2015 – 2020

Kirklees Future in Mind Transformation Plan

Children and Young People's Mental Health and Wellbeing

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS
North Kirklees
Clinical Commissioning Group

Kirklees
COUNCIL

Contents

Additional content provided separately to this document

Foreword

This plan is a once in lifetime opportunity to make the changes to mental health services for children and young people that we all want to see. We know that transformation is needed and we are all committed to making this happen. In Kirklees we want to get into the fast lane to make the changes needed - this is not the time for a hesitant approach.

The work on the national report 'Future in Mind' has brought forward the voices of children, young people and families who need and deserve the best that we can all offer. These voices form the basis of what we do next. Better support for families and children and young people earlier will make a big difference.

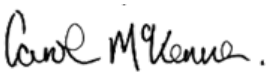
Through the Health and Wellbeing Board we are committed as a partnership to improve the way we respond to any mental health concern.

The Transformation Plan sets out our vision and the outcomes we will be delivering. The document sets out the details for Year 1, but it is a 5 year plan so work will continue to develop and shape service provision and options. The only way we will achieve the scale of change required is if we all work together, share resources, remove barriers, work on best practice and keep the voices of children young people and families at the centre of everything we do.

Alison O'Sullivan
Director of Children's Services Board
Kirklees Council

David Kelly
Deputy Chair of Health and Wellbeing

Chris Dowse
Chief Officer - North Kirklees CCG



Carol McKenna
Chief Officer - Greater Huddersfield CCG

Richard Parry
Director of Commissioning,
Public Health, Adult Social Care

Executive Summary

Future in Mind – Summary Year 1

The following is a summary of the Year 1 priorities for the Kirklees Transformation **Plan for Children and Young People's Mental Health and Wellbeing.**

Included against each priority is an indication that the priority will be funded either by the new Future in Mind allocation, from existing resource, or by national resource.

Please note: Where existing resource has been used as a classification, this may include reinvested resources that have been made available in current provisions, released by new investment in other priorities for example, eating disorder provision investment. The priorities are presented by their Future in Mind theme, the detail in relation to outcomes and objectives achieved by each priority are referenced in the corresponding thematic section of this plan. Funding has been prioritised for front line service delivery rather than managerial functions, governance and contractual functions.

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

- Redesign and implement a school nursing service that is more focused on emotional health and wellbeing, and provides an early intervention function across all educational settings. **Existing resource**
- Implement clear joint working arrangements and clear pathways between schools and emotional health and wellbeing provision. The provision will be based on presenting need and linked to the Social, Emotional and Mental Health Difficulties (SEMHD) Continuum work that is being developed. **Existing Resource and Future in Mind Funded**
- We will have emotional health and wellbeing provision that is collaboratively commissioned with educational settings. **Existing Resource**
- We will collaboratively design with young people peer education programmes for children and young people that promote resilience, and assist with early identification of emotional health and wellbeing issues. **Future in Mind Funded**

  Total Future in Mind funding required £100,000

Theme 2 - Improving access to effective support – a system without tiers

- To redesign the specification for Tier 2 and Tier 3 CAMHS provision transforming services to provide a "tier free" new service model that is based on the "Thrive" approach. **Existing Resource**
- Increase front line capacity within Tier 2 and Tier 3 provisions to reduce waiting times and improve access for children and young people. **Future in Mind Funded**
- Provide a comprehensive eating disorder service across Kirklees, Calderdale and Wakefield in line with best practice and guidance issued. **Future in Mind Funded**
- Implement Tier 2 and Tier 3 CAMHS Link workers to directly liaise with and support schools, primary care and other universal provision. **Existing Resource**
- Implement a joint training programme to support the link roles within primary care, schools, Tier 2 and Tier 3 CAMHS provision and to support joined up working across services. **Future in Mind Funded**
- Have in place a single point of access model for advice, consultation and assessment and coordination of provision. **Future in Mind Funded**
- Provide a one stop shop approach providing advice and support, that has been collaboratively commissioned with the voluntary and community sector. **Future in Mind Funded**
- Provide a local crisis model that ensures assessment within 4 hours and is in line with the Crisis Care Concordat, and utilises our redesigned psychiatric liaison service. **Existing Resource**
- To work with our local Systems Resilience Group to Design and implement all age psychiatric liaison provision in line with the "Core 24" service specification. Where appropriate we will work on a regional basis across acute footprints to develop collaborative approaches**. Future in Mind Funded**

Total Future in Mind funding required £346,430

Theme 3 - Caring for the most vulnerable

- To invest in and implement a flexible multiagency team to address the emotional health and wellbeing needs of looked after children, children in the youth offending team, children experiencing child sexual exploitation (CSE) and children on child protection plans. **Future in Mind Funded**
- To provide the CAMHS link and consultation model within the range of provision across Kirklees for the most vulnerable children. **Existing Resource**
- Ensure rapid access to CAMHS interventions for those children who are part of the Stronger Families programme. **Existing Resource**
- To provide cohesive CAMHS provision on a regional basis for looked after children (LAC) who are placed within the 10 CC (West Yorkshire Clinical Commissioning Groups, Commissioning Collaborative) footprint. **Future in Mind Funded**
- To work with Kirklees Safeguarding Child Board to undertake a "deep dive" into the way in which vulnerable children and young people experience the CAMHS system, and use the learning to inform the development of our discrete provision for vulnerable children **Existing Resource**

Total Future in Mind funding required £280,000

Theme 4 - To be accountable and transparent

- To implement the lead commissioning arrangement for all CAMHS provision covered within the Transformation Plan, discharged through the Joint Commissioning Manager jointly funded by North Kirklees Clinical Commissioning Group (CCG), Greater Huddersfield CCG and Kirklees Council**. Existing Resource**
- Use the Transformation plan as the basis for our commissioning priorities over the next 5 years. **Existing Resource**
- Embed the responsibility for overseeing the commissioning intentions within the Health and Wellbeing Boards work plan and oversight function**. Existing Resource**
- Ensure the Integrated Commissioning Group is overseeing the implementation of the Future in Mind detailed operational commissioning plan. Ensuring that commissioned services are evidence based and that the National Institute for Health and Care Excellence (NICE) guidelines are implemented throughout the service provision**. Existing Resource**
- Ensure the Integrated Commissioning Group closely monitor the CAMHS minimum dataset and waiting time standards, whilst developing a rigorous

outcome based dataset to monitor and improve performance across the system. **Existing Resource**

