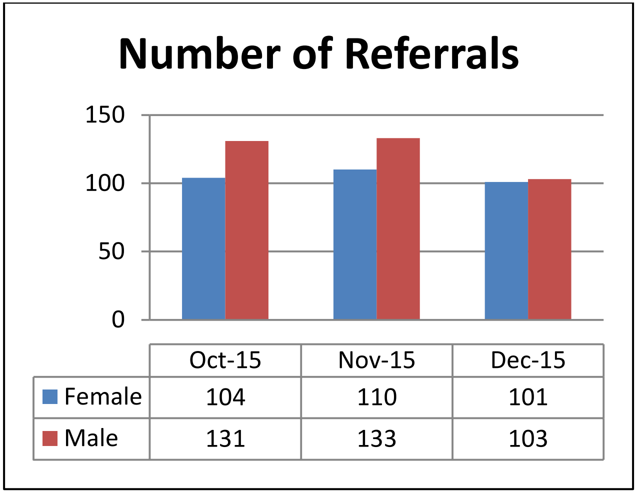
Our commitment to the CYP IAPT programme (early membership) and our plans to develop a suite of ROMs across all CAMHS services, clearly further demonstrates our commitment to commission for outcomes and not activity

Collaborative commissioning is successful in Sandwell and allows us to be both optimistic and enthusiastic in respect of further improvements to provision. The partnership are excited about emerging opportunities e.g. STPs, New Care Models, Vanguards etc

**Key successes:**

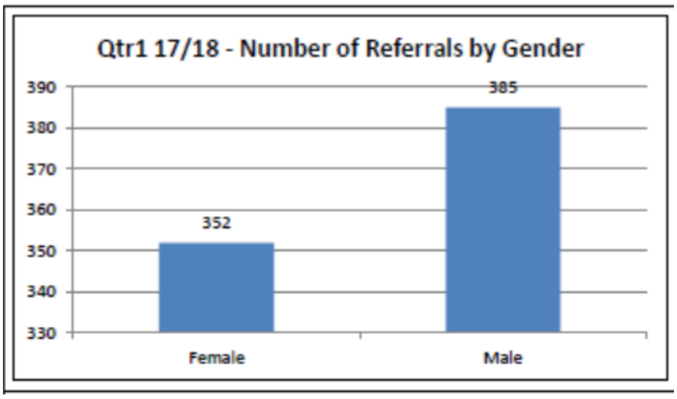
**Single point of access, leading to increased access**

Referrals Qtr 3 2015-16 (first data following implementation) **total 682**



| | Oct-15 | Nov-15 | Dec-15 |
|---|---|---|---|
| 🟦 Female | 104 | 110 | 101 |
| 🟥 Male | 131 | 133 | 103 |

Referrals Qtr 1 2017-18 **total 737**



This demonstrates an increase of 8%, in respect of CYP accessing CAMHS Tier 1, 2 and 3. However this figure is not inclusive of cyp facing crisis and accessing provision via urgent care

## Comprehensive Tier 2 provision, including drop in sessions and self-referral

Case Study 1
Name: HB, age: 10, Area/Town: West Bromwich, Ethnicity: White British

**Home situation.**

HB lives with Mom, Dad and 8-year-old brother

**Reason for Referral.**

Mum took HB to the GP because she was concerned about behaviours he was presenting at home. These included him making strange sounds and having extreme mood swings that often led to violent outbursts.

**Work/targets undertaken.**

In the first session HB attended the drop in with his mum and dad. He was extremely shy and unable to engage with me. His eye contact was poor, with mum and dad doing most of the talking. They explained that they suspected he may have autism as his behaviours seemed to be suggesting this. An intense dislike for self was prevalent which resulted in him hitting his head off the floor and stating that he wanted to die. HB also struggled with social interactions and was unable to make or keep friendships easily. This was affecting his feelings towards school as he became quite isolated. He then bottled up these frustrations all day, letting them out in fits of rage when he came home. When he returned the following week he felt a little more at ease and was able to meet with me on his own. He gradually began to talk about his difficulties, exploring his thoughts, feelings and reactions to them. We also looked at changes that were possible to his behaviours and how he might be able to implement them. In-between sessions I contacted the school who informed me that they had no concerns about HB and hadn't observed any autistic traits from him and as such a referral to Inclusion Support was deemed unnecessary. The sessions carried on for a number of weeks, each time HB would talk through his week, identifying what had worked and what was more challenging. From this he was able to put strategies in place in a step by step approach that helped him reduce the difficulty and increase positivity. Client's response to intervention. After the initial reluctance he acknowledged his difficulties and was quite upset that his reactions had become so problematic. As a result, he was willing to work through strategies to help him instigate changes. HB is small in stature and disliked it when people talked to him as if he were younger than he was. At the drop in he responded well to the conversation as he felt that he was treated in a way that was appropriate for his age. He told me that he preferred working with me as some of the female staff didn't understand him. One particular week I was busy when he arrived at the drop in and it would have meant a very long wait if he wanted to see me. He was given the option to work with someone else but he refused and went home without being seen. The following week we were able to explore this in more detail and it became a focus of our work for a while. He struggled with relationships and needed support to help navigate ways of accepting himself as well as other people. He responded well to the identification of his positives as a starting point and gradually became kinder to himself as a result. He also felt that because he didn't have a wide circle of friends that this was negative. In our exploration of relationships, he was able to see that the few trusted friends he did have were good and it was beneficial for him to invest in them. By the end of our time together his relationships with friends in school where much better and was the eventual catalyst to the conclusion of our work. HB explained his current feelings, how things had moved in a positive direction and that he wouldn't need the service anymore. He left with a greater appreciation of his own qualities and a group of friends that he was able to connect with.

Changes observed by self and others.

HB demonstrated significant changes in the way he engaged with me at the drop-in. When we first met he struggled to speak to me or give me eye contact. By the end he was engaged in full conversation, explaining his emotional journey really well. He was also able to engage with different people at the drop-in not just me and seemed to have a lot more self-belief. Mum explained that his behaviours at home were better and although he still had arguments with his brother he had a way of calming himself which he wasn't able to do before. The self-hatred that she had upsettingly witnessed was not happening anymore which was a huge relief.

**Barriers to positive progress.**

Mums initial feelings that he had a medical difficulty were a barrier to begin with as she was looking for a diagnosis. She gained an understanding of the emotional wellbeing service as the sessions went on and how the intervention could support her son to make positive changes. Although HB made a significant amount of progress he still has low self-esteem, which will be a continual difficulty that he will have to overcome.

**Recommendation for the future based on Client's progress.**

HB would benefit from a safe place to talk about any difficulties that arise for him such as a mentor in school. He doesn't need continual support, but someone on hand if he needed to would be beneficial.

HB has been given the option of using the drop-in if he feels that is needed at some point in the future.

## On line Provision

Sandwell commission Kooth, an online counselling and emotional well-being support service for children and young people available free at the point of access, as an early intervention solution. Kooth helps to reduce waiting times for young people seeking help while removing the stigma associated with accessing mental health support.

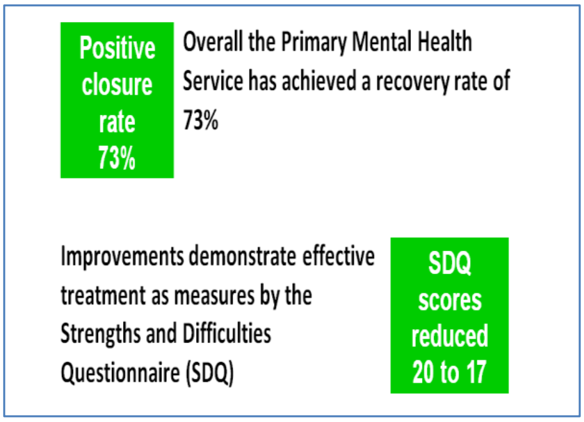
Feedback from children and young people has been very positive:

*"I love this website it kind of helped me and I can actually share with someone without knowing who it is and the happiest thing is that it gives me a logical way of thinking."* Sandwell young person

"*Kooth is very supportive and I'm only in year 7 but I think I'll be on kooth until I'm almost 18. it's so supportive and I love how I don't know the people"* Sandwell young person

## Community based Primary Mental Health Workers, including specialists for: LAC, YOT and CSE

Positive responses in respect of the PMHW service

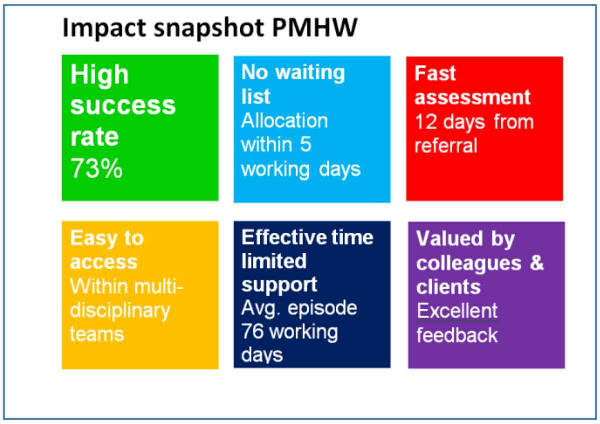


Positive closure rate 73%

Overall the Primary Mental Health Service has achieved a recovery rate of 73%

Improvements demonstrate effective treatment as measures by the Strengths and Difficulties Questionnaire (SDQ)

SDQ scores reduced 20 to 17



Impact snapshot PMHW

**High success rate** 73%

**No waiting list** Allocation within 5 working days

**Fast assessment** 12 days from referral

**Easy to access** Within multi-disciplinary teams

**Effective time limited support** Avg. episode 76 working days

**Valued by colleagues & clients** Excellent feedback

## Comprehensive ED service

Capacity has improved as demonstrated below: in 2014-15, 40 young people accessed the service, in 2016-17 the number rose to 91

**Eating Disorder Referrals Under 18 years 2014-2017**

| Age at Referral | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
|---|---|---|---|---|---|---|---|
| 2014/15 | | | 1 | 2 | 2 | 35 | 40 |
| 2015/16 | 2 | 3 | 5 | | 5 | 22 | 37 |
| 2016/17 | | 7 | 13 | 19 | 13 | 39 | 91 |
| Total | 2 | 10 | 19 | 21 | 20 | 96 | 168 |

## Schools Charter Mark

Impact to date:

- 66 schools have engaged so far
- The majority of schools that have completed the cycle have seen improvements in staff sickness, pupil attendance, tier 2 referrals, and school change requests.
- Pre-and post-staff perception surveys show an increase in average scores across five domains: Environmental, quality, self-esteem, emotional processing, self-management and social participation.
- 26 other Educational Psychology Services from other LA’s have adopted the model.
- The pupil wellbeing survey has been used by schools to identify students requiring additional support as well as give an overall baseline position for cohorts of pupils. Following factor analysis and standardisation the measures have been adjusted, so we will be in a position to compare scores before and after the action planning process in the future.

## Early Intervention service, in partnership with Adult commissioners

**Key outcomes**

- Meeting KPIs
    - 95% of all routine EI referrals receive initial assessment within 5 working days
    - 80% of caseload 17 years or under have a carers care plan
    - 85% of caseload will have a crisis or relapse prevention care plan

- Meeting NICE guidelines
    - A maximum wait of two weeks from referral to treatment
    - Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia

- Meeting the CQUIN targets
- Reduced Duration of Undiagnosed Psychosis
- Strengthened links between Primary Care and Secondary Care
- Improved Patient and Carer experience
- Skilled staffing within service to offer Medical Support
- Ability to offer Family Therapy and Support
- Reduced Hospital Admissions
- Reduction in relapses
- Comprehensive physical health Evaluation

## Formal Engagement

Sandwell undertook a wholescale engagement exercise in 2015, to inform on the Local Transformation Plan. The plan outlined the commitment to further formally engage with children, young people, parents, carers and providers on an annual basis.

Since the initial consultation/engagement exercise in 2015, over 140 people have participated in activities to share their views about CAMHS. The outcomes to date are:

- Over 120 young people are aware that their voice is important in the transformation of services they have access to.
- Over 20 parents/ carers and relevant professionals are aware that they can input into the transformation of services their children, or children they work with could use.
- 5 young people were highly engaged to help lead on the engagement work locally and co-design activities, integral to the work but also sought to develop their skills and knowledge.
- Baseline views around what young people worry about, and what they believe would be a good service was sought. This will be referred to throughout the transformation when focusing on specific elements of CAMHS.
- Baseline views around crisis situations and what young people think they are and what support they would want if they were in that situation. This will be expanded upon and support recommendations to the crisis intervention home treatment team service, which is being formerly reviewed (as part of the commissioning cycle) in November 2017.

## Next steps!

- Sandwell will consult with all partners on the content of this draft ‘refreshed’ transformation plan.
- Amendments were necessary will be made, before publication, and following assurance from NHSE.
- The refresh will be formerly discussed at the Health & Wellbeing Board on November 28th 2017
- The refresh will be formerly discussed at the CAMHS Transformation Board on November 21st$^{th}$ 2017
- Plans will be edited into a plain English version to ensure that it is accessible to all.
- A summary document that outlines the plans will be developed following full assurance, and sign off from all partners
- The plans will be made available via Sandwell & West Birmingham CCG website.
- Links to the plans will be made available on Local Authority websites.

## Contributions

Anet Baker: SWB CCG

Sarah Hogan: BCPFT

Paulette Morris: BCPFT

Sarah Cresswell: Childrens Society

Mandip Chahal: Sandwell LA

Sarah Farmer: Sandwell PH

Kevin Roland: Sandwell LA

Liz England: Clinical Lead, SWB CCG

Adnan Khaliq: CAMHS Finance Lead, SWB CCG

Phil Walsh: NHSE

## Appendices

| | | |
|---|---|---|
| **1** | 2015-16 Initial LTP | Sandwell CAMHS Transformation Plans |
| **2** | 2017-18 KLOE | Copy of REFRESHED KLoE Guidance for L |
| **3** | JD: Health EHC Planning Officer for Special Educational Needs and Disability (SEND) | JD Health EHC planning Officer for S |
| **4** | CYPMHS Transition to Adult Services: Engagement and Implementation Plan | 5. Engagement Plan CYPMHS Transition t |
| **5** | SANDWELL CAMHS 5-18 CARE PATHWAY: EATING DISORDERS | **SANDWELL CAMHS Care Pathway Templ** |
| **6** | POA: Operational Guidance | POA Operational Guidance Final Versio |
| **7** | | |
| **8** | | |

Sandwell
Metropolitan Borough Council

Agenda Item 4

# REPORT TO CHILDREN'S SERVICES AND EDUCATION SCRUTINY BOARD

**05 February 2018**

| | |
|---|---|
| **Subject:** | Children's Oral Health |
| **Cabinet Portfolio:** | Adult Social Care, Health and Wellbeing |
| **Director:** | Executive Director of Children's Services – Jim Leivers<br>Executive Director of Adult Social Care, Health and Wellbeing- David Stevens<br>Director of Public Health-Ansaf Azhar |
| **Contribution towards Vision 2030:** | ♥ 🎓 |
| **Contact Officer(s):** | Valerie DeSouza<br>Valerie_DeSouza@sandwell.gov.uk<br>Cindy James<br>Cindy_james@sandwell.gov.uk |

## DECISION RECOMMENDATIONS

**That Children's Services and Education Scrutiny Board:**

1. Consider the update on Children's oral health in Sandwell, including access to services.
2. Make any comments and recommendations as necessary.