- Implement clear and transparent outcome monitoring supported by membership of CAMHS Outcomes Research Consortium (CORC), and the implementation of session by session outcome monitoring across CAMHS provisions. **Existing Resource**
- Receive quarterly service feedback from children, young people and families in all performance reporting to the Integrated Commissioning Group. **Existing Resource**

Theme 5 - Developing the workforce

- Ensure Tier 2 and Tier 3 providers are fully participating in children and young person's Improving Access to Psychological Therapies (CYP IAPT) core curriculum in 2016/17. **National resource**
- Ensure that Tier 2 and Tier 3 provider managers are involved in the introduction to CYP IAPT in 2015/16. **National resource**
- Ensure that where required staff and parents receive appropriate training and continuing development opportunities to enable them to deliver relevant evidence based interventions. **Future in Mind funded**
- Develop a comprehensive workforce development strategy for CAMHS across Kirklees. The strategy will inform and direct how workforce development will be supported and implemented. **Existing Resource**

Total Future in Mind funding required £20,000

Introduction

In Kirklees we fully welcome and support the recommendations in the "Future in Mind" report. The recommendations outlined, coupled with the national focus on the improvement of children and young people's mental health will be a catalyst to help rapidly transform our local provision. The Kirklees Health and Wellbeing Board fully endorse this strategic plan.

Kirklees faces some significant challenges in relation to our Child and Adolescent Mental Health Service (CAMHS) provision including its interface with the wider system, and timely access to services. We are in the midst of addressing these issues as a partnership; there is strong local commitment to transform services and access to CAMHS provision across the range of children's services. The extensive contributions to early drafts of this report and to the final version demonstrate the shared commitment to transformation across all agencies, stakeholders and families and children and young people.

Identified challenges are reflected in our Transformation Plan; this plan will help form the basis for fundamental actions directing resources to priorities to improve our local provisions. We also have a challenge in the level of funding for our Tier 3 provision (CAMHS interventions) which, when benchmarked against other areas in the Yorkshire and Humber, shows a significant underinvestment.

As a partnership we are working together closely to address this and have agreed some local resourcing to move towards bringing our local spend per head of child population up to the regional average. There has been a rigorous focus on our provision through high level summit meetings including Chief Officers from both CCGs, Kirklees Council and providers. This process supported the renewed focus on reviewing investment and redesigning service provision across the system.

The Kirklees response to the Future in Mind recommendations and allocated local resource helps us to build on our investment above and beyond the regional average, so we are committed to significant improvement and development. We are working closely with all partners and stakeholders, and developing a phased approach to deliver an ambitious programme of system wide transformation to improve children and young people's mental health and wellbeing over the next five years.

The scope of the Kirklees Transformation Plan for Children and Young People's Mental Health and Wellbeing brings 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 in Kirklees.

The plan covers 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. This will make it easier for them to access the support they need when and where they need it.

The commissioning priorities and performance indicators outlined in this plan are based on our self-assessment, local service data, Joint Strategic Needs Analysis (JSNA) data, ChiMat information, children and young people's feedback and views, parental and schools consultation and feedback.

The priority transformation outcomes have also been influenced by a wide range of agencies and groups in Kirklees using a range of methods including individual meetings, feedback, planned engagement events and authoring of the plan. The plan has also been developed in partnership with NHS England specialised commissioning.

The Transformation Plan sets out our priorities, ambitions and priority transformation outcomes over the next five years, but also includes an initial focus on the primary objectives for Year 1 as required by NHS England. We will focus on the targets we have identified, both national and local, and keep in view our shared vision for transforming provision on Kirklees. It is important to emphasise that as this is a five year plan, some priority objectives will be the focus of later years' action planning. The plan needs to be realistic and achievable.

The Year 1 focus is:-

- Building capacity and capability across the system.
- Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes (IAPT).
- Develop evidence based community Eating Disorder services for children and young people.
- Bring education and local children and young people's mental health services together around the needs of the individual child through a joint mental health training programme.
- Care for the most vulnerable.

The plan is also being developed in line with existing improvement programmes such as the Mental Health Crisis Care Concordat, a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The plan is also being developed in line with our local plans for developing care closer to home, our early intervention

and prevention strategy, our Safeguarding Board, Health and Wellbeing and Children Trust priorities.

The core principles which underpin the development of the plan are:

- Promoting equality and reducing health inequalities across Kirklees.
- Taking a whole system multiagency approach to transforming our CAMHS provision.
- Transparency of data, finance and performance activity and clear accountability.
- Involvement, engagement and consultation.
- Promoting an outcome based approach to integrate commissioning intentions into existing provision and initiatives where possible.
- Collaborative commissioning approaches will be used across the partnership to transform our commissioning intentions into reality.
- Ensuring services are evidence based NICE compliant and provide best value for money.
- Promoting choice across the system.
- Taking an asset based strengths approach as a starting point for provision.

The Kirklees Transformation Plan's format follows the five Future in Mind themes and is presented in thematic sections. There is an in-depth baseline needs assessment, followed by a brief summary of findings, needs and gaps are included in each section. At the end of each thematic section priority transformation objectives are outlined alongside the resources involved in delivering the intentions.

The transformation priority objectives all correspond with a specific recommendation from Future in Mind, the theme and subsection recommendation number is recorded next to the priority as a cross reference. It should be noted that throughout the document mention is made of the current tiers of provision. This is because at times we are referring to the current system as is, not the future tierless provision. To be able to deliver a comprehensive programme of change we will conduct quality impact assessments and equality impact assessments in relation to all our commissioning intentions. We recognise that scale of the change required by our plan is far reaching and challenging. Therefore we will utilise Kotter's 8 step change process[1] to lead and drive the change throughout the next five years.