## 1 PURPOSE OF THE REPORT

1.1 To update the board on Children's oral health in Sandwell, including access to services.

## 2 IMPLICATIONS FOR SANDWELL'S VISION

- Sandwell is a place where we life healthy lives and live them for longer.
- Our children benefit from the best start in life

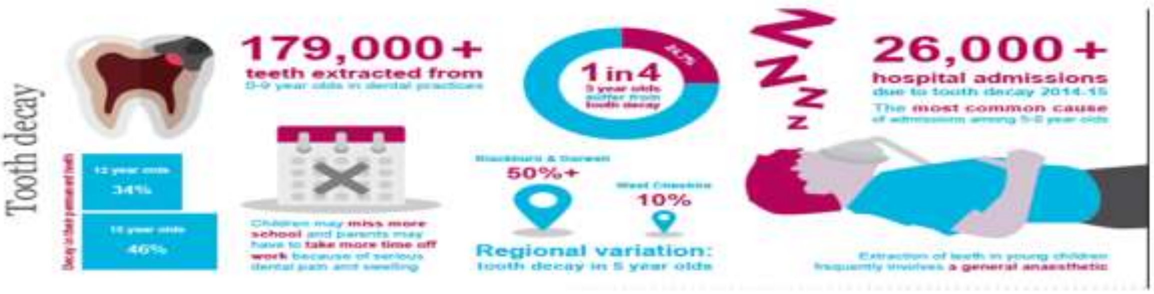
## 3 BACKGROUND AND MAIN CONSIDERATIONS

Good oral health is essential to good general health and achieving a good quality of life. The World Health Organisation defines good oral health as a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing. Poor oral health impacts not just on the individual's health but also their wellbeing and that of their family.

Oral health is an important aspect of a child's overall health status and of their school readiness. Tooth decay is the most common oral disease affecting children and young people in England yet it is largely preventable. Findings from Public Health England's (PHE) *2015 national dental epidemiology survey of 5 year old children* showed that in 2015 in England, approximately a quarter (25%) of 5 year olds had experienced tooth decay. In those children who had experienced decay an average of 3 or 4 teeth were affected. The vast majority of tooth decay was untreated.

Every child who has teeth is at risk of tooth decay. Children are more at risk of developing tooth decay if they are eating a poor diet and brushing their teeth less than twice per day and not using toothpaste containing fluoride. These risks are more common for those living in more deprived areas.

Poor oral health impacts on children's and families' wellbeing and is costly to treat. It suggests wider health and social care issues such as poor nutrition, obesity, the need for parenting support, and in some instances safeguarding and neglect. Children who have toothache or who need treatment may have to be absent from school.



Parents may also have to take time off work to take their children to the dentist. Dental treatment is a significant cost, with the NHS in England spending £3.4 billion per year on all ages primary and secondary dental care (with an estimated additional £2.3 billion on private dental care).

Children who experience high levels of disease that are treated with fillings and other restorations at a very young age will require complex and expensive maintenance as they get older.  Those children with a poor oral health regime and unrestricted dietary habits will fare the worst and have treatment which not only maintains their historic decay and poor oral health but also require treatment of new oral problems as they age.

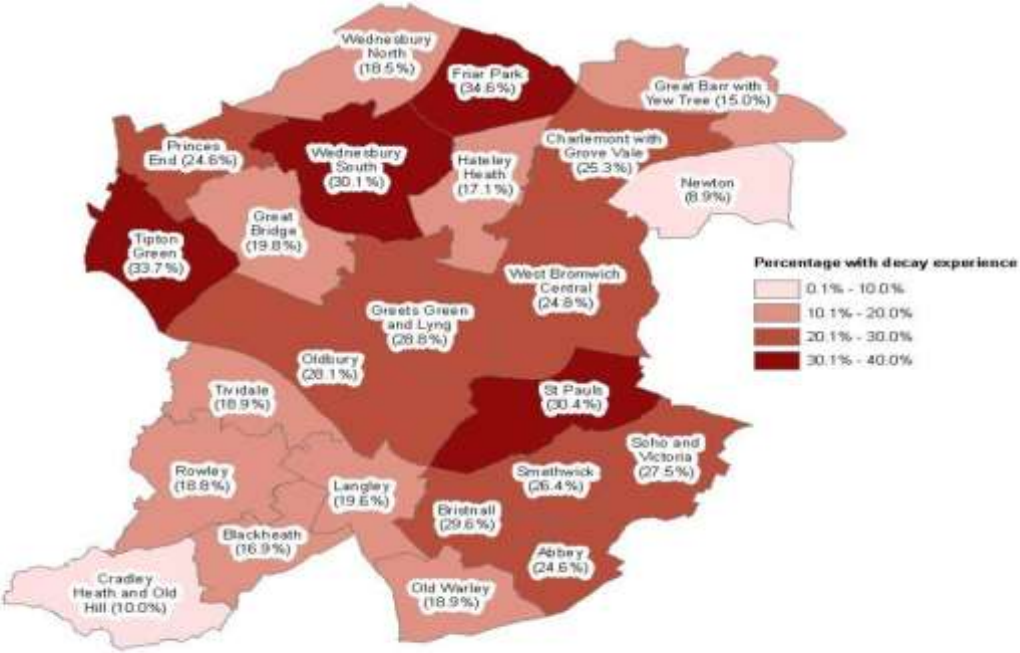
## 4 THE CURRENT POSITION

### 4.1 Dental Health of five-year-old children in Sandwell

The level of dental decay in five year old children is a useful indicator of the success of a range of programmes and services that aim to improve the general health and wellbeing of young children.  In the public health outcomes framework one of the indicators is the proportion of children aged five years free from dental decay.

In the 2015 National Dental Epidemiology Programme survey, 4,196 children were sampled of whom 2,568 (62.4%) parental consent was provided to take part in the survey and were clinically examined at school by trained and calibrated examiners, who used the national standard method.  It is important to note that the parents who consented to take part in the service may be more interested in their children’s oral health than the general population, which may impact the results of this survey.

Figure 2. Map showing decay prevalence by wards in Sandwell local authority (2015).



Source: Public Health England

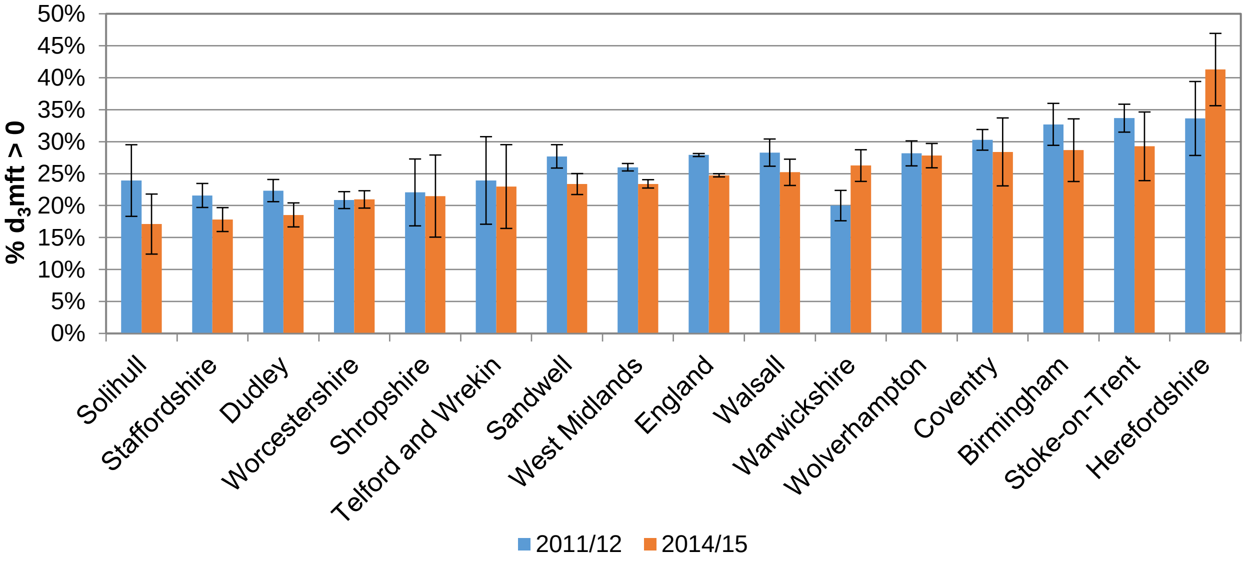
Overall Sandwell local authority has levels of decay that are lower than the average from England (Table 1). The higher levels of decay in Sandwell are concentrated in the wards of Friar Park, Tipton Green, St Pauls and Wednesbury South (Figure 2).

**Table 1**: The average number of decayed, missing (due to decay) or filled teeth (d3mft), the proportion of children affected by dental decay along with the average d3mft in those children with decay experience in Sandwell compared with England and local authorities in the West Midlands region.

| LA | Average d3mft | % with decay experience | Average d3mft in those with decay experience |
|---|---|---|---|
| Herefordshire, County of | 1.4 | 41.3 | 3.5 |
| Stoke-on-Trent | 1.2 | 29.3 | 4.1 |
| Coventry | 1.0 | 28.4 | 3.7 |
| Wolverhampton | 1.0 | 27.8 | 3.6 |
| Telford and Wrekin | 0.9 | 23.0 | 3.8 |
| **ENGLAND** | 0.8 | 24.7 | 3.4 |
| Birmingham | 0.8 | 28.7 | 2.9 |
| Warwickshire | 0.8 | 26.3 | 3.1 |
| Shropshire | 0.8 | 21.5 | 3.7 |
| **WEST MIDLANDS** | 0.7 | 23.4 | 3.1 |
| Sandwell | 0.7 | 23.4 | 2.9 |
| Walsall | 0.7 | 25.2 | 2.7 |
| Worcestershire | 0.6 | 21.0 | 3.1 |
| Solihull | 0.6 | 17.1 | 3.3 |
| Staffordshire | 0.5 | 17.8 | 2.8 |
| Dudley | 0.5 | 18.5 | 2.5 |

Source: Dental Health Profile – Sandwell 2015

Figure 3. Oral Health of 5 years old % across the West Midlands that have experienced decay



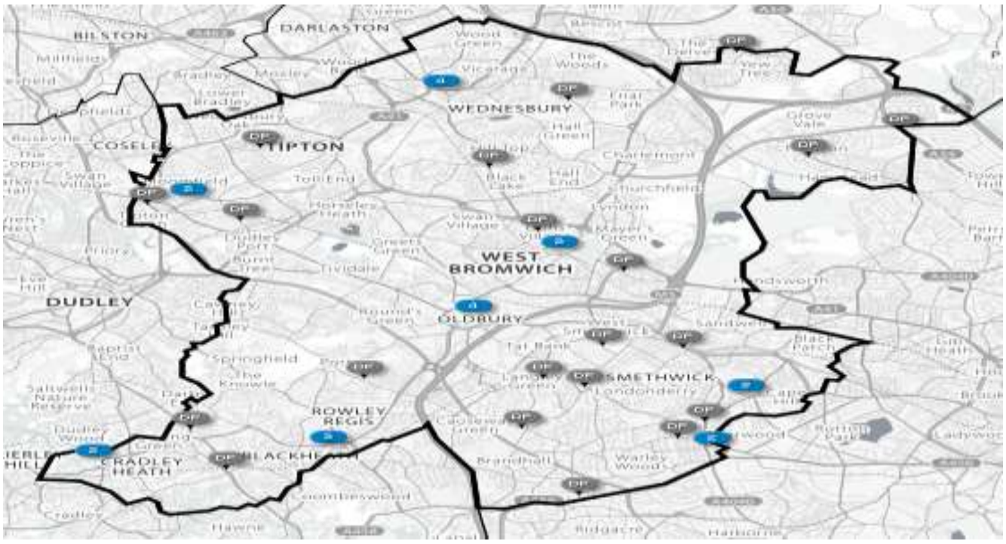
Source: Public Health England

## 4.2 Access to Dental Services in Sandwell

Dental treatment is free if you are under 18, or under 19 and in full-time education, pregnant or have had a baby in the previous 12 months. It is advised that children should be seeing a dentist as soon as their teeth start to appear. All children over three years should have fluoride varnish applied to their teeth, if younger children are at particular risk of tooth decay the dentist may also apply this.

Within Sandwell there are 44 NHS Dental Practices commissioned widely across the six towns of Sandwell.

Figure 5. NHS Practices across Sandwell



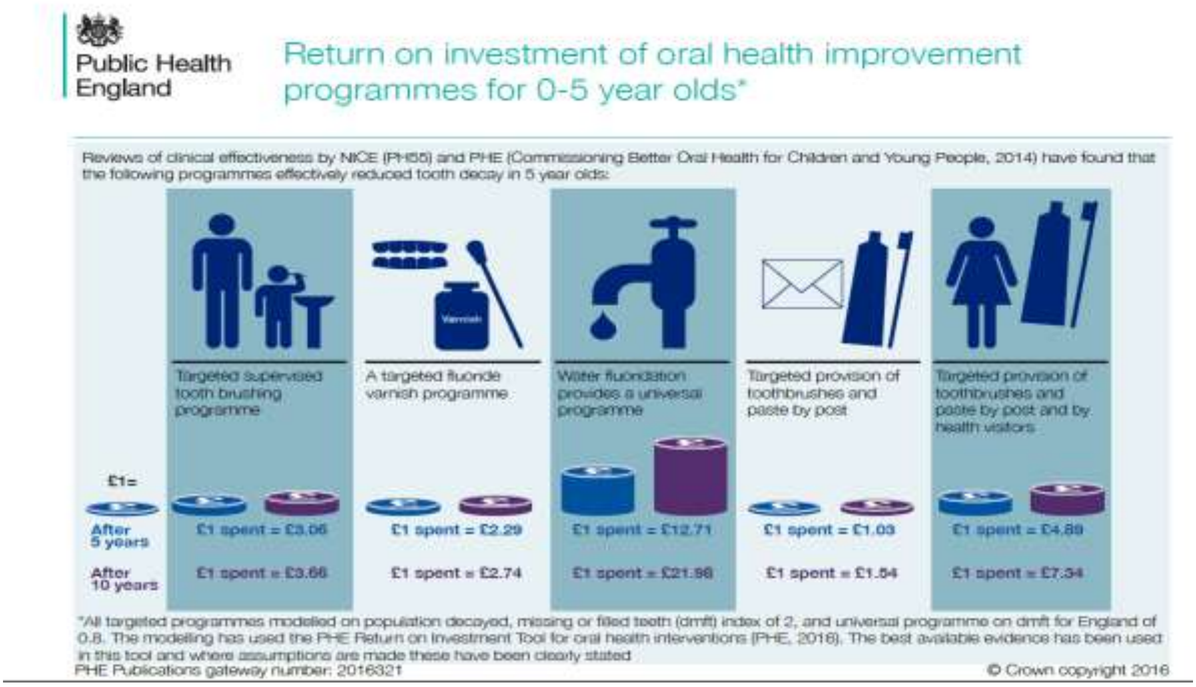
Source: Public Health England

The table below (2015 data) highlights that although access to dental provision in Sandwell is high, uptake from families with small children below five years is quite low although rates do improve when the child grows older.