The ambition for this plan is to influence and drive the pace of change for the whole market, leading to a sustainable and diverse range of wellbeing, treatment and support providers.

[1] http://www.kotterinternational.com/the-8-step-process-for-leading-change

Through the transformation process Kirklees will have a CAMHS where there are continuous improvements in quality and choice. We want a CAMHS delivering innovative and cost-effective outcomes that enhance the emotional and mental wellbeing of young people in Kirklees. We also want to be clear about the direction of the market and spending within it so providers can attract investment for resources and technology.

The emotional and mental wellbeing marketplace is complex, some detail is known about the services provided that meet specific needs individuals have and there are a number of specific services that meet these needs. Less is known about the support on offer to those in the market that is provided by friends, family and informal volunteers. Less still is known about the purchasing habits of schools, community organisations, parents and carers that meet emotional mental wellbeing needs. We need to develop our understanding of the value, importance and contribution of these sorts of services make to prevent, delay and reduce the need for more complex and costly services.

Equality and health inequalities

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to:

a. eliminate discrimination, harassment and victimisation,
b. advance 'Equality of Opportunity', and
c. foster good relations.

All public authorities have this duty so the partners will need to be assured that "due regard" has been paid through the delivery of this formal consultation.

Greater Huddersfield, North Kirklees CCGs and Kirklees Council are committed to promoting equality and diversity and reducing health inequalities. To ensure that we are meeting equality duties, improving health and reducing health inequalities we will:

- Adhere to the 'Brown principles'[2] outlined in case law to demonstrate that 'due regard' has been given as follows:
    - The organisations must be aware of their duty.

[2] Equality Act 2010

    - Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind.
    - The duty cannot be satisfied by justifying a decision after it has been taken.
    - The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
    - The duty is a non-delegable one.
    - The duty is a continuing one.
- Ensure any changes to services will include local engagement with patients, public, carers and wider stakeholders and ensure that this includes involvement of protected characteristic groups and that equality monitoring is undertaken for all engagement activity.
- All service reviews undertaken as part of this plan, will undertake an equality impact assessment.
- Service contracts and service specifications will reflect the need for equality monitoring and ensure that providers demonstrate and report on how they are meeting their public sector equality duty.
- Any decision making resulting from this plan will give consideration to any identified ‘impact’ on protected characteristic groups and where appropriate identify and implement mitigating actions.

Baseline Needs and Current Services

1. Introduction

In Kirklees we have a record of ongoing and proactive engagement with young people, both through our large scale surveys[3] and through more focussed group and individual work.[4] Transforming this knowledge and insight into services is critical to the success of our emotional and mental wellbeing support infrastructure. We also have robust needs assessment information though our Joint Strategic Needs Assessment, which combines some of the raw research with national trend information. We also have some service information, although this does not give a full picture of support in Kirklees. However, when combining "wants" from our research with expected "needs" from prevalence and other trend data, along with "service" data we begin to see a picture of the gaps between the expectations of our population and what we should be seeing in terms of volumes and service provision.

2. Population

There are 107,402 children and young people aged 0 to 19 in Kirklees. They are equally spilt between males and females. There are around 50,000 young people in North Kirklees and just over 57,000 in the Greater Huddersfield CCG areas.

The area served by Greater Huddersfield CCG covers the Huddersfield wards of Almondbury, Ashbrow, Colne Valley, Crosland Moor and Netherton, Dalton, Denby Dale, Golcar, Greenhead, Holme Valley North, Holme Valley South, Kirkburton, Lindley and Newsome. Poverty and deprivation levels are highest in Huddersfield, along with higher rates of unhealthy behaviours.

The area served by North Kirklees CCG covers Batley, Birstall and Birkenshaw, Dewsbury, Cleckheaton, Heckmondwike, Liversedge & Gomersal and Mirfield. North Kirklees is overall more deprived than Greater Huddersfield. The population of South Asian origin is increasing and there are a higher proportion of babies being born to south Asian mothers, now up to 2 in 5 births.

3. Prevalence and issues to be addressed

The CHiMAT report brings together key data and information outlining condition prevalence, demand, risk factors, provision and outcomes for services within the Kirklees and Kirklees CCG populations. Further analysis has taken place to increase the accuracy of rates per 1,000 population for borough and CCG areas.

[3] https://democracy.kirklees.gov.uk/documents/s3734/School%20Survey%20Report.pdf

[4] https://democracy.kirklees.gov.uk/Data/Overview%20and%20Scrutiny%20Management%20Committee/20110118181000/Agenda/smc18011141655D.pdf

CHiMAT Analysis – Kirklees LA and Kirklees CCG areas

(http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=41&geoTypeId)
CHiMAT data has been used to understand the change in prevalence in mental health problems of our local young people, and the proportion that are likely to be in need of services. It has allowed us to understand where the gaps in prevalence and actual service use have been. The data has been referenced at various boards in discussion with senior managers and commissioning discussions. CHiMAT has assisted us in developing our previous strategies and have shaped our thinking with regard to the potential transformation of mental health services.

3.1 Mental health disorders

Overall 9.6% (6,125) of 5-16 year olds have some form of mental health disorder; the variance between gender is interesting particularly in the 5-10 age group where prevalence in boys is almost double that of girls (10.4% against 5.3%), (1,700 against 855). In the 11-16 age group the gap narrows but there is still a 3% increase in prevalence amongst boys.

When the two Kirklees CCG areas are compared, North Kirklees CCG has between 7% and 10% higher prevalence rates in all age and gender groups. With the greatest variance being in the boys aged 11-16 groups. Using per 1,000 population rates means this is not related to population concentration - we know North Kirklees has a higher young population. It suggests that broad mental health disorders are more common in North Kirklees - and across Kirklees are more common in boys.[5]

3.2 Conduct disorders

Conduct disorder prevalence broadly doubles between the 5-10 and 11-16 age groups; this increase is the same for both genders. However the prevalence in boys is much higher than groups where 7.2% of boys against 3% of girls have a conduct disorder in the 5-10 age groups (480 against 1,185). This gap reduces slightly in the 11-16 groups but boys remain 3 percentage points ahead of girls.

When CCG areas are compared as before, there is greater prevalence of conduct disorders in North Kirklees, where in the 11-16 age group prevalence across genders is 12% higher in North Kirklees.

3.3 Emotional disorders

The variance in emotional disorder prevalence between genders is much closer in each age group across Kirklees. However CCG prevalence is again higher in North Kirklees than greater Huddersfield with around 7% more disorders.

[5] http://www.kirklees.gov.uk/you-kmc/partners/health/jsna/pdf/KirkleesJSNANKCCGSummary.pdf

3.4 Hyperkinetic disorders

Hyperkinetic disorders are six times more common in boys than girls. These are less common than emotional disorders and broadly in line with national prevalence rates.

3.5 Neurotic disorders in 16–19 year olds

There are large gender variances in neurotic disorders; this is particularly the case for anxiety and depressive disorder where girls are 2.5 times more likely to suffer than boys (1,315 against 570). Similar differences are seen in depressive episodes where girls are twice as likely to suffer as boys.

3.6 Children and young people who entered the Youth Justice System

There were 69 children aged 10-14 who entered the criminal justice system in 2013/14. This rose to 87 in the 15 year old age group, 83 in the 16 year old age group and 132 in the 17 year old age group. There were around 400 Orders imposed on young people under 18 supervised by the Youth Offending Team in 2013/14.

3.7 Autistic spectrum disorders (ASD)

ASD gender breakdown is not available through CHiMAT. Local intelligence suggests around a 70/30% split between boys and girls with ASD. Local data suggests around 1 in 100 children have an ASD, equating to around 980 children in Kirklees. The needs of children and young people with ASD are being dealt with locally through a separate redesign and service transformation process to meet the NICE guidance for ASD assessment. Therefore ASD is not being addressed within this “Future in Mind” Transformation Plan.

3.8 Eating Disorders

Although not covered in CHiMAT, some local analysis has taken place around expected need and young people already using services. Based on 2009 prevalence research[6] around 51 young people would be expected to have an eating disorder in Kirklees. However, services are seeing more than this number where there is an identified “eating difficulty”; ChEWS (Children’s Emotional Wellbeing Service) are treating 64 young people with an “eating difficulty” from across Kirklees, and CAMHS (Tier 3 Provision) are treating 29 young people with an “eating disorder”, with 7 from North Kirklees and 22 from the Greater Huddersfield CCG areas. The numbers of people seen by specialist services (the current Tier 4) were low but are more likely to require long term in patient support from these services.

[6] Page 44 of Eating Disorder Guidance

3.9 Child Sexual Exploitation (CSE) Victims

Again not in the CHiMAT data but in Kirklees 58 young people were identified as potentially at risk in March 2015. The specific needs of this group are discussed later in this plan.

4. What have young people, parents and carers told us?

Listening to and engaging with children and young people and local research over several years has identified important issues that affect their emotional and mental health. Children and young people have also suggested ways in which they believe services and support can be developed and improved.

The experiences identified by children and young people which may lead to the need for help and support include:

- Struggling at school, particularly around exam time, transition and stress related to school.
- Parental relationships breakdown.
- Breakdown of relationship with friends, parents or carers.
- Anxiety, distress or dissatisfaction with appearance or health.
- Being bullied.
- An inability to relax at times of stress and anxiety.
- Bereavement and other traumatic experiences.

Some of these issues may appear to be a “normal” part of growing up, however the effect that these issues have on some young people can have long-term detrimental impact. Challenging the perception that low level issues do not require an intervention is a major part of any system transformation.

Sometimes these issues will be the precursor to eating disorders, lifelong self-esteem issues, poor educational attainment, alcohol and tobacco use, substance misuse, severe behavioural issues, involvement in offending, young people becoming the victim of sexual exploitation and other significant, high impact problems which can occur later.

4.1 What do children and young people want from a service?

The work undertaken with young people to understand what sort of emotional and mental health services they need provided fundamental messages which remain constant:

a. Have the right adults working with us - people we can trust, who we can talk to in confidence, who are not judgemental, who like young people.

b. Provide young-people-friendly venues – with a range of services in one building, friendly and welcoming, relaxed and informal culture, clean and safe, choice of venue within walking distance of home or something more central for anonymity.

c. Offer us flexible and accessible services – not 9am-5pm or wait until Monday, access to all inclusive services that can support all aspects of our lives, drop in services and self-referral, opportunity to take part in activities that are creative and fun and help build a range of softer skills such as friendships.

d. We want to know what we can expect from a service and are able to make choices – choice about the kind of therapist we see, to be offered a range of treatment options, not just medication or counselling, we'd like to try other therapies including music, art, drama and equine therapy.

e. We need to understand and be reassured by confidentiality policies.

f. Involve us in planning and delivering services and activities.

4.2 Support from family and friends

Children and young people have been consistently clear that they see combined support for their parents, carers, siblings and friends as being very important. They suggest "skilling up" the family to help each other; enabling families to reflect on their behaviour, communicate effectively and learn how they impact on each other. Children and young people want to be able to discuss problems, knowing parents and carers have the knowledge and resources to help support them.

Some children and young people feel most able to share their difficulties with their friends but many "supportive friends" felt they needed training or skills to be able to help the person in difficulty and maintain their own emotional and mental health.

The development of peer mentoring and support groups in school is seen as valuable by some children and young people, particularly where the support is provided by young people who have themselves encountered and been helped to manage their own emotional or mental health difficulties. However, they did add that it could be unhelpful too when people advised the wrong things.

4.3 Help us to help ourselves

Children and young people suggest they need better education about mental health, such as feelings, emotions and reactions to environments and events so that they have a better awareness of how their mental health might be affected as they grow up. Encouraging open dialogue about mental health will help children and young people to feel more confident in approaching an adult or peers about their problem.

A common theme that emerged from young people is that if a person can manage a difficult experience without adult intervention, it is better for them. Helping children and young people to develop coping strategies in advance of any difficult situations

was a clear suggestion from young people. Providing young people with the knowledge of what support is on offer and where to seek it was vital.