**Table 2:** Access to dental services by ward in the Early Years (2015)

| **Ward Name** | **Percentage of 0 to 2 year olds** | **Percentage of 3 to 5 year olds** |
|---|---|---|
| Abbey | 19.8 | 63.4 |
| Blackheath | 17.9 | 58.4 |
| Bristnall | 18.3 | 63.7 |
| Charlemont with Grove Vale | 21.3 | 67.9 |
| Cradley Heath and Old Hill | 13.7 | 62.3 |
| Friar Park | 23.9 | 68.4 |
| Great Barr with Yew Tree | 19.8 | 70.0 |
| Great Bridge | 21.1 | **74.6** |
| Greets Green and Lyng | 21.8 | 52.9 |
| Hateley Heath | 20.5 | 54.9 |
| Langley | 18.3 | 58.1 |
| Newton | 20.1 | 58.6 |
| Old Warley | 18.1 | 66.3 |
| Oldbury | 17.8 | 59.4 |
| Princes End | 14.3 | 52.4 |
| Rowley | 20.5 | 67.0 |
| Smethwick | 12.9 | 49.7 |
| Soho and Victoria | 15.1 | 58.9 |
| St Pauls | 12.7 | 51.2 |
| Tipton Green | 22.1 | 68.2 |
| Tividale | 21.8 | 53.2 |
| Wednesbury North | **22.4** | 55.4 |
| Wednesbury South | 24.6 | 65.5 |
| West Bromwich Central | 17.8 | 51.8 |

## 4.3 INTERVENTIONS TO SUPPORT GOOD DENTAL HEALTH


Public Health England

Return on investment of oral health improvement programmes for 0-5 year olds*

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:

| £1= | Targeted supervised tooth brushing programme | A targeted fluoride varnish programme | Water fluoridation provides a universal programme | Targeted provision of toothbrushes and paste by post | Targeted provision of toothbrushes and paste by post and by health visitors |
|---|---|---|---|---|---|
| After 5 years | £1 spent = £3.06 | £1 spent = £2.29 | £1 spent = £12.71 | £1 spent = £1.03 | £1 spent = £4.89 |
| After 10 years | £1 spent = £3.66 | £1 spent = £2.74 | £1 spent = £21.98 | £1 spent = £1.54 | £1 spent = £7.34 |

*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated

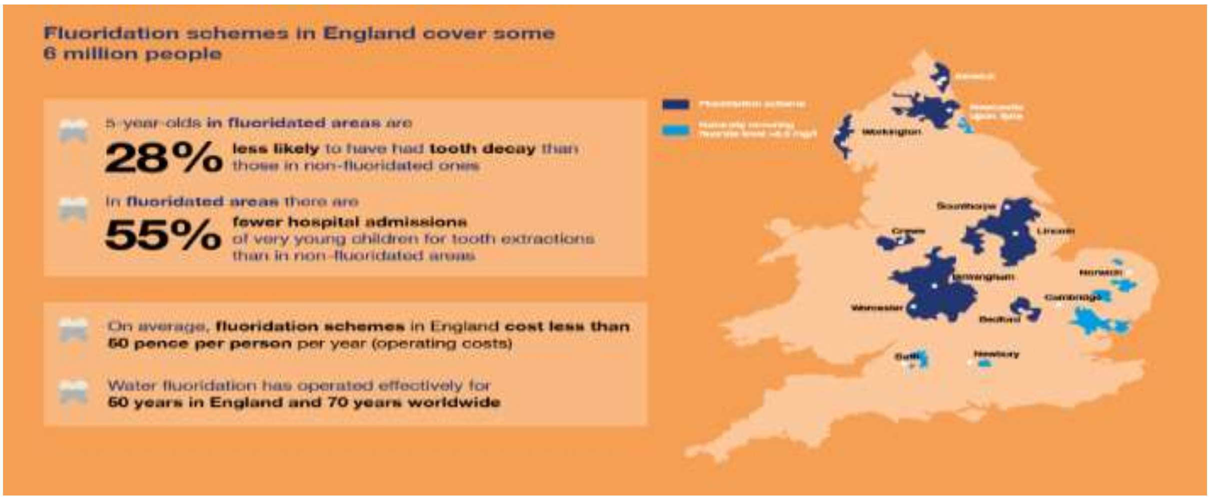
PHE Publications gateway number: 2016321

### 4.3.1 Access to Fluoride

Fluorides are widely found in nature and in foods such as tea, fish and in some natural water supplies. The link between fluoride in public water supplies and reduced levels of tooth decay was first documented early in the last century. Since then fluoride has become more widely available, most notably in toothpaste and is widely recognised as having improved oral health in the UK.

There is abundant evidence that increasing fluoride availability to individuals and communities is effective at reducing tooth decay levels.

### 4.3.2 Water Fluoridation


**Fluoridation schemes in England cover some 6 million people**

5-year-olds **in fluoridated areas** are **28%** **less likely** to have had **tooth decay** than those in non-fluoridated ones

In **fluoridated areas** there are **55%** **fewer hospital admissions** of very young children for tooth extractions than in non-fluoridated areas

On average, **fluoridation schemes** in England **cost less than 50 pence per person** per year (operating costs)

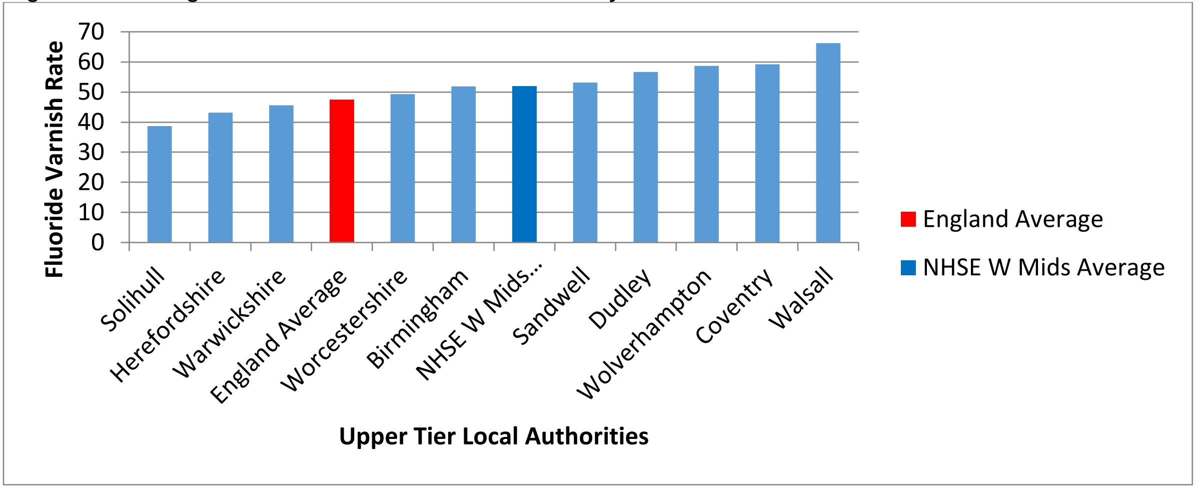
Water fluoridation has operated effectively for **60 years in England and 70 years worldwide**

Currently approximately 10% of England's population or about six million people benefit from a water supply where the fluoride content, either naturally or artificially. All tap water supplied in Sandwell is artificially fluoridated to the optimum level of dental health. Public health funds this fluoridation and we believe it is one of the reasons tooth decay in children in Sandwell is lower than the national average, despite the population having a higher prevalence of a number of risk factors.

### 4.3.3 **Fluoride varnish**

Fluoride varnish is one of the best options for increasing the availability of topical fluoride, regardless of the levels of fluoride in the water supply. A number of systematic reviews conclude that applications of fluoride varnish two or more times a year produce a mean reduction in tooth decay of 37% in the primary (milk teeth) and 43% in the permanent. The evidence supports the view that varnish application can also arrest existing lesions on the smooth surfaces of primary teeth and roots of permanent teeth. As fluoride varnish is administered in dental practices, this comparison can also be viewed as a measure of access to dentists in Sandwell.

Figure 4. Average Fluoride Varnish Rate for 3 – 16 year olds in West Midlands Local Authorities



Source: Public Health England

### 4.3.4 **Sugar Reduction**

Healthier eating advice is routinely given to families by a number of professionals to promote good oral and general health e.g. development checks, children centre sessions. The main message is to reduce both the amount and frequency of consuming foods and drinks that contain free sugars. Free sugars include monosaccharides and disaccharides that are added to foods and drinks by the manufacturer, cook or consumer, as well as sugars naturally present in honey, syrups and fruit juices. It does not include sugars found naturally in whole fresh fruit and vegetables and those naturally present in milk and milk products.

In June 2014, Public Health England (PHE) published ‘Sugar reduction: Responding to the challenge’ which outlined what PHE would do to review the evidence and identify where action was most likely to be effective in reducing sugar intakes. This was followed in 2015 by PHE’s ‘Sugar reduction: the evidence for action’ which reported on the findings from the review and an assessment of the evidence-based actions to reduce sugar consumption.

## 4.4 SERVICES TO SUPPORT CHILDREN’S DENTAL HEALTH

### 4.4.1 Oral Health Promotion Team

Within Sandwell there is an Oral Health Promotion team who are part of the Community Dental Service provided by Birmingham Community Healthcare Trust (BCHC) who are commissioned by NHS England. They provide education, support and guidance to children, parents and relevant health professionals across the borough. The team also trains and advises children’s centre staff, nurseries, schools, care homes and staff working with groups with additional needs. The team also works closely with Health Visitors and School Health nurses to promote oral health to children across the borough.

### 4.4.2 Starting Well Initiative

NHS England has launched Starting Well: A Smile4Life Initiative. This programme of dental practice-based initiatives aims to reduce oral health inequalities and improve oral health in children under the age of five years.

A Starting Well event for dental teams has taken place in January and covered context including delivering better oral health, the current picture for oral health access, fluoride varnish rates, examining and treating the very young child and contractual issues.

### 4.4.3 Public Health Initiatives

- Oral Health is promoted widely in the Changes Antenatal Education Programme which is offered to all expectant women living in Sandwell and runs from local children centres across the borough.
- Dental advice in pregnancy is also highlighted in the My Pregnancy magazine which is distributed to all expectant women during their booking appointment with their midwife.
- Health Visitors and the Best Start Programme (focusing on vulnerable families) promote oral health promotion and signpost parents to local dentists as part of their child’s 12 month and 2 year development check.

- A new parenting magazine is currently being developed in conjunction with the Health Visiting service which will be distributed to all new parents, Starting Well and oral health will be promoted throughout the magazine.
- School Nurses work with pupils, parents and schools to promote good oral health and deliver sessions on healthy eating and oral health through their School Ambassador programme.
- The public health department is currently working with local schools and school meal providers on a number of sugar reduction projects including a commitment to reduce total sugar content of school meals by 5% a year until 2020.
- Public Health current funds the fluoridation of all tap water in Sandwell to optimum levels to support dental health.

## 5 CONSULTATION (CUSTOMERS AND OTHER STAKEHOLDERS

5.1 Necessary consultation has been carried out for children & young people, parents, carers and other stakeholders.

## 6 ALTERNATIVE OPTIONS

6.1 There are no alternative options.

## 7 STRATEGIC RESOURCE IMPLICATIONS

7.1 There are no specific financial and resources implications.

## 8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 Legal and governance considerations have not been considered

## 9 EQUALITY IMPACT ASSESSMENT

9.1 All NHS provision is subject to an Equality Impact (EI) assessment.

## 10 DATA PROTECTION IMPACT ASSESSMENT

10.1 There are no data protection implications.

## 11 CRIME AND DISORDER AND RISK ASSESSMENT

11.1 There are no crime and disorder or risk implications.

## 12 SUSTAINABILITY OF PROPOSALS

12.1 There are no sustainability implications.

## 13 HEALTH AND WELLBEING IMPLICATIONS (INCLUDING SOCIAL VALUE)

**13.1** There are no further health and wellbeing implications further to those detailed in the body of the report.

## 14 IMPACT ON ANY COUNCIL MANAGED PROPERTY OR LAND

14.1 There are no implications for any Council managed property or land.

## 15 CONCLUSIONS AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

15.1 This report is to update the Board.

## 16 BACKGROUND PAPERS

16.1 None

## 17 APPENDICES:

None.

## 5. REFERENCES

Public Health England (2014) Public Health Outcomes Framework

Dental Health Profile – Sandwell (2017)

Black Country Starting Well Presentation for Dental Staff (2018)

Delivering Better Oral Health (2017)

**Ansaf Azhar**
**Director of Public Health (Interim)**

Sandwell
Metropolitan Borough Council

**Agenda Item 5**

# REPORT TO
# CHILDREN'S SERVICES AND EDUCATION SCRUTINY BOARD

## 05 February 2018

| | |
|---|---|
| **Subject:** | **Independent Reviewing Officer Annual Report 2016-2017** |
| **Cabinet Portfolio:** | **Councillor Simon Hackett - Cabinet Member for Children's Services** |
| **Director:** | **Executive Director of Children’s Services – Jim Leivers**<br>**Director – Children and Families – Vince Clark** |
| **Contribution towards Vision 2030:** | ★ ♥ 🎓 ⚖ 🏅 |
| **Contact Officer(s):** | Carol Singleton, Principal Social worker & Group Head Safeguarding and Quality Assurance<br>Carol_singleton@sandwell.gov.uk |

**<u>DECISION RECOMMENDATIONS</u>**

**That Children's Services and Education Scrutiny Board:**

1. Consider the Independent Reviewing Officer Annual Report 2016-2017.

2. Consider areas of positive performance referred to within the Report, particularly evidence that the IRO Unit has directly contributed to improving outcomes for children and young people in care.