Young people say that information about who to contact when in crisis or need support should be readily available, preferably on line. They have suggested that services explore digital emotional health and wellbeing approaches in partnership with young people, looking further at how text, apps and web resources could be created to help support their emotional and mental health.

4.4 What have parents and carers told us?

Through consultation and feedback with parents and carers including several representatives from PCAN (our local Parents of Children with Additional Needs group), we have identified a number of common themes in relation to their experience of the CAMHS system along with wider service provision. Firstly, parents feel that the whole system is difficult to navigate, and there is a lack of communication in relation to the "right" entry point. Therefore when they are trying to get help for their son or daughter they spend a lot of time ringing different agencies and are told different things.

When parents do eventually find the correct referral mechanism for example, their G.P or school, referrals are made but access to support takes too long and communication back to referrals and parents is poor. Therefore a strong message from parents was the need for a single point of access and a system without tiers.

Secondly, parents told us they need some support in their own right when managing their children's conditions or behaviours. This is important because parents feel their own health and social circumstances can suffer due to their caring role, and ultimately impacts on them and the wider health and social care system. Parents have suggested that programmes such as mindfulness training would be helpful, which we have recently piloted, as well as taking whole family approaches to care including care planning for the whole family.

Thirdly, parents told us that given the right support that they want to be part of the solution for helping their children. Therefore if a CAMHS system gave them more support and training in how to manage certain behaviours and difficulties that they could manage certain aspects of their children's behaviour without need one to one support from services.

Further detail of engagement work that has been undertaken to support the co-production of the Transformation Plan is provided in Appendix 6.

5. Current service delivery – The Tiered Approach

When service data is reviewed, issues with the current arrangements can be identified, some of which may not be obvious through normal service monitoring.

5.1 Prevention, early intervention and universal support

Across all agencies and organisations improvement needs to be made in recognising the value of prevention. There needs to be greater understanding of the factors that are likely to impact on the emotional wellbeing of a child and young person. It is not a specialist intervention; often it is support at a very low level that can make someone feel supported and less alone, boosting their self-esteem. The value of intervening early can prevent escalation of the problem, improve outcomes for the child and young person concerned and be cost effective.

The whole system must understand more about combinations of adversity, and the potential long term effects of ignoring issues. This should be seen as a responsibility for all those working with or involved with children and young people.

As discussed elsewhere in the document when support is required rapid access to appropriate provision is needed. Schools and other community venues should plan to include accessible space for such support.

Intelligence from the latest Kirklees Young People Survey data generated through a questionnaire to Years 7, 9 and 12 gives us broad population trends in young people aged 11-16. Whilst this may appear at odds with the CHiMAT analysis featured earlier in the submission, self-reported resilience and wellbeing is not comparable to expected condition prevalence.

The Young People Survey suggests that students in the lower years have more resilience than students in the upper years of secondary school; that girls have more resilience than boys and that young people living in more deprived areas have a greater degree of resilience than those living in the less deprived areas of Kirklees.

Wellbeing and Resilience scores in the survey were consistently lower in children who were involved in risky behaviours, namely sexual intercourse, alcohol consumption and substance misuse. Resilience scores were also lower in children who were bullied.

Teaching and support staff are aware of the broad headlines around resilience, however any child or young person can experience circumstances where additional emotional support is needed. Unfortunately there will always be inconsistencies with how individual schools are able to respond to these instances.

Schools where emotional support infrastructure are in place often have accessible services based onsite, or staff such as teaching and pastoral staff that are able to respond. Work is currently underway to develop a concept of 'Learning and Community Hubs' to enable schools to become community leaders. In particular, supporting schools, parents, and the community to shape and influence services and resources to meet identified local need.

Learning and community hubs are designed to maximise school and community resources for the benefit of their local population. It is planned that the community hub approach will extend to the commissioning and development of innovative and integrated services that improve mental and emotional wellbeing outcomes for children and young people and families.

5.2 Referrals and service demands - The Children's Emotional Wellbeing Service Current Tier 2.

The Children's Emotional Wellbeing Service (ChEWS) has provided a range of service activity data. During 2014 - 2015 this service received 1,406 referrals, over half of which came from parents/ carers or General Practitioners.

ChEWS supplied details of the principle reason for referral. Further work needs to be undertaken to analyse the combinations of issues that most commonly appear together. Increasing understanding of this will affect the work undertaken around prevention and also help professionals to appreciate what else is likely to be going on in the lives of young people requiring emotional support.

ChEWS Referrals - Presenting Issue	Total	%
Behavioural	455	21%
Anxiety	352	16%
Low Mood	247	11%
Relationships - Family	175	8%
Low Self-Esteem/Confidence	152	7%
Self-Harm	161	7%
Sleep Related	79	4%
Relationships - Peers	70	3%
Domestic Violence	60	3%
Eating Difficulties	59	3%
Suicidal Thoughts	59	3%
Bereavement	50	2%

ChEWS Service Activity 2014-2015

When the available reasons for referral are analysed it is reassuring that over 90% of the presenting issues match with the issues young people identified themselves. The data for the first quarter of 2015/2016 has the same top three presenting issues.

What ChEWS recognises is that the presenting issue does not reveal is the cause and effect relationship, for instance behavioural problems could be an effect of bereavement, poor relationships, low self-esteem or bullying. The concern is that delays in referrals and assessments may be compounding or exacerbating issues for some young people.

5.3 CAMHS (Current Tier 3) - April to June 2015 Data

The CAMHS Tier 3 service data relates to the first three months of the 2015 financial year, which although not ideal, does give a view of service activity.

5.3.1. Inappropriate Referrals – CAMHS (Current Tier 3)

The first issue that is apparent is the level of inappropriate referrals, with around 3 in 7 (43%) of referrals deemed as being inappropriate. This increases to 58% for the generic CAMHS services and 61% for ADHD services. Review of these referrals highlights that there are a number of possible reasons for this; firstly it may be that referrers do not fully understand the scope of the services provided, secondly it may be that referrers are not skilled up enough to deliver an intervention at the appropriate level, and thirdly the service may not have the capacity to deal with the referrals and some are rejected to ease service pressure in the treatment part of the system. Further investigation needs to be undertaken to assess exactly what the issue is and some of the reasons behind inappropriateness of referral.

Total Referrals Received	433
Total Inappropriate Referrals (as deemed by CAMHS)	187
Inappropriate Referral Rate	43%

CAMHS Service Data (April – June 2015)

This must not overshadow the fact that the young person is potentially told they cannot be helped or they should not have been referred: the effect this will have on the young person and their families will be detrimental. It also raises the question where do they go for support if Tier 3 CAMHS is not appropriate? Developing an understanding of the post inappropriate referral journey needs to be investigated. The service data does talk about onward referrals but again whether these are effective or just a movement of the problem needs to be investigated as part of the development of the Transformation process.

5.3.2 Assessments, attendance and emergencies – CAMHS (Current Tier 3)

Emotional ill health should be seen on an equal footing with physical ill health. The speed at which a young person receives support after referral is critical to reduce the impact of the reason for referral and also to reduce to time it takes to get back to emotional wellness. A significant issue for commissioners to note is that whilst people are waiting, some issue in their lives continues to escalate, and additional risks could be being undertaken by the young person. Their family and support network will still potentially be lacking the knowledge about how to support the young person.

As described above, addressing the issue of inappropriate referrals will increase capacity in the initial assessment phase of support. Based on current trends for the first quarter of 2015, 14% of referrals were assessed within four weeks. Ensuring there is some form of support for the young person between referral and initial assessment is crucial. It is clear that any deterioration between these two points will take longer to treat, cost more and have a greater effect on the young person.

Total Choice Contacts (Initial Assessments)	125
% of Choice (Initial Assessments) Contacts Within 4 Weeks	14%

CAMHS Service Data (April – June 2015)

When a young person has been referred there are issues with some not attending the appointment. Overall 18% of young people do not manage to attend their appointments. There are a number of reasons including; a lack of confidence in accessing support, the wait has been so long they have found they own (sometimes more harmful) ways of dealing with the issue and transport problems. There may be other issues. Young people may be disengaging with people and services in different areas of their lives which can lead to increasing chaos for emotionally unwell young people.

The service is losing capacity through missed appointments. There needs to be a better understanding about why a young person misses an appointment and non-attendance must not automatically discharge a young person whatever the circumstances.

Did Not Attend (DNA) Appointments	Average
Choice (Initial Assessment) DNA Rate	17%
Partnership (Treatment) DNA Rate	19%

Tier 3 CAMHS Service Data (April – June 2015)

Supporting young people in crisis who need emergency support is a very important part of the service offer. In the service data less than half of the emergency referrals made were seen in 24 hours. The potential damage this delay has on the young person and their path to recovery cannot be underestimated. Rapid access support should be at the core of all services, particularly for those in crisis.

Emergency Referrals	59
% Emergency Referrals seen in 24 hours	46%

CAMHS Service Data (April – June 2015)

5.4 Waiting times across the system – ChEWS & CAMHS

Data regarding waiting times is available from both ChEWS and CAMHS and they outline the challenges involved in achieving the anticipated waiting time targets. This is not a matter of benchmarking or service anomalies. This is telling us that young people needing emotional support for the sorts of issues listed above can be waiting up to 3 months for support. Those young people needing more intense mental health services after they have been assessed are waiting over 6 months.

The potential duration between recognising there is a problem, seeking support, a referral being made, an assessment being undertaken (CAMHS only), and then a wait for treatment cannot be accurately calculated. However it is worth reflecting that long term damage and cost increases will be developing within the child or young person during this period.

The ChEWS service has been able to supply data from the last full financial year which captures the duration of wait between referral and direct or indirect treatment. Almost half (47%) of young people receive treatment within 31 days of referral. However there are 37% of young people waiting over 45 working days (9 weeks) between referral and treatment either direct or indirect. In the past year this equated to over 1000 young people, around half of these young people were waiting for direct support such as one to one counselling. Average waiting times were 68 working days in 2014/15. This has improved in the first 20 weeks of the 2015 financial year to an average waiting time of 60 working days or 12 weeks.

ChEWS (Current Tier 2) waiting times – April 2014 – March 2015

Average number of People Waiting For Treatment (**post referral**)	60
Average length of Wait – Working Days	68
Average length of Wait - Weeks	13

ChEWS Service Activity 2014-2015

CAMHS waiting times (Current Tier 3) – April – June 2015

Average number of People Waiting For Treatment (post assessment)	438
Average length of Wait - Days	243
Average length of Wait - Weeks	35

CAMHS Service Data (April – June 2015)

5.5 Admissions and service demands – Specialist Support (Current Tier 4)

Based on available service data the general trend over the past three years has been a gradual reduction in admissions to inpatient specialist services. Average

stays have remained the same but due to the small numbers of cases further analysis is not possible at this stage.

6 Commentary on Needs and Current Services

Young people have been consistent about the sorts of things going on in their lives they need support with; these issues are being seen in services. Firstly we need to understand how we can reduce the numbers of young people experiencing issues.

We also need to make sure that when young people need a support service; it is accessible, staffed by professionals who are able to respond quickly to the needs of the young person. The support infrastructure around the person also needs to be considered, getting this support right will enhance the effectiveness of any professional intervention and reduce the likelihood of readmission in the future.

Professionals also need to get better at understanding which issues are likely to be linked and the probability of detrimental downstream issues if the primary issue is not addressed in a timely manner; this should particularly be the case for those experiencing or at risk of harm such as CSE victims.

Professionals need to have a better understanding of the scope of services they are referring into. The use of a system wide triage or gateway assessment should be considered, so referrals are appropriate and creative support can be given in the period between referral and assessment. There is potential for this to impact on reducing waiting times, referrals that are appropriate could start receiving support sooner because professional assessment time is not being wasted. The issue of non-attendance also needs to be understood from the point of view of the young person; as discussed, there are likely to be a number of factors affecting non-attendance. We also need to further develop the role of self-help, care and advice to ensure that young people can access resources at the earliest possible stage. This also needs to include information about what services there are and how to access them.