3. Consider the IRO Unit’s commitment to better deliver its statutory responsibilities to children and young people in care and their parents or carers, in particular increased consultation, participation and challenge

4. Make any comments and recommendations as necessary.

## 1 PURPOSE OF THE REPORT

1.1 To present the Independent Reviewing Officer Annual Report 2016-2017 in line with the statutory requirement for the IRO Manager to produce a report for the scrutiny of the Corporate Parenting Board, as detailed in the IRO Handbook (2010).

1.2 The report provides an overview on the quality and provision of the Service provided to Sandwell children by the Council's Independent Reviewing Officer and Child Protection Chairs Service. It covers the work of the unit for the period from 1 April 2016 to 31 March 2017 and outlines recent developments and concludes with detailing the proposed future developments of the Unit.

1.3 Following presentation to the Sandwell MBC Corporate Parenting Board and the Sandwell Safeguarding Childrens Board, this report, and a Children and Young People's version,Once will be a publicly accessible document.

## 2 IMPLICATIONS FOR SANDWELL'S VISION

2.1 1. Sandwell is a community where our families have high aspirations and where we pride ourselves on equality of opportunity and on our adaptability and resilience.

2. Sandwell is a place where we live healthy lives and live them for longer and where those of us who are vulnerable feel respected and cared for.

4. Our children benefit from the best start in life and a high quality education throughout their school careers with outstanding support from their teachers and families.

5. Our communities are built on mutual respect and taking care of each other, supported by all the agencies that ensure we feel safe and protected in our homes and local neighbourhoods.

10. Sandwell now has a national reputation for getting things done, where all local partners are focused on what really matters in people's lives and communities.

## 3 BACKGROUND AND MAIN CONSIDERATIONS

### 3.1 Key points and highlights

The IRO Unit has undergone significant change and progress over the last 12 months. The Unit is now starting to deliver quality independent reviews of the care and care planning for looked after children. Looking forwards the ongoing changes and improvements to the IRO Unit offer the opportunity to meaningfully improve the experiences and outcomes for looked after children within Sandwell. With the achievements made during 2017-18, the IRO Unit can look forward with confidence to the next twelve months.

- Section 1 introduces the annual report and its purpose
- Section 2 details the reporting period of the annual report (1 April 2016 - 31 March 2017)
- Section 3 details the legal, statutory and national context of the IRO role
- Section 4 informs the reader about Sandwell's IRO Service
- Section 5 focuses on IRO caseloads and unit performance
- Section 8 focuses on the profile of looked after children in Sandwell
- Section 9 provides details about the impact on the outcomes for children and young people as a result of the work of the IRO Unit.
- Section 10 provides an update on the Quality Assurance & Safeguarding priorities for 2015/16
- Section 11 discusses the service improvement plan for 2017/18
- Section 12 details a closing summary
- Section 13 identifies recommendations for the Corporate Parenting Board

## 4 THE CURRENT POSITION

### 4.1 The Sandwell IRO Service

Responsibility for the IRO service in Sandwell comes under the Service Director for Children and Families. The IRO Unit are located at the Metsec building where there is office space and conferencing facilities. Over the course of the next year (2017/18) there is a refurbishment of the building planned, as the service moves into a Trust, with an emphasis on upgrading the conferencing facilities with an emphasis on making it 'family friendly'.

4.2 All IROs have a mix of Child Protection (CP), Looked After Children (LAC) and Foster Carer Reviews (FCR) which allows them to develop their skills and knowledge in more than one area. This gives the service a flexibility, increasing its capacity to respond to any fluctuations in demand with respect to CP conference dates. Progress has also been made this year in relation to the timeliness of Foster Carer Reviews.

4.3 The IRO Unit has a permanent and stable management team in place. During 2016/17 there was recruitment to the management team and permanent managers appointed. The Group Head for Safeguarding started in the service in May 2016. The second IRO Team Manager post was recruited to and this manager started in June 2016. A new Business Support Manager was appointed and started in June 2016. The IRO Team Managers are members of the West Midlands Regional IRO Group and attend regularly. The Group meet on a bi-monthly basis to share information, report on common and emerging themes and priorities and provide peer support and sector-led improvement opportunities.

## 5 CONSULTATION (CUSTOMERS AND OTHER STAKEHOLDERS)

### 5.1 Consultation Prior to Reviews

Table 7 (Page 8) shows the percentage of children and young people seen and spoken to by the IRO prior to the Review.

### 5.2 Consultation using MoMo (Mind of My Own App)

In order to increase the participation of children and young people the MoMo (Mind of My Own) App was introduced in October 2016. Table 7a and Table 7b (Page 9) show the number of staff trained to use Momo and the number of statements made by children and young people.

5.3 To ensure that there is a variety of consultation methods, work was undertaken in Q4 of the reporting period to design and introduce consultation documents that can be sent out to family, carers and children. This has been launched in April 2017 and will be another method of consultation with children and young people. In addition, the IRO Unit is keen to know what children and young people think of their IRO and how their reviews are run. Over the next 12 months the IRO Unit will be engaging children and young people in a feedback survey. It is envisaged that feedback will be gathered by the Participation Team each year.

### 5.4 Family Friendly meetings

It is intended that all CP and LAC meetings are family friendly that enable parents/carers/family members as well as children to participate in their meetings

5.5 Feedback has started to be gained for CP conferences but this is still to be implemented for looked after children's reviews. This will commence in April 2017. IROs are now routinely visiting children and this report evidences the improvement made.

5.6 Consultation with children needs to be more dynamic than just visiting and the IRO Unit has designed a consultation document during Q4 for children and carers and professionals, which will be launched in April 2017.

5.7 This report highlights that there is improvement still to make to children’s involvement and participation in their meetings. Most children who need an Advocate and Independent Visitors (IV) now have them, and the service has funded additional IVs to bridge a gap identified in the service.

## 6 ALTERNATIVE OPTIONS

6.1 There are no alternative options.

## 7 STRATEGIC RESOURCE IMPLICATIONS

7.1 Increasing numbers of child protection cases and looked after children during the course of this year (2017/18) has implications for the budget – staffing required to manage the high numbers.

## 8. LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 Section 3 (page 2-3) reports:

- The appointment of an Independent Reviewing Officer (IRO) for a looked after child or young person in the care of the Local Authority is a legal requirement under s.118 of the Adoption and Children Act 2002.

- In March 2010, the *IRO Handbook* was issued, providing Local Authorities with statutory guidance on how the IRO’s should discharge their duties. The Handbook (para. 2.14) states that the IRO has several specific responsibilities. These include;
  - promoting the voice of the child;
  - ensuring that plans for looked after children are based on a detailed and informed assessment, are up to date, effective and provide a real and genuine response to each child’s needs;
  - making sure that the child understands how an advocate could help and his/her entitlement to one;
  - offering a safeguard to prevent any ‘drift’ in care planning for looked after children and the delivery of services to them; and
  - and monitoring the activity of the local authority as a corporate parent in ensuring that care plans have given proper consideration and weight to the child’s wishes and feelings and that, where appropriate, the child fully understands

- the regulations require that the Local Authority appoint an IRO to all children who become looked after and that an IRO must also be a qualified Social Worker. Further requirements of the IRO are detailed in Section 3.

## 9. EQUALITY IMPACT ASSESSMENT

9.1 The IRO Unit has a commitment to better deliver its statutory responsibilities to children and young people in care and to ensure there is an equal, positive impact on each of the equality strands (protected characteristics).

## 10. DATA PROTECTION IMPACT ASSESSMENT

10.1 There are no data protection issues arising from this report.

## 11. CRIME AND DISORDER AND RISK ASSESSMENT

11.1 There are no crime and disorder implications arising from this report.

11.2 The Corporate Risk Management Strategy has been complied with – to identify and assess the significant risk associated with this decision/project. This includes (but is not limited to) political, legislation, financial, environmental and reputation risks.

## 12. SUSTAINABILITY OF PROPOSALS

### 12.1 Service Improvement Plan for 2017/18

The service improvement plan for 2017/18 identifies 5 key areas for the IRO Unit to work and build on over the next 12 months. These are linked to the overarching Directorate Improvement Plan.

## 13. HEALTH AND WELLBEING IMPLICATIONS (INCLUDING SOCIAL VALUE)

13.1 Health implications and wellbeing are not applicable in this context.

## 14. IMPACT ON ANY COUNCIL MANAGED PROPERTY OR LAND

14.1 There is no impact on Council managed property or land.

## 15. CONCLUSIONS AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

15.1 That Members note the content of the Independent Reviewing Officer Annual Report 2016/2017.

## 16. BACKGROUND PAPERS

None.

## 17. APPENDICES:

Appendix 1 - Independent Reviewing Officer Annual Report 2016 - 2017.

**Jim Leivers**
**Executive Director of Children’s Services (Interim)**

# Independent Reviewing Officer
# Annual Report 2016 - 2017

Sandwell
Metropolitan Borough Council

**Report Author: Carol Singleton**

**Date: 29-9-17**

## 1. Introduction and Purpose of the Annual Report

1.1. In line with the statutory requirement for the IRO Manager to produce a report for the scrutiny of the Corporate Parenting Board, as detailed in the IRO Handbook (2010). This report provides an overview on the quality and provision of the Service provided to Sandwell children by the Council's Independent Reviewing Officer and Child Protection Chairs Service.

1.2. Following presentation to the Sandwell MBC Corporate Parenting Board and the Sandwell Safeguarding Childrens Board, this report, and a Children and Young People's version, will be a publicly accessible document.

## 2. Reporting Period

2.1. This report covers the work of the unit for the period from 1st April 2016 to 31st March 2017. It outlines recent developments and concludes with detailing the proposed future developments of the Unit.

## 3. The Legal, Statutory and National Context of the IRO Role

3.1. The appointment of an Independent Reviewing Officer (IRO) for a looked after child or young person in the care of the Local Authority is a legal requirement under s.118 of the Adoption and Children Act 2002.

3.2. In March 2010, the *IRO Handbook* was issued, providing Local Authorities with statutory guidance on how the IRO's should discharge their duties. The Handbook (para. 2.14) states that the IRO has several specific responsibilities. These include;

- promoting the voice of the child;
- ensuring that plans for looked after children are based on a detailed and informed assessment, are up to date, effective and provide a real and genuine response to each child's needs;
- making sure that the child understands how an advocate could help and his/her entitlement to one;
- offering a safeguard to prevent any 'drift' in care planning for looked after children and the delivery of services to them; and
- and monitoring the activity of the local authority as a corporate parent in ensuring that care plans have given proper consideration and weight to the child's wishes and feelings and that, where appropriate, the child fully understands

3.3. The regulations require that the Local Authority appoint an IRO to all children who become looked after. An IRO must also be a qualified Social Worker.

3.4. The IRO role includes assuring themselves that children's plans are progressing and a difference is being made to their lives. This involves challenging Social Workers, Team Managers (TMs), Senior Managers and partner agencies about the progress on children's cases. For IROs to maintain their independence, the Local Authority is required to set up clear mechanisms for the IROs to challenge appropriately including independent legal advice. Independent legal advice is available to IROs in Sandwell MBC via a partnership arrangement with Wolverhampton City Council.

## 4. The Sandwell IRO Service

4.1. Responsibility for the IRO service in Sandwell comes under the Service Director for Children and Families. The IRO Unit are located at the Metsec building where there is office space and conferencing facilities. Over the course of the next year (2017/18) there is a refurbishment of the building planned, as the service moves into a Trust, with an emphasis on upgrading the conferencing facilities with an emphasis on making it 'family friendly'.

4.2. All IROs have a mix of Child Protection (CP), Looked After Children (LAC) and Foster Carer Reviews (FCR) which allows them to develop their skills and knowledge in more than one area. This gives the service a flexibility, increasing its capacity to respond to any fluctuations in demand with respect to CP conference dates. Progress has also been made this year in relation to the timeliness of Foster Carer Reviews.

4.3. The IRO Unit has a permanent and stable management team in place. During 2016/17 there was recruitment to the management team and permanent managers appointed. The Group Head for Safeguarding started in the service in May 2016. The second IRO Team Manager post was recruited to and this manager started in June 2016. A new Business Support Manager was appointed and started in June 2016. The IRO Team Managers are members of the West Midlands Regional IRO Group and attend regularly. The Group meet on a bi-monthly basis to share information, report on common and emerging themes and priorities and provide peer support and sector-led improvement opportunities.

4.4. The drive to recruit IROs into post has been a primary objective for this year. The full establishment of IROs for the beginning of the year was 13.2 IROs. At the start of the reporting year there were 11.2 IROs in post. Recruitment to 2 temporary posts was undertaken, and the new IROs started in September 2016. Following a recognition by the senior leadership team that IRO caseloads were too high (average 90 cases) there was an increase to the IRO establishment of 2 IROs from 13.2 IROs to 15.2 IROs. A further 2 IROs started in January 2017. At the end of the reporting period all 15.2 posts had an IRO in them. There was 1 IRO post to recruit to but this was covered by an agency IRO. This meant that caseloads had reduced to 76, almost in line with the recommended 50-70 cases in the IRO Handbook. New IROs starting in the Unit has revitalised the Unit. Whilst some children have had to have changes of their IRO as part of this recruitment process all efforts have been made to minimise the impact of these changes.

4.5. All IROs in the Unit access training opportunities. There has been a focus this year of introducing Signs of Safety to Looked After Children Reviews and Child Protection Conferences (July 2016) with all IROs given the opportunity to attend the 5 day Signs of Safety course. The IROs attend the monthly Children and Families' Managers Workshops ensuring that the voice of the IRO is present in the workshops as well as encouraging relationship building with colleagues from the frontline service.

4.6. The monthly IRO service meetings have a workshop focus on improving practice and standards of the IRO role in Sandwell. A focus of these service meetings has been on embedding Signs of Safety. This has been particularly in relation to family friendly meetings and outcome focussed plans, together with increasing and recognising the need for IROs to raise issues with the service including DRPs (Dispute Resolution Process) when the service needs to be challenged. The meeting has also been used for setting out IRO standards for Looked After Children Reviews and Child Protection Conferences, increasing the IRO Footprint with IRO visits to children, preparation meetings with Social Workers and IRO mid-point audits.

4.7. During the reporting period and the appointment of the new Business Support Manager for the Unit, there has been a focus on building a cohesive, consistent and co-dependent relationship between the Business Support Service and the IRO Unit. The Business Support Manager being part of the same management team has helped with this cohesion. Towards the end of the reporting year this relationship has improved, is working well, and there is a synergy in the Unit.