Changing the view of the importance of prevention of emotional and mental health issues is crucial including how this will reduce overall demand. Alongside this is the understanding about how addressing emotional and mental health issues rapidly will reduce treatment duration and likelihood of escalating issues. This will be at the centre of thinking for the transformation of emotional and mental health services in Kirklees.

7 Child Sexual Exploitation (CSE) Victims' needs

The Kirklees Children's Trust has instigated a review of CSE victim support in its broadest sense. What has emerged from early work are two critical issues: firstly timely access to counselling, mental health and emotional wellbeing support. Secondly, once in the support system, CSE victims are experiencing significant issues when they transition into adult mental health services.

CSE victims do engage with emotional and mental health services, but around 40% of victims fail to engage once a referral is made. This is often due to missed appointments and some common factors can be seen in CSE cases of discharge, chaos and substance misuse.

The needs of those at risk or affected by CSE

Those at risk or experiencing sexual exploitation need to be able to see the value of themselves as individuals but also recognise they are victims.

A gap in current support is around victim recognition; the vast majority of cases reviewed featured a victim who was seen as such by everyone but themselves. The lack of victim recognition is a major stumbling block for support providers; often realisation of being a victim is the route into support and part of the healing process.

A further gap is around mental health service transition. These issues seem to be effective professional liaison problems rather than the lack of a service offer; which combined with the service pressures mentioned above is not working effectively for CSE victims. This is of course common to a large number of children, but due to the complexity of other issues going on with CSE victims they are more likely to become disengaged by services and during transition.

Victims need support to recognise their emotional intelligence, physical worth and life potential. They also need to see the value of change in their circumstances and the effect that will have on their self-esteem and self-worth. More practically they need to see how they can break away from the exploitation, and be supported to make the decision to do so themselves.

The grooming and exploitation process and the effects of substance misuse and poor emotional health has in many cases broken down any support networks the victim may have had. Helping a victim to understand the process of exploitation is difficult but critical. The victim will need support and direction to unpick the process, their memories of it, along with the effects it has had upon them. What needs to be recognised by professionals is they have a role to develop responses that support victims and those around the victim onto their own path of recovery and reconciliation.

Health, emotional and care needs

By far the greatest area of need is that of a positive role model to support the development of self-esteem and self-worth within the individual. This has to be thought of as a means of counteracting the grooming process of the perpetrators and installing positive life choices and the boundaries of what is a normal relationship within the victim.

Accessing counselling and psychological therapies is an important need for CSE victims. As described above part of the need is to work with the victim to recognise themselves as victims and build a desire to change from within the victim. This consequently leads to underlying issues not being addressed. There is also the need to address the trauma of the abuse and other difficulties such as support to rebuild familial or carer relationships.

Emotional wellbeing needs in CSE victims can be understood using Strength and Difficulties questionnaires where looked after CSE victims experience significantly worth emotional wellbeing than their looked after peers.

There is a need for sexual advice counselling. This would be around supporting the victim to work through the psychological issues arising from exploitation. It would also support the victim to recognise themselves as such, and prepare them for the emotions of normal relationships in the future. In many cases where sexual abuse was present the boundaries and stages in sexual relationships did not exist. Victims receiving support to understand what these boundaries are and why they exist would be beneficial and assist in the victim recognition process.

The sexual health of CSE victims must be thought of in terms of physical and emotional sexual health. Whilst 1 in 5 of cases reviewed had concerns around sexually transmitted infections or emergency contraception use, there were instances of a lack of recognition of the emotional value and importance of sex. Sexual risk taking was a feature in 2 in 5 cases this involved both physical and emotional sexual risk.

There are a number of children who because of being victims of CSE have become looked after. There are a range of reasons for this, some are from chaotic homes, some have been violent or uncontrollable and others have become looked after because of offending and substance misuse. There may be opportunities to rebuild relationships but, importantly, these children need a positive and consistent role model in their lives.

Victims have a number of emotional and psychologically linked needs such as needs around; behaviour and anger issues, self-harm, and suicidal thoughts. Again these are effects of CSE and its associated risks.

The needs of those around the victim

There were a number of identified needs that were more around the family of the victim, addressing some of the precursors going on within the cases.
Parenting support would potentially be useful in CSE cases. This would facilitate better parent and child relationships which may prevent the deterioration of relationships which has been seen as a precursor to exploitation. Similarly home management support was a beneficial feature in a quarter of all cases. Helping parents understand and have supportive conversations about online access and mobile use was another important issue.

Kirklees self-assessment – Future in Mind

The Kirklees Transformation Plan's format follows the five Future in Mind themes and is presented in thematic sections. There is an in-depth baseline needs assessment, followed by a brief summary of findings, needs and gaps are included in each section. At the end of each thematic section priority transformation objectives are outlined alongside the resources involved in delivering the intentions. In the appendices for each set of thematic priority transformation objectives, there will be detailed delivery plans for each theme.

The transformation priority objectives all correspond with our self-assessment priority actions areas from Future in Mind, the theme and subsection recommendation number is recorded next to the priority in order to provide cross referencing.

Theme 1. Promoting resilience, prevention and early intervention for the mental wellbeing of children and young people.
Chapter 4 - Future in Mind

Our aims

We can demonstrate our commitment in Kirklees to developing a cohesive early intervention offer for all children, young people and their families though the Council priority for the Early Intervention and prevention programme and the Kirklees Clinical Commissioning Group's (CCG) priority for the care closer to home programme.

The development of our early intervention offer draws together a number of strands including the redesign of the healthy child programme 0-5 and 5-19, our redesigned early years and children's centre offer, our integrated youth support service offer and our Stronger Families programme.

The aim of our early intervention programme is to refocus resources further "upstream" to prevent harm in early years and build resilience in children, young people and the families in which they live supported and enabled by more confident staff.

We aim to ensure that we promote good mental health universally, prevent the development of mental health issues and identify issues as early as possible to ensure the right support is available at the right time. We will achieve this by strengthening and developing our emotional health and wellbeing universal provision, and by identifying any emerging issues as quickly as possible, providing a rapid response to those issues at the earliest stage.