4.8. The Sandwell Local Safeguarding Children Board (LSCB) Business Manager has become part of the Management Team and this has brought the Sandwell Safeguarding Children Board (SSCB) closer to the IRO Unit. The IRO Team Managers are involved in the SSCB strategic groups with one IRO manager representing the service on the Child Death Overview Panel (CDOP) and one responsible for ensuring there is a link between any critical incidences and Significant Incident Notifications Forms (SINFs) to the SSCB and Ofsted notifications. The Group Head for Safeguarding chairs the Quality of Practice and Performance Sub-Group for the SSCB, and represents the service on the Serious Case Review Sub-group as well as the Safer Sandwell Partnership Domestic Homicide Review Panels. There is still work to do to ensure that the learning from these groups is not just systematically disseminated through the service, but that the learning is applied to practice.

4.9. Towards the end of the reporting period an initial meeting with CAFCASS has been held between the IROs and the Service manager for CAFCASS. The joint working protocol was reviewed and named links for escalating concerns to were agreed. A review of communication and notification by CAFCASS of the named Guardian to the IROs was confirmed. It was agreed that there would be twice yearly meetings between CAFCASS and the IRO Unit in October and March of each year.

## 5. IRO Caseloads and Unit Performance

### 5.1. Caseloads

5.2. In common with the most of its regional peers, Sandwell IRO's have a dual function. As well as the independent review of looked after children, the IRO's provide independent chairing of Child Protection Conferences, a separate statutory function under Working Together 2015 for which they are accountable to the Director of Children's Services. The most significant benefit of integrating LAC Reviews with the chairing of Child Protection Conferences is the opportunity to provide a greater level of consistency and oversight for children and young people. The benefit of continued and sustained relationships, and the potential for relationships to improve outcomes for children, irrespective of a child's status, is a key and important strength. The argument in favour of separating the functions is the ability to prioritise looked after children and young people's cases. It is acknowledged that the integrated model in use in Sandwell does place an additional task upon the IRO Unit to ensure that there is always Initial Child protection Conference (ICPC) availability to ensure that the meetings are held within the timescales set out in the Working Together 2015 guidance.

**Note: due to the change from ICS to LCS system in January 2017 some of the tables below represents 10 month's data.**

**Table 1. Total Unit Caseload and IRO Average Caseload at Year End**

| IRO Caseloads and Averages | 2016/17 | | | | 2017/18 | | Averages | | |
|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | 07/09/2017 | 2016-17 | 2015/16 | 2014/15 |
| LAC | 555 | 593 | 589 | 608 | 597 | 640 | 586 | 534 | 544 |
| CP | 387 | 393 | 407 | 417 | 534 | 657 | 401 | 317 | 322 |
| Foster Carers **(0.5 of a case)** | 89 | 88 | 86 | 84 | 72 | 79 | 87 | 177 | 191 |
| Total | 1031 | 1074 | 1082 | 1109 | 1203 | 1376 | 1074 | **851** | **866** |
| Number of IRO's in post | 11.2 | 11.2 | 13.2 | 14.8 | 15.2 | 15.2 | 14.8 | 11.6 | 11 |
| Average | 92 | 96 | 82 | 75 | 79 | 91 | 73 | 73 | 78 |
| On average, each IRO carries approximately 10 CIN cases | | | | | | | | | |

5.3. Table 1 shows caseloads by quarter for the reporting period and the historical comparisons. The data confirms a decrease in the 2016/17 return and total caseloads.

5.4. In May 2016, 2 vacant IRO posts left a staff group of 11.2 with caseloads of 92, significantly above IRO Handbook recommendation of 50-70. Successful recruitment to full capacity (13.2

IROs) by Q3 reduced IRO caseloads and the creation of a further 2 IRO posts (15.2 IROs) was agreed to bring caseloads down to the recommended level. Q4 evidences the successful recruitment and reduction of IRO caseloads to a reasonable level with all 15.2 IROs in post and an average caseload of 75.

### 5.5. Number of Reviews

**Table 2: LAC Reviews and Child Protection Conferences undertaken**

| Total Unit Activity | | | |
|---|---|---|---|
| | | **Historical** | |
| | **2016 -2017** | **2015-2016** | **2014-2015** |
| **LAC** | 1449 | 1225 | 1163 |
| **CP** | 916 | 740 | 730 |

5.6. Table 2 evidences that within the reporting period the Unit have chaired a total of 1449 LAC Reviews (compared with 1225 in 2015/16 and 1163 in 2014/15) and a total of 916 Child Protection Conferences (compared with 740 in 2015/16 and 730 in 2014/15). This is a sharp increase of 400 children during 15/16 compared to an increase of 72 the previous year (14/15). This overall sharp increase in the numbers of Looked After Children and children subject to CP Plans has impacted on the ability to reduce IRO caseloads further.

### 5.7. Timeliness of Reviews

**Table 3: Timeliness of Reviews**

| Reviews within timescales by Quarter 2016 - Feb 2017 | | | | | 2016/Feb 2017 | 2015/16 | 2014/15 |
|---|---|---|---|---|---|---|---|
| | **Q1** | **Q2** | **Q3** | **Q4** | | | |
| **Reviews** | **96.5%** | **95.3%** | **93.3%** | **No Data** | **95%** | **93.1%** | **82.7%** |

*Note: No Data available for Quarter 4 due to changes in the client data base*

5.8. Table 3 reports the percentage of looked after children who had all their reviews on time within the reporting period. At the time of writing this report there is no data available for Q4 due to the migration to a new computer based system at the end of January 2017. There is a service target for review timeliness of 90%. The service had met this target by February 2017 at 95% and increased those children having their meeting on time from preceding years of 82.7% 2014/15 and 93.1% 2015/16. The increase in IRO recruitment to vacancies and two additional posts to the Unit has helped in reaching this target. The increasing number of CP plans and

LAC within the service requires the IRO Unit to continue to monitor and review timeliness as throughout the next 12 months to ensure this progress is maintained .

## 5.9. Participation in Reviews

**Table 4: Method and Percentage LAC Participating in their Review taken from the IRO Monitoring Form**

| | | | | **Historical** | |
|---|---|---|---|---|---|
| | | **2016/ 2017** | **2016/ 2017** | **2015/2016** | **2014/2015** |
| Code | Method | Figure | Percent | | |
| PN0 | Child under 4 at the time of Review | 262 | 19.5% | 15.6% | 8.5% |
| PN1 | Attends or speaks for him/herself | 379 | 28% | 33% | 34% |
| PN2 | Attends, views rep. by Advocate | 20 | 1.5% | 2.9% | 2% |
| PN3 | Attends, views conveyed non-verbally | 13 | 1% | 0.4% | 2% |
| PN4 | Attends, but does not convey views | 21 | 2% | 2% | 1% |
| PN5 | Does not attend but briefs an advocate | 123 | 9% | 10.2% | 10% |
| PN6 | Does not attend but conveys in wri. Etc. | 504 | 37% | 34% | 41.5% |
| PN7 | Does not attend nor views conveyed | 28 | 2% | 1.9% | 1% |
| Total | | **1350** | **100%** | **100%** | **100%** |

*Note: No Data available for Quarter 4 due to system change over, manual monitoring sheets integrated into the system and reports not available.*

5.10. Table 4 demonstrates within the reporting period that 78.5% of Looked After Children contributed to the review of their care, with only 2% not contributing by choice, and 19.5% by virtue of their age. There were 32.5% of children attending their Review. The percentages are low and the IRO Unit recognises that this needs to improve. Children participating and being involved in their review and their Care Plan is important and this is an area that needs to be improved by the IRO Unit over the next year.

**Table 5: Number of Children and Young People Chairing or Co-Chairing their own Review:**

| **Number of Reviews Chaired and Co-Chaired by Young People** | | | |
|---|---|---|---|
| | **2016/2017** | **2015/16** | **2014/2015** |
| Reviews | 60 | 41 | 181 |

5.11. Historically (2014/15) the number of children chairing or co-chairing their reviews looks high in Table 5. This is due to how the data was collected and an interpretation by some IROs of children chairing/co-chairing their meetings that was based on children attending their reviews rather than actually co-chairing their meeting. This practice has now ceased and the data is more reflective and accurate regarding children chairing/co-chairing their reviews.

5.12. The IRO Handbook states *'It is hoped that for many older children and young people, especially as they begin to plan for independence, the IRO will hand over at least part of the chairing role to them so that they can take an increased ownership of the meeting'* (IRO Handbook para.3.37). The last 2 years has begun to reflect a more accurate capture of children truly chairing/co-chairing their meetings. 2016/17 sees an increase of 15 children. Moving forward we know that there will only be a relatively small number of children or young people who wish to Chair or Co-Chair their review but we need to ensure that the opportunity is there should children wish to do so. The IRO Unit will continue to encourage all children and young people to consider Chairing or Co-Chairing their review and ensure that they are supported to do so.

### 5.13. Consultation Prior to Reviews

**Table 7: Percentage of children and young people seen and spoken to by the IRO prior to the Review**

| Number of Children Seen and Spoken to prior to the Review | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016/17** | **2015/16** | **2014/15** |
| Seen | 183 | 206 | 300 | 292 | 981 | 634 | 832 |
| Not Seen | 159 | 168 | 106 | 79 | 512 | 336 | 261 |

5.14. There is a statutory expectation that children and young people are visited by the IRO and consulted with prior to the review of their care and Care Plan. However, the IRO Handbook does acknowledge that there are some circumstances where the IRO will use their discretion and determine whether this is necessary or not.

5.15. During the reporting period, the IRO Unit recognised that their visits to children were below what is expected of a Sandwell IRO. The IROs have strived for every child to have an IRO visit and if this isn't possible then a contact. The purpose of the visit is not just to consult with the child or young person but to ensure that the IRO is assuring themselves that the child is thriving in their placement and the information that is being given by professionals and family can be evidenced. This standard has been a challenge to the IRO Unit and following a drive to improve visits during November 2016 the data for Q3 shows an uplift of children having their visits. The IRO Unit want to continue to improve over the coming year.

## 5.16. Consultation using MoMo (Mind of My Own App)

In order to increase the participation of children and young people the MoMo (Mind of My Own) App was introduced in October 2016.

**Table 7a - Number of staff trained to use Momo**

| STAFF TRAINED: | Q1 Apr-June | Q2 July-Sep | Q3 Oct-Dec | Q4 Jan-Feb |
|---|---|---|---|---|
| Social Workers (LAC) | N/A | 19 | 2 | 0 |
| IROs | N/A | 13 | 4 | 0 |
| Social Workers (Care Mgt) | N/A | 0 | 0 | 0 |
| Foster Carers | N/A | 0 | 0 | 0 |
| Other Professionals | N/A | 10 | 10 | 5 |
| Total | N/A | 42 | 16 | 5 |

**Table 7b - The number of statements made by children and young people**

| ACTIVITY: | Q1 Apr-June | Q2 July-Sep | Q3 Oct-Dec | Q4 Jan-Feb |
|---|---|---|---|---|
| Share Good News | N/A | 1 | 13 | 5 |
| Change | N/A | 0 | 4 | 3 |
| Worker Visiting | N/A | 10 | 20 | 10 |
| Preparation for Meeting | N/A | 4 | 7 | 3 |
| Problem | N/A | 0 | 4 | 1 |
| Total | N/A | 15 | 48 | 22 |

5.17 Table 7a evidences that 58 staff (including IROs and LAC staff) were trained during Sept/Oct 2016, to use MoMo. Foster Carers and Care Mgt staff are due to be trained between April and June 2017. Table 7b demonstrates that there has been a slow start after an initial burst of activity, with 85 MoMo statements made over the first 6 months. There is further work to do with the IRO Unit and SW service to increase the usage of MoMo as a consultation tool to ensure it is embedded within the service. 5 children raised MoMo statements that said that they had a problem. All 5 children wished to raise their problem as an informal complaint rather than as a formal complaint through the Complaints Officer. The informal complaints were sent to the Social Worker, IRO and Team Manager by the Participation Team. In all cases where children raise an issue as a problem the Participation Team keep a record and track these to ensure that the problems are resolved for children. In all 5 cases, the problem was resolved. Table 7c (below) evidences the outcomes for the children.

**Table 7c - Outcomes of problems raised by children on MoMo**

| Date of Problem | Outline of the Problem in Childs Voice | Problem Sent to | Informal/Formal Problem | Outcome for the child from Worker |
|---|---|---|---|---|
| **15.09.16** | I'm not sure what I want to do, I don't want to use this app. | SW | Informal | Young person is aware of the MOMO app but has stated that he is not interested in using it. Young person stated that he would prefer to text Social Worker instead and then shared his mobile number. |
| **06.10.16** | Waiting for my social worker to send my mom's letter as she told me that she will post it over a month ago, I just want my letter. | Team Manager | Informal | The letter was completed by the social worker as instructed by the Team Manager. |
| **20.11.16** | Not listened to, wrong decision, and want to talk someone and want to be heard. | IRO & SW | Informal | Discussion between IRO & Social Worker around regular contact with young person. Social Worker made contact with young person to inform them they contact any time. |
| **23.11.16** | Was due to have contact today and didn't get picked up. Want contact next week. Want to know what's happened. | SW | Informal | This was explained to the young person due to no contact worker being available and contact was arranged at a later date. |
| **14.01.17** | Haven't received my Independent Living Allowance and want an explanation. | SW | Informal | This issue was resolved, the issue was due to ILA payments delayed due to Christmas. Young person was given the option to pick up or wait, young person chose to wait to receive 2 payments through the bank. |

5.18 To ensure that there is a variety of consultation methods, work was undertaken in Q4 of the reporting period to design and introduce consultation documents that can be sent out to family, carers and children. This has been launched in April 2017 and will be another method of consultation with children and young people.

5.19 In addition, the IRO Unit is keen to know what children and young people think of their IRO and how their reviews are run. Over the next 12 months the IRO Unit will be engaging children and young people in a feedback survey. It is envisaged that feedback will be gathered by the Participation Team each year.

### 5.20 Distribution of Review Records

**Table 8 - Data for - Number of records distributed within 20 working days (number and % within 20 working days and outside of 20 working days – Quarters and Total for the year).**

| Activity 2016/17 | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| **LAC Minutes completed in timescale** | n/a | 207 | 222 | n/a | **429** |
| **LAC Minutes completed out of timescale** | n/a | 154 | 140 | n/a | **294** |

*Note: No Data available for Quarter 4 due to system change over, manual monitoring sheets integrated into the system and reports not available.*

5.21 During the reported period Q2 the IRO Unit started to gather information regarding how quickly children, parents and professionals received their review minutes and recommendations. It also measured whether they received their minutes within the 20 working days set out in the IRO Handbook. The change of systems from ICS to LCS in January 2017 meant that the data was not available for Q4. This will need to continue to be worked on and improved by the IRO Unit during the next year.