Evidence suggests that 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[7]. We also note the evidence which underlines that where children have developed

[7] 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.

clinically significant problems into adulthood, that in at least 60-70% of those cases they did not have an appropriate intervention at an early enough stage[8].

Benefits of the new approach

Taking this approach should reduce the need for more specialist service provision through the life course of children and young people into adulthood, whilst equipping children and young people with the tools to develop resilience. This benefits children, young people and families.

Evidence suggests when an appropriate early intervention is put in place with children with clinically significant problems that outcomes are improved and there is economic benefit in the long term in relation to public funding**.**

Kirklees Health and Wellbeing Board have agreed early intervention and prevention as a priority, and the development of resilience for children and young people is a core principle of the Kirklees Health and Wellbeing Board Strategy.

We recognise that we are at the beginning of the journey in developing a clear offer of early intervention, promotion of resilience and universally improving emotional health and wellbeing. This is evidenced by the outcomes of our "Future in Mind" self-assessment, which has enabled us to identify the priority actions which form the basis of our commissioning priorities.

Prevention and Early intervention

One of our most pressing needs is taking forward our prevention and early intervention offer in relation to school based support and intervention. There are 107,402 children and young people in Kirklees most of who are in an educational setting. Therefore, ensuring a clear early intervention and prevention offer is available in all our educational settings will ensure almost universal access to this offer for our children and young people. Within the universal offer we do need to target certain areas and educational settings.

Our needs assessment highlights that North Kirklees has higher prevalence rates for most disorders, and also higher deprivation and health inequalities than South Kirklees. Conversely, we know from our most recent young people's school survey (undertaken 2014), that those young people from higher socio-economic areas consider themselves to be less resilient that those from lower socio-economic areas.

It is also highlighted from prevalence data that there is an inequality between boys and girls in Kirklees aged between 5-10 years, with boys having almost double the rate of mental health disorder than girls. We also know that there are inequalities in developing resilience between boys and girls and differing year groups that need to be addressed. In order to tackle these inequalities our early intervention offer to

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

schools we will take whole school approaches to tackling resilience, but also focus on the differing needs of age groups and sexes. We will also support schools in developing evidence based approaches using available intelligence locally and evidence of what works.

The identified needs from our schools survey, JSNA, equality impact assessment and important messages from schools, children and young people and families have all been paramount in framing our transformation offer.

The messages following consultation with local schools and children and young people, include:-

- The need to improve front line links between schools and our targeted and specialist CAMHS provision.
- The need to reduce access and waiting times to our CAMHS services as they are unacceptably long.
- There is shared support for the principle of moving away from a tiered approach to CAMHS provision. Schools, children and young people feel the tiers can often be a barrier to children getting the support they need, as eligibility criteria can mean referrals are rejected.

As an example of the consultation process with schools, one young person who has used services highlighted that when difficulties were experienced there were referrals made to serval different tiers of provision, none of which accepted this young person or met their needs. This kind of experience clearly emphasises that young people can fall through the gaps in tiers when in need of help and support.

The need for emotional health and wellbeing input into educational settings will also need to cover post 16 provision into our local colleges, and link with their existing provision to support learners across a range of settings.

School Link pilot-actions and learning

We need to improve pathways, communication and access in relation to specialist and targeted referrals into our CAMHS system, and the high number of inappropriate referrals to our CAMHS provision supports this. The piloting of the schools link approach has set out ways of addressing the identified issues from schools through the following actions:-

- Further develop expertise in schools relating to emotional health and wellbeing and creating nurturing environments. This will help children and young people to grow up to be confident, resilient and supported to fulfil their goals and ambitions.
- Strengthen the confidence and skills of school staff to intervene and support children and young people experiencing mental health problems.
- Pilot the named lead approach using qualitative and quantitative measures to evaluate learning from this approach.

- Implement and roll out a single CAMHS pathway across the pilot schools, supported by increased joint working and improving communication between schools and CAMHS providers. This should ensure children and young people have easy access to early support at the right time, in the right place, and only tell their story once.
- Ensure timely access to CAMHS provision is provided and waiting times reduced. This will be achieved by streamlining referral processes, reducing inappropriate referrals ensuring CAMHS services meet the needs of children and young people, regardless of tiers of need, by implementing a continuum of support that coordinates the work of mainstream schools, Pupil Referral Units (PRUs), special schools and services.
- Provide early intervention and prevention services to keep vulnerable children safe and in control of their lives, whilst supporting self-care principles.

Alongside the provision of training and support for school staff and supporting children to develop resilience we also need to ensure that parents have the right support. Ensuring parents have the right support and training is essential to helping them manage their children's emotional and health and wellbeing issues. We have piloted provision of mindfulness training previously with parents and this has been evaluated positively. We will embed this kind of support and training for parents throughout Kirklees, but will initially pilot this within the school link areas.

Universal prevention and young people's views

Another sizable challenge highlighted by the self-assessment is the need to have a clearer, comprehensive universal prevention service offer within schools. To develop this offer we will include aspects such as utilising the planned redesign of the healthy child programme 5-19 and drawing on the early help services on offer through our early intervention programme. When we have asked young people what kind of help they would like included. They said they want help when:

- Struggling at school - and transition and stress related to school.
- Parental relationships breakdown.
- Relationship with friends, parents or carers breakdown.
- They are bereaved.
- Their appearance or health status causes them emotional distress.
- They are bullied.
- They want to relax at times of stress and anxiety.

Resilience and PHSCE - young people's comments

Developing the resilience strategy with Public Health aims to promote and support resilience in children and young people and support self-care principles. The principle of developing resilience will form the basis of our universal prevention offer within schools, as will the above list of areas highlighted by young people. To

complement this, we will develop our integrated Personal, Social, Health, Citizenship and Economic education (PSHCE ed) programme to have a greater focus on developing resilience. We will also explore the development of peer education approaches within schools, developing self-care and the development of resilience. Young people also said that they would like more innovative approaches to help with their emotional health and wellbeing including art therapy, drama and other approaches