# 6 Profile of Looked After Children in Sandwell

## 6.1 Number of Looked After Children

**Table 9: Number of Children and Young People in Care (excluding Short Breaks)**

| Number of LAC | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | | **Comparators** | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016- 2017 (Avg)** | **2015/16** | **2014/15** | **Regional** | **National** |
| **Number** | 555 | 593 | 589 | 608 | 586 | 533 | 544 | n/a | 676 |
| **No. Per 10k** | 72.2 | 77.1 | 76.6 | 79.1 | 76.2 | 69.3 | 70.8 | 135 | 89.2 |

6.2 Within the reporting period there has been a steady increase of Looked After children in Sandwell. The number of LAC is still slightly lower than the national average as evidenced in Table 9. The increase in Sandwell is due to the strengthening and robustness of the application of thresholds.

In addition, there have been an increased number of children subject to Public Law Outline (PLO) followed by care proceedings. The service predicts that the numbers of LAC will increase again over the next 12 months and be more in line with the national levels. This is based on a number of legacy cases where children have experienced delay and these are now being progressed. The increased numbers are also projected on the size and level of deprivation in Sandwell, and the proportion of children per 10,000 expected to be LAC for the size of Sandwell, together with a number of legacy cases. To manage this there has been a strengthening of the process for children coming into care with a multi-agency Resources and Placement Panel, offering oversight, monitoring, and scrutiny.

### 6.3 Gender of Looked After Children/CP

**Table 10: Number of Children in Care by Gender**

| Number of LAC | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | Historical | |
| | Q1 | Q2 | Q3 | Q4 | 2016-2017 | 2015/16 | 2014/15 |
| Number | 555 | 593 | 589 | 608 | 586 | 534 | 551 |
| Male | 310 | 328 | 328 | 347 | 328 (56%) | 293 (55%) | 313 (57%) |
| Female | 245 | 265 | 261 | 261 | 258 (44%) | 241 (45%) | 238 (43%) |

6.4 Within the reporting year the number of female and male looked after children is broadly representative of Sandwell's population and Table 10 evidences that over the last 3 years the percentage of LAC has only fluctuated slightly.

### 6.5 Ethnicity of Looked After Children/CP

**Table 11: Percentage of Children in Care by Ethnicity at Year End**

| | 2016/2017 | | 2015/2016 | |
|---|---|---|---|---|
| Ethnicity | Number | Percentage | Number | Percentage |
| White | 363 | 60% | 321 | 60% |
| Mixed | 111 | 18% | 88 | 17% |
| Asian or Asian British | 77 | 13% | 54 | 10% |
| Black or Black British | 39 | 6% | 35 | 7% |
| Other | 0 | 0% | 33 | 6% |
| Not Recorded | 18 | 3% | 3 | 0% |
| TOTAL | 608 | 100% | 534 | 100% |

6.6 Within the reporting year the ethnicity of looked after children in Sandwell is broadly representative of Sandwell's population and Table 11 evidences that there has been a slight increase of Asian/British Asian children and the increased numbers of Unaccompanied Asylum Seeking Minors is likely to account for the marginal increase.

6.7 The Fostering service has recognised as part of the fostering marketing plan that an increase of recruitment to carers from different cultural and ethnic backgrounds, to reflect the LAC population, is required.

### 6.8 Age of Looked After Children/CP

**Table 12: Number of Children by Age at Period End**

| **Children by Age** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016-2017** | **2015/16** | **2014/15** |
| **Under 1yr** | 30 | 44 | 37 | 36 | 37 (6.3%) | 30 (5.6%) | 25 (4.5%) |
| **1-4yrs** | 85 | 96 | 90 | 107 | 95 (16.2%) | 78 (14.6%) | 92 (16.7% |
| **5-9yrs** | 125 | 130 | 124 | 137 | 129 (22%) | 115 (21.5%) | 123 (22.3%) |
| **10-15yrs** | 212 | 215 | 220 | 217 | 216 (36.8%) | 212 (39.7%) | 219 (39.7%) |
| **Over 16yrs** | 103 | 108 | 118 | 111 | 110 (18.7%) | 99 (18.5%) | 93 (16.8%) |
| **Total** | 555 | 593 | 589 | 608 | 587 | 534 | 552 |

6.9 Within the reporting period, there have been some slight changes in the age profile of children and young people in care. There has been a 2.3% increase in the number of babies and 1-4 year olds becoming looked after children. This difference starts to reflect improvements in assessment practice, earlier intervention and improved decision making whilst children are still young. Looked after children aged 10-15 years old have shown a 2.9% decrease in numbers. This reduction may reflect a greater edge of care focus by the Family Support Team and Multi-Systemic Therapy Service within the reporting period. A Permanency Monitoring Group to ensure that as children come into care that they don't stay in care too long started in Q4 of the reporting period.

### 6.10 Time in Care of Looked After Children

**Table 13: Number of Children by Period of Care at Period End**

| **Children by Care Length** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016-2017** | **2015/16** | **2014/15** |
| **Less than 6mths** | 85 | 113 | 89 | 94 | 95 (16.2%) | 85(15.9%) | 65 (11.9%) |
| **6-12mths** | 67 | 75 | 81 | 96 | 80 (13.7%) | 51(9.5%) | 46 (8.4%) |
| **1-2 yrs** | 73 | 79 | 93 | 98 | 86 (14.7%) | 69(12.9%) | 71 (13.1%) |
| **2-5 yrs** | 171 | 164 | 150 | 136 | 155 (26.5%) | 180 (33.7%) | 198(33.1%) |
| **More than 5yrs** | 159 | 162 | 176 | 184 | 170 (29.0% | 149 (27.9%) | 164 (30.0%) |
| **Total** | 555 | 593 | 589 | 608 | 586 | 534 | 544 |

6.11 Within the reporting period, there has been an increase of 4.5% of looked after children who have been in care less than 12 months compared to last year. This reflects that more children have come into care in Sandwell over the last 12 months and evidences the start of improvements in assessment practice, and improved decision making for children and young people cared for by the service. The decrease of 7.2% for those children and young people cared for between 2-5 years evidences the focus on securing permanency by way of Special Guardianship, Child Arrangement Orders and discharge of Care Orders following care proceedings. The number of looked after young people over 5 years has remained stable with only a slight increase of 1.1%. It is expected that there will always be a cohort of children who are long term looked after children.

### 6.12 Legal Status of Looked After Children

**Table 14: Legal Status of Children and Young People in Care as Percentage of whole**

| Legal Status % | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | | | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016/ 2017** | **2015/ 2016** | **2014/ 2015** | **Regional** | **National** |
| Care Orders | 59% | 54% | 57% | 55% | 56% | 62% | 65% | No Data | 42% |
| Interim Care Orders | 13% | 21% | 19% | 20% | 18% | 12% | 9% | No Data | 17% |
| Accom. S20 | 18% | 16% | 15% | 14% | 16% | 16% | 16% | No Data | 27% |
| Placement Order | 9% | 8% | 8% | 10% | 9% | 11% | 10% | No Data | 14% |
| Other | 1% | 1% | 1% | 1% | 1% | 0% | 1% | No Data | 0% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | No Data | 100% |

6.13 Within the reporting period, there has been a continued reduction in the numbers of children subject to Care Orders, with a 6% reduction compared to last year. However, Sandwell remains an outlier with a 14% difference between the national average and Sandwell. This and the reduction in Placement Orders made in the last year can be explained through the use of other permanence options such as Special Guardianship Orders as well as the reduction in those children who have been looked after between 2-5 years through discharge of Care Orders. However, as the national data evidences there is still work to do on alternative permanency provisions.

6.14 As expected with the increase of children coming into care in Sandwell there has been a 6% increase in the number of care proceedings and Interim Care Orders compared with last year. This brings Sandwell in line with national figures.

6.15 It is also noticeable that within the reporting period, whilst the numbers of children have increased coming into care the number of children who are accommodated under s.20 CA 1989 has remained stable. 11% of SMBC children are accommodated which is lower than the national average for voluntary care.

6.16 The recent National and Judicial scrutiny of the use of accommodation; N (Children) (Adoption: Jurisdiction) [2015] EWCA Civ 1112 has resulted in new ADCS Practice Guidance for the Use of Section 20. This Practice Guidance noted:

> *We share judicial concern about those s20 cases which have drifted without decent care plans for children, where individual children looked after have suffered demonstrable harm or detriment as a direct result. This type of practice can never be excused or condoned. All local authorities should take steps to ensure they do not have a single s20 arrangement of this sort. This assurance can only be achieved by ensuring that every s20 case open to a local authority has been actively reviewed and that s20 status remains the appropriate current legal option and framework for the child.*

6.17 In light of this direction the service has ensured that all children and young people accommodated under s.20 CA 1989 held in the Care Management Service have had their legal status reviewed. All children and young people held in the Looked After Child service will be reviewed during the next few months. The IRO Unit has worked proactively to ensure the right permanence plan, including legal status, is in place for looked after children and young people in care. Despite this IRO managers have identified that there is still work to do to ensure all IRO independently assure themselves that the right legal status is in place for every child or young person. As the service improves its quality assurance work the IROs will ensure that where the proposed legal status of the child is not appropriate and meeting the child's needs then the IRO will take the matter forward using the local Dispute Resolution Process (DRP). It is anticipated that there may be a further reduction of s.20 looked after children through this process as well as those children whose status is reviewed through the Permanency Monitoring Group where an IRO Team Manager is involved.

### 6.18 Placement Stability of Looked After Children

**Table 15: Percentage of LAC having 3 or more placement moves**

| Three or More Placements During the Year | | | | | | Historical | |
|---|---|---|---|---|---|---|---|
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016/2017** | **2015/2016** | **2014/2015** |
| **3+ Moves** | 54 | 43 | 56 | 51 | 51 | 53 | 73 |

6.19 The IRO Unit is aware that it can make a positive contribution to the stability of looked after children. Where children have disruptions to their placement or there is a Care Plan that proposes changes the IRO must ensure that any placement change is in the best interest of a child or young person and that any disruption, particularly education, is minimised. The slight decrease in the number of children experiencing 3 or more placement moves in Sandwell is positive, particularly given the overall rise in numbers of looked after children within the service. There are several measures in place to ensure that those children experiencing placement moves are tracked. The number of complex looked after children has increased and these are the children likely to have more placement moves. These children are monitored through their Review process as well as through the Resource and Placement Panel. There is an increased emphasis, where placements do disrupt, to convening an early Disruption Meeting (Signs of Stability Meeting) prior to the disruption wherever possible. IRO's are not always alerted to changes in the child's circumstances This alert is essential so they can determine if an early convening of the child's Statutory Review is required. There is still work to do between the IRO Unit and the service to ensure that this routinely happens. Changes have been made to the placement request form to require social workers to alert the IRO and IRO have been linked to teams to remedy this.

6.20 Long term matched children are tracked through the Permanency Monitoring Group (PMG). This means that if their placement were showing early signs of instability the PMG can advise that a Signs of Stability Meeting is required.

6.21 To increase placement choice, particularly for complex children there is a drive to increase the internal fostering resource.

### 6.22 Placement Type for Looked After Children

**Table 16: Type of placement for LAC children**

| **Placement Types** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | **Historical** | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **2016- 2017** | **2015/16** | **2014/15** |
| **Internal Foster Placement** | 282 | 287 | 274 | 273 | 281 (48.0%) | 266 (50%) | 294 (54%) |
| External Foster Placement | 148 | 164 | 163 | 184 | 165 (28.2%) | 137 (26%) | 123 (23%) |
| Placed with Parents | 33 | 43 | 54 | 62 | 46 (7.9%) | 31(6%) | 36 (7%) |
| Children's Homes and Hostels | 36 | 42 | 39 | 36 | 38 (6.5%) | 42 (8%) | 34 (6%) |
| Placed for Adoption | 26 | 26 | 21 | 23 | 25 (4.3%) | 28 (5%) | 28 (5%) |
| Other | 30 | 31 | 38 | 30 | 30 (5.1%) | 30 (5%) | 29 (4%) |
| Total | 555 | 593 | 589 | 608 | 585 | 535 | 544 |

6.23 Within the reporting period whilst there has been an increase in the number of looked after children being placed in internal foster care the overall percentage has decreased by 2.0%. This is due to the increased number of children coming into care over the last 12 months and the internal fostering resource not being able to keep up with demand. This has led to a 2.2% increase in the use of external foster placements. Work will be undertaken in relation to a Sufficiency Strategy to ensure that Sandwell has the right number of foster carers to meet the needs of our looked after children and young people.

6.24 The number of young people placed in residential units has remained stable and this has resulted in an overall decreased percentage of 1.5%. It is important for the IRO Unit and the Resources and Placement Panel to keep this monitored to ensure that only the young people who cannot be placed in a family or fostering setting are placed in residential care.

6.25 There has been a 1.9% increase in the number of looked after children placed with parents. Whilst this is only a slight increase we believe that this is the result of the increased number of children in care proceedings where there has been delay for the children, and the judiciary placing children with parents under an Interim Care Order (ICO) whilst the care proceedings are taken through court. It is important that this does not continue to increase, and for the service and IRO Unit to keep this under review. For those children who are already subject to a full Care Order and placed at home, the Permanency Monitoring Group keeps them under review. This group monitors that assessment and revocation work is undertaken with the family if the Statutory review has recommended this, and reviews delay and blockages that prevent children returning home.

### 6.26 Placement Location of Looked After Children

**Table 17: Number of Placements by Location of new LAC**

| Placement Locations | | Historical | |
|---|---|---|---|
| | **2016 /2017** | **2015/16** | **2014/15** |
| **Placements in LA** | 243 (42.3%) | 254 (47.6%) | 251 (45.6%) |
| **Placements Outside LA** | 263 (45.8%) | 219 (41.0%) | 230 (41.8%) |
| **Placements +20miles** | **68 (11.8%)** | **61 (11.4%)** | **69 (12.5%)** |

6.27 Within the reporting period the number of children placed within the local authority area has decreased slightly in number (11 children) and overall by 5.3%. The largest increase is the number of children placed outside the local authority with an increase of 44 children (4.8%). The number of children in placements outside the local authority but within a 20-mile radius has remained almost the same with a slight increase of 7 children (0.4%). Overall this means that whilst the looked after children numbers have increased, foster care provision within the local authority has decreased and the ability to place children within 20 miles has also decreased with more children being placed externally outside the local authority. This means that some children will have had to have had changes to the stability of their local schools, local communities and may have experienced difficulties in maintaining clubs and hobbies. The IRO Unit is aware of the contribution it can make to ensuring that placements are appropriate and every effort is made by the service to place children as close to home and community as is safely possible.

### 6.28 Health and Education of Looked After Children

**Table 18: Health Assessments and Dental Checks, Under 5's Developmental Checks, Strengths and Difficulties Questionnaire Scores and Personal Education Plans**

| Health and Education of LAC | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | Historical | |
| | Q1 | Q2 | Q3 | Q4 | 2016/17 | 2015/16 | 2014/15 |
| **Health and Dental Checks** | 9.0% | 23% | 40% | 86% | 86% | 70% | 93% |
| **No. of SDQs completed** | 11 | 165 | 207 | 334 | 334 | 334 | 411 |
| **Up-to-date PEP in Place** | 93% | 96% | 91% | 96% | 96% | 98% | 92% |

6.29 Health and education are two key dimensions within the developmental needs of children and young people who are looked after in Sandwell. The IRO Unit is aware of the contribution that it can make by monitoring multi-agency activities such as the Initial and Review Health Assessments, SDQs (Strengths and Difficulty Questionnaires) and PEP (Personal Education Plan) meetings to ensure that looked after children and young people are getting the help and support they need. Table 18 evidences that progress has been made in relation to children's health and dental checks in the reporting period but that more can be achieved. The same could be said for SDQs and up to date PEPs being in place and reviewed. There will be a focus on compliance over the coming months.

# 7 IRO impact on the outcomes for children and young people

## 7.1 Dispute Resolution and Escalation

**Table 18. DRPs**

| DRPs | Q1 | Q2 | Q3 | Q4 | 2016/2017 |
|---|---|---|---|---|---|
| **Informal** | 0 | 0 | 0 | 26 | 26 |
| **Formal** | 2 | 6 | 11 | 31 | 50 |
| **Total** | 2 | 6 | 11 | 57 | 76 |

7.2 One of the key functions of an IRO is to oversee the needs and rights of every looked after child and young person in the care of the local authority. This responsibility is outlined in the Care Planning, Placement and Case Review (England) Regulations 2010 and IRO Handbook 2010. Every looked after child has an Independent Reviewing Officer appointed to ensure that their Care Plan fully reflects their needs and that the outcomes and actions set out in the plan are consistent with the local authority's legal responsibilities towards them as a looked after child or young person. An IRO will ensure that the wishes and feelings of the child are given due consideration by the local authority throughout the whole time the child is in care, and will monitor the performance of the local authority in relation to the child's case. On occasions this means that it will come to the attention of the IRO that there is a problem in relation to the care of a child or young person, for example in relation to planning for the care of the child, or the implementation of the plan or decisions relating to it, resource issues or poor practice by the Social Worker. When this happens the IRO is required to seek a resolution.

7.3 It is acknowledged that resolving disputes can be time consuming and can create tensions between the IRO and the front-line SW service. However, the child's allocated IRO is personally responsible for actively seeking a resolution, even if it may not be in accordance with the child's wishes and feelings, but the IRO believes that this is the child's best interests, welfare and his or her human rights. In accordance with the IRO Handbook there is an emphasis on informal resolution, with a formal Dispute Resolution Process (DRP) if the need arises.

7.4 In the 2015/16 Annual Report, the IRO Unit reported that the DRP process had not worked well, The DRP process had not been well understood or complied with. This was due partly to the service not responding to concerns raised and partly due to IROs not taking up issues on behalf of children or when they did there was an over reliance on an adversarial approach. The IRO Unit reported that the IROs had become disconnected from the operational service and working relationships with the service needed to be built, so that IROs could meet their statutory duties and appropriately challenge the service where needed on behalf of children.

7.5 The IRO Unit has worked during this reporting period to engage with the service, and relaunch the DRP process. Work has progressed on getting the right balance and making a difference to children. Table 18 evidences that there was a slow start to implementing and embedding the DRP process in the service but following a push at the end of Q3 and into Q4, has demonstrated that IROs are now actively challenging the service and seeking resolution when there is an issue. Q4 also evidences that IROs are endeavouring to resolve issues informally. The service is now more responsive to DRPs. There is more work to do with DRPs. A DRP process is only effective if IROs, Social workers and Managers perceive it to be effective. This work has started and needs to be continued and built upon over the next 12 months. The IRO Unit are working towards having a DRP process that can be tracked directly through the LCS system.

7.6 The IRO Unit needs to ensure that the DRPs do make a difference to children's lives. Below are some examples from the 50 formal DRPs where a difference has been made for a child/ren.

| Outline of Problem that resulted in DRP | Outcome/Impact on child |
|---|---|
| IRO raised concerns that the CO and PO had been made in December 2016 but there had been a delay in finding a family for the child. The child's Foster carers who had cared for him from birth had expressed an interest in adopting the child. A request from the Foster Carers to be assessed for the child had not been responded to. | Assessment of Foster Carers is positive and the child is likely to be adopted by his Foster Carers. |

| | |
|---|---|
| Children made subject of CP Plan in May 2016. Family known to Children's Services since 2013. Children suffering severe neglect, e.g. severe head lice causing scabbing to the scalp. LPM held on recommended that PAMs Assessment to be undertaken. Case had drifted with no progress made. IRO issued DRP in March and again in May as she was concerned about the safety of the children. | The case is now before the Court, the children are looked after and safe. |
| Children need life story work to help them to understand why they are looked after | The children now have Life Story Work |
| Family fleeing DV were temporarily housed with the children who are subject of CO's and living with relatives. | The "fleeing family" where found alternative accommodation, and the children were safe. |
| IRO raised concerns about the child's safety; no risk assessment of perpetrator, CP Plan not updated following Core Group, No Safety Plan in place, Core Group records not up to date, Child's voice not evident, Visits to child not recorded, Family members have not been explored. Child on CP Plan for 12 months. | Child had no unsupervised contact with the perpetrator until risk assessment was completed, Safety Plan written and put on file, Parents asked to put forward family members to support the child. Visits evidenced and Legal Planning Meeting initiated to consider legal mandate for the children. |

### 7.7 Quality Assurance by the Unit

7.8 As well as Chairing Looked After Reviews and monitoring individual cases on an ongoing basis, the IRO Handbook notes that:

> *The IRO also has a duty to monitor the performance of the local authority's function as a corporate parent and to identify any areas of poor practice. This should include identifying patterns of concern emerging not just around individual children but also more generally in relation to the collective experience of it's looked after children of the services they receive (para. 2.13).*

7.9 During this reporting period, the IRO Unit have raised collective corporate parenting patterns of emerging concerns through the IRO monthly service meetings. This is the first year that the IROs have achieved this. The IRO Unit has invited the Group Head for LAC to attend the Service Meeting to provide a response to their concerns. The IROs have raised 5 issues during the year and the response has been positive.

- **Long Term Fostering -** IROs were concerned that Sandwell did not have an official policy and procedure for long term fostering, and this was affecting children knowing who their long-term foster carer was. The new Group Head LAC agreed with the concern, set up a steering group and had an IRO represented on the group. There is now a policy in place for children, and their long term fostering plans are being progressed.

- **2. Childrens Savings -** IROs were concerned that sometimes when children moved placement that their savings did not always move with them. In addition, some carers were not putting savings in an account for children placed with them. This meant that children did not have their own money and savings put by. The Group Head for LAC pulled together a list of children where savings needed to move or needed to be saved, and this was put right for those children. The Group Head for LAC also put in place clear guidance and expectations for Foster Carers and Supervising SWs to ensure that this does not happen again.
- **3. Reunification of children placed with parents -** IROs were concerned that some children were not having a reunification assessment undertaken with them before they returned home (as stipulated in Working Together 2015). There were no policy or procedure to explain to workers what was required. The Group Head LAC responded by pulling together a document which specified when there should be a LAC assessment for a child in care. The guidance is on Tri-x. This has taken time to embed within the service and at the end of the reporting year there is still work to do.
- **4. Life Story Work -** IROs were concerned that many children did not have their Life Story Work either started or completed. The approach taken by the service needed to change, as a commissioning approach had been taken which meant that allocated workers did not take responsibility for the life story work. Also, despite plans being put in place the life story work had still not been completed. The Group Head for LAC agreed to put 2 life story work champions in place to ensure that life story work was kick started. At the end of the reporting year children who need therapeutic life story work have had this commissioned and completed, but there are many children who are in their long-term placements who do not yet have their life story work in place for them. The Group Head for LAC also commissioned some training which was well attended but there were only 30 places. IROs have issued DRPs in respect of some children not having life story work. Life Story Work remains and issue for the whole service, and is highlighted in the Childrens Service Improvement Plan and commissioned training for the service is a priority for the forthcoming year.
- **5. Independent Visitors -** IROs were concerned that there were several young people on a waiting list for an Independent Visitor (IV) and there was no timescale for how long they would have to wait. The Group Head for LAC agreed to spot purchase additional IVs so that these young people could have an Independent Visitor sooner.

7.10 The IRO Unit needs to build its Quality Assurance Framework during the course of next year to gain a collective understanding of children's experiences of corporate parenting. This will be undertaken in a variety of ways;

- **Audit -** the IROs have started to undertake audits for children subject to child protection. This was piloted for LAC in March 2017 and is due for roll out during April

2017. It is the intention that these audits will enable collective concerns to be gathered to understand how well we are doing as corporate parents, ensure that children's plans are progressing, and that they are involved.

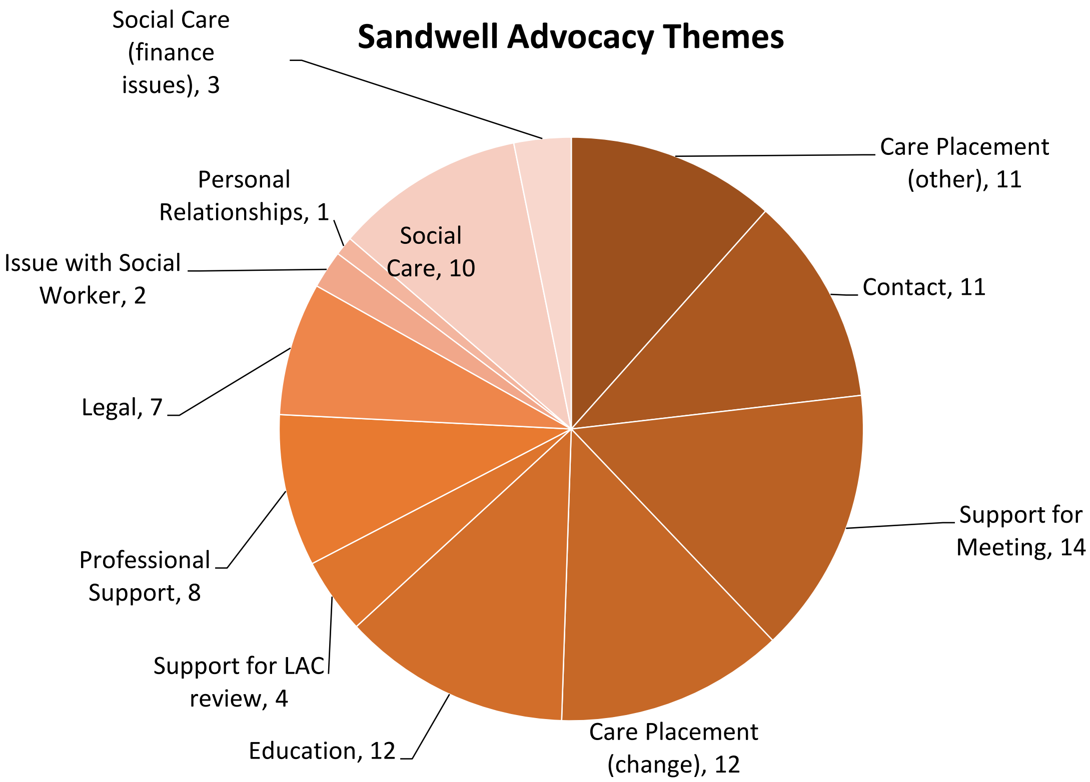
- **Feedback -** the IROs started gathering feedback from children, parents and professionals in relation to child protection work during this reporting period. There is a plan to replicate this for looked after children from April 2017 onwards. This means that the IRO Unit will have the views of looked after children, their parents, carers and relevant professionals to triangulate how well the service are doing as corporate parents.
- **Corporate Parenting Pledge to LAC -** the Corporate Parenting Pledge was launched in February 2017. There is a need to understand how well the service meet this pledge to our looked after children and young people. During the forthcoming year, this needs to be measured and the information used to improve the quality of corporate parenting to our looked after children and young people.

### 7.11 Advocacy and Independent Visitors

7.12 The IRO Unit continues to have an established working relationship with the Black Country Childrens Society who provide Sandwell with our Independent Visitors and Advocates. The scheme is funded by 5 Black Country local authorities and led by Dudley. The Service offers advocacy to looked after children and young people in care and, if necessary, will support them through the Corporate Complaints procedure. The aim of the Independent Visitors is to provide looked after children with an independent adult who will tailor interaction to the needs of the child or young person. This may include befriending, advocacy, new experiences, crisis support, family support and preparation for reviews or meetings.

### 7.13 Referrals for Advocacy

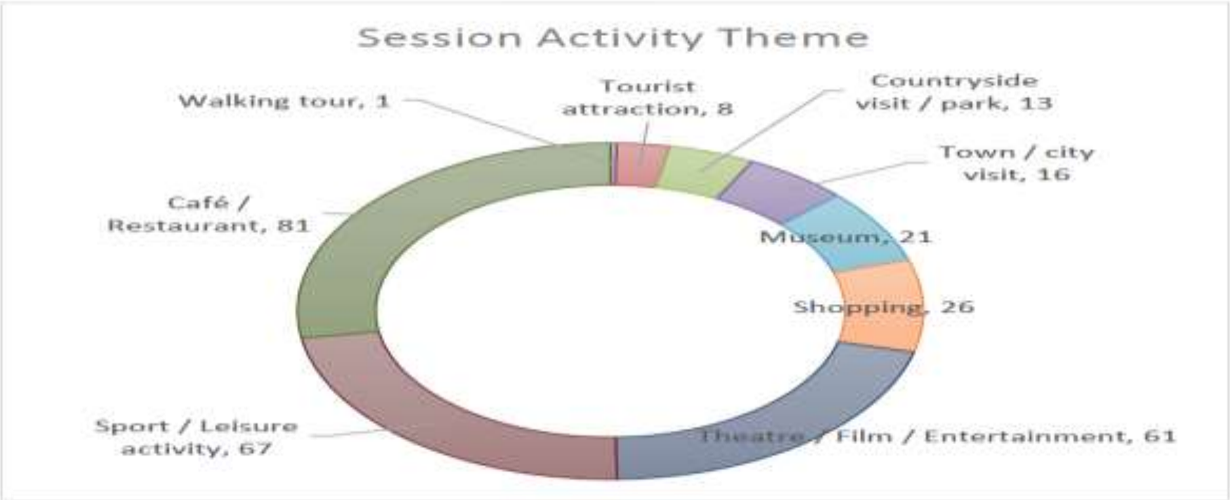
7.14 The Black Country Childrens Society reported last year that they worked with 77 young people. The work covered a range of themes (see pie chart below), with some young people having more than one theme. Most young people wanted help and support in their placements and attending/getting views over in meetings.



## 7.15 Referrals for Independent visitors

7.16 The Black Country Childrens Society reported that last year during the reporting period 1-4-16 to 31-3-17 they had 39 Independent Visitor volunteers who spent 946 hours with young people split over 200 sessions across the 5 local authorities. Sandwell had 7 Independent Visitors assigned. The average length of the session was 5 hours. As stated in paragraph 9.14 there was a waiting list for Independent Visitors for looked after children and additional funding was agreed through a spot purchase with the Black Country Childrens society.

7.17 Feedback about the Independent Visitor Scheme received 12 responses with 92% reporting feeling very happy after spending time with their IV. 92 % also agreed that they had fun opportunities for fun with the their IV. 100% either agreed or strongly agreed that adults support them, they can make decisions and they feel confident. The reported themes are identified in the chart below, with most children choosing to spend time undertaking a sports or leisure activity or going to see a film, theatre or other entertainment.


Session Activity Theme
Walking tour, 1
Tourist attraction, 8
Countryside visit / park, 13
Town / city visit, 16
Museum, 21
Shopping, 26
Theatre / Film / Entertainment, 61
Sport / Leisure activity, 67
Café / Restaurant, 81


How do you feel after you've spent time with your IV?
0%
50%
100%
Very happy
Happy
In between
Unhappy

# 8 Update on QAS Service Priorities 2016/17

8.1 In the Annual Report 2015/16 five key areas of focus were identified for the IRO Unit to work on during 2016/17. This Section provides an overview of progress made by the IRO Unit on the five identified areas during the reporting period 01 April 2016 to 31 March 2017.

**8.2 Assurance - IROs need to assure themselves that children's plans are progressing and a difference is being made to their lives.**

- During the year progress has been made on increasing the IRO Footprint on children's files. Changes were made to the recording system to enable IROs to evidence on the child's file the type of activity that they are undertaking with children, their families, carers and professionals. IROs are now routinely recording their work on the system. This means that they know if children's plans are progressing and when they see them that a difference is being made to their lives.
- During the latter part of the reporting period IROs have evidenced their challenge to the service when there is a problem in relation to the care of a child or young person, the plan or decisions relating to it, or resource issues or poor practice by the Social Worker.
- IROs are now challenging the service through informal resolution or the DRP process.
- IROs have started to audit children's files during February 2017. They are undertaking 2 CP audits and 2 LAC audits per month and over the coming year, caseloads permitting, this will increase to 50% of children on their caseloads being audited.
- IROs now have a clear route and pathway for independent legal advice on occasions where this is required and all IROs and IRO managers know how to access this advice.

8.2.1 By progressing the actions above means that IROs should know if children's plans are progressing and when they see them that a difference is being made to their lives.

**8.3 Staffing - there is a need to recruit to all IRO and manager vacancies to ensure that IRO caseloads reduce and are between 50-70 to enable IROs to fulfil their role**

8.3.1 As this report highlights, there has been active recruitment to the IRO posts and at the year end all posts are filled with permanent staff or temp/agency covering permanent secondments.

8.3.2 The Unit has successfully increased the IRO staffing by 2 posts which are also filled. Caseloads at the end of the reporting period are 75 just above the IRO recommended caseload. There is further work for the unit to progress regarding caseloads. There has been a drive on standard setting for the IROs and the IRO Team Managers have worked with the IROs at building a set of standards for both LAC and CP as well as Foster Care Reviews.

8.3.3 Supervisions have been held monthly with the IROs and this is now embedded as consistent management practice. Supervision file audits show that the quality of the supervision IROs receive is improving across the Unit. Team Meetings have been established through the year as well as monthly Signs of Safety Group Supervision.

8.3.4 There is a need to improve the frequency and quality of the Signs of Safety Group Supervision to ensure that it makes a difference. Back to the Floor Days have been established by the Group Head and IRO Team Managers to dip into the quality of practice. This has shown that we need to do further work in relation to quality of case recording and DRPs and auditing.

### 8.4 Family Friendly meetings - that all CP and LAC meetings are family friendly that enable parents/carers/family members as well as children to participate in their meetings

8.4.1 Signs of Safety was launched in LAC and CP meetings during July 2016. All IROs received the 2 day Signs of Safety training and during the year 6 IROs have been on the 5 day Signs of Safety Training. All IROs will receive the 5 -day training over the course of next year.

8.4.2 Feedback has started to be gained for CP conferences but this is still to be implemented for looked after children's reviews. This will commence in April 2017. IROs are now routinely visiting children and this report evidences the improvement made.

8.4.3 Consultation with children needs to be more dynamic than just visiting and the IRO Unit has designed a consultation document during Q4 for children and carers and professionals, which will be launched in April 2017.

8.4.4 Signs of Safety has started to make a difference to children's Care Plans. Plans are starting to evidence outcomes, but there is still work to do with plans being child and family friendly, understandable and attainable by families, and firmly focussed on making a tangible difference to children.

8.4.5 This report highlights that there is improvement still to make to children's involvement and participation in their meetings. Most children who need an Advocate and Independent Visitors (IV) now have them, and the service has funded additional IVs to bridge a gap identified in the service.

### 8.5 Communication with the service - that a good working relationship is built with the service and the IRO role is known with a clear distinction between challenge and support to the service

8.5.1 The IROs have been much more visible this year with a bank of desks identified at the beginning of the year in the SW office. This was to encourage IROs to work agilely and build better links with SW and TMs. Some of the IROs have been better at using this resource than others. Where IROs have been present in the SW office been strong support relationships have been built. SWs have also been encouraged to work at the IRO office and this has been well utilised by SWs. As the year, has progressed there is work underway to link IROs to individual teams to build on the work that has started this year. Getting the support to the service right is important so that when the service is challenged the relationships hold.

8.5.2 Consideration was given to a move of the IROs to the SW Office with conferencing facilities at the SW Office. This had to be put on hold when there was the announcement regarding the service moving into a Trust. This work will be progressed over the next year with an emphasis on refurbished, accessible, family friendly conferencing rooms. These will be available from February 2018.

8.5.3 The IRO Unit implemented meetings between the IRO and the Social Worker 20 days prior to every CP or LAC review this year. These were introduced as preparation meetings with SWs to ensure that the review is properly planned for and progress has been made with the plan. This gives the IRO the opportunity for IROs to challenge the service and allow remedial action to be taken prior to the review meetings are both face to face and by telephone. The development of the IRO scorecard in May 2017 will inform how many of these meetings are being held and where improvements can be made.

8.5.4 There has been progress made this year ensuring that the IRO role is known to the service particularly the role of challenge. IROs have been invited to the monthly workshops for Team Managers and Group Heads, and attend when they can. IRO TMs have presented at the workshop regarding the IRO role and DRPs (dispute resolution process). There is still work to do and next year the IROs being linked to teams and building a relationship over time through team meetings will ensure that the IRO role is known and understood.

### 8.6 Dataset and Scorecard - to ensure that the Unit has a dataset and scorecard that details IRO involvement with children and that this is automatically generated each week/month

8.6.1 The IRO scorecard was built by the Data Team during the second quarter of the year as planned. This has helped the IRO Unit to focus on priority areas eg. Children de-listed from CP Plans at 3 months.

8.6.2 The planned Individual IRO scorecard was delayed by the implementation of the new LCS system. This will be progressed in the early part of next year to ensure that IRO quantitative performance data on children’s files can be used in IRO supervision to track progress.

8.6.3 The Business Support Manager put in place a system for tracking minutes of conferences and reviews and the timeliness of these. As detailed in this report this was put in place for Q2 and Q3. The implementation of the LCS system impacted on the ability to report in Q4. This data will be tracked over the forthcoming year, and improvements made to the timeliness of minutes for children, families and carers.

## 9 Service Improvement Plan for 2017/18

9.1 The service improvement plan for 2017/18 identifies 5 key areas for the IRO Unit to work and build on over the next 12 months. These are linked to the overarching Directorate Improvement Plan

### 9.2 Key area 1. Quality of recording

- Ensure that the IRO Footprint, including visits to children, are routinely recorded to a good quality standard. There should be a focus on consultation and the child’s involvement in their plan.
- Ensure that CP and Care Plans are outcome focussed, family friendly and easily understandable and have achievable goals and trajectories for families.
- IROs to routinely use Signs of Safety in all their work, and are confident to do so when chairing meetings.

### 9.3 Key area 2. Challenge to the service

- IROs to ensure that informal resolution and formal DRPs are routinely used and tracked to unblock issues for children, and to ensure that they make a difference to children's lives.
- Design and implement a Traffic lights system for every child (CP and LAC) so it is clear to the service which children the IRO has a concern about.

### 9.4 Key area 3. Consultation and participation

- Embed consultation documents to ensure that the wishes and feelings of children are known and there is assurance that the child is involved with their plan.
- Increase usage of the MoMo consultation App through training more staff and providing the service with updates on usage.
- IROs to ensure that more children participate in their meetings, and to encourage children to chair/co-chair their meetings if appropriate to do so.
- IROs will ensure that children know who their IRO is and how to contact their IRO, as well as what an IROs role and responsibilities are.

### 9.5 Key area 4. Quality assurance

- The IRO Unit to actively and routinely seeks feedback from children, parents, carers, and professionals. This will include a survey undertaken by the Participation Team with looked after children.
- IROs will routinely undertake mid-point audits on cases allocated to them, to assure themselves that plans are progressing for children and there is quality work being undertaken with children.
- IRO Unit will use the looked after children's pledge in their work to help understand for individual children and their plans, how well the service is meeting the pledge to our looked after children and young people.
- IROs to collectively challenge the service and seek resolution through the senior management team, when there is an issue that is affecting multiple children within the service.
- The IRO Dataset to be improved and include the Monitoring Form data. The individual IRO Scorecard to be finalised and used by IROs and the IRO TMs to improve service delivery.

### 9.6 Key area 5. Staffing

- IRO TMs to track caseloads and put in measures to ensure that IROs have caseloads of 50-70 children.
- All remaining IROs (and new IROs) to be trained in the Signs of Safety model of practice and give opportunities to undertake the 5 day training.
- Recruitment of IROs to be maintained to ensure that there is a full establishment of permanent experienced IROs who provide a consistency for children when their plans are reviewed.

# 10 Summary

10.1 The IRO Unit has undergone significant change and progress over the last 12 months. The Unit is now starting to deliver quality independent reviews of the care and care planning for looked after children. Looking forwards the ongoing changes and improvements to the IRO Unit offer the opportunity to meaningfully improve the experiences and outcomes for looked after children within Sandwell. With the achievements made this year, the IRO Unit can look forward with confidence to the next twelve months and building a better and improved service for looked after children.

# 11 Recommendations to the Corporate Parenting Board

11.1 It is recommended that Sandwell MBC Corporate Parenting Board consider the following:

11.2 Note the areas of positive performance referred to within this IRO Annual Report, particularly the evidence that the Unit has directly contributed to improving outcomes for children and young people in care;

11.3 Note and support the Unit's commitment to better deliver its statutory responsibilities to looked after children and young people, their parents or carers, in particular increased consultation, participation and challenge;

11.4 Use the annual reporting requirement of the Unit to inform the ongoing work of the Corporate Parenting Board in raising outcomes for looked after children in Sandwell MBC.

**Carol Singleton -**

**Principal Social Worker and**

**Group Head for Safeguarding and Quality Assurance**

**29th September 2017**

**Agenda Item 6**

# REPORT TO
# CHILDREN'S SERVICES AND EDUCATION SCRUTINY BOARD

**05 February 2018**

| | |
|---|---|
| **Subject:** | Update on the Sandwell Children's Trust |
| **Cabinet Portfolio:** | Councillor Simon Hackett - Cabinet Member for Children's Services |
| **Director:** | Executive Director of Children's Services – Jim Leivers |
| **Contribution towards Vision 2030:** |  |
| **Exempt Information Ref:** | |
| **Contact Officer(s):** | Jim Leivers<br>Jim_leivers@sandwell.gov.uk |

| **DECISION RECOMMENDATIONS** |
|---|
| **That Children's Services and Education Scrutiny Board:**<br>1. Considers and comments on the progress of the Sandwell Children's Trust. |

## 1 PURPOSE OF THE REPORT

To consider an update on Sandwell Children's Trust.

## 2 IMPLICATION FOR THE COUNCIL'S AMBITION

2.1 Sandwell Children's Trust aims to improve outcomes for vulnerable children and families and improve social care practice. Therefore, the Trust will help achieve the ambitions around caring for vulnerable children and families and helping the community feel safer.

2.2 Sandwell Children's Trust will support the Council's ambitions:

2.3 5. Our communities are built on mutual respect and taking care of each other, supported by all the agencies that ensure we feel safe and protected in our homes and local neighbourhoods.

2.4 4. Our children benefit from the best start in life and a high quality education throughout their school careers with outstanding support from their teachers and families.

2.5 2. Sandwell is a place where we live healthy lives and live them for longer and where those of us who are vulnerable feel respected and cared for.

2.6 1. Sandwell is a community where our families have high aspirations and where we pride ourselves on equality of opportunity and on our adaptability and resilience.

## 3 BACKGROUND AND MAIN CONSIDERATIONS

3.1 To be outlined in the presentation.

## 4 THE CURRENT POSITION

4.1 To be outlined in the presentation.

## 5 CONSULTATION (CUSTOMERS AND OTHER STAKEHOLDERS)

5.1 There is no requirement to consult on this issue.

## 6 ALTERNATIVE OPTIONS

6.1 The Local Authority is under a statutory direction to set up a new arrangement in the form of a Children’s Trust to deliver children’s social care services. There are no alternative options.

## 7 STRATEGIC RESOURCE IMPLICATIONS

7.1 There are no strategic resource implications directly from this report.

## 8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 To be outlined in the presentation.

## 9 EQUALITY IMPACT ASSESSMENT

9.1 The Local Authority aims to ensure equality for vulnerable children and families and improve social care practice. In this way the Trust will contribute towards equality in the wider community.

## 10 DATA PROTECTION IMPACT ASSESSMENT

10.1 There are no data protection issues arising from this report.

## 11 CRIME AND DISORDER AND RISK ASSESSMENT

11.1 There are no crime and disorder implications arising from this report.

## 12 SUSTAINABILITY OF PROPOSALS

12.1 The proposals contained in this report have been future proofed for future requirements.

## 13 HEALTH AND WELLBEING IMPLICATIONS (INCLUDING SOCIAL VALUE)

13.1 Sandwell Children’s Trust aims to improve outcomes for vulnerable children and families and improve social care practice. In this way, the Trust will contribute towards the health and wellbeing of the wider community.

## 14 IMPACT ON ANY COUNCIL MANAGED PROPERTY OR LAND

14.1 There is no effect to assets or land owned or managed by the Council.

## 15 CONCLUSIONS AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

15.1 To be outlined in the presentation.

## 16 BACKGROUND PAPERS

16.1 None.

## 17 APPENDICES:

17.1 None.

**Jim Leivers**
**Executive Director of Children’s Services (Interim)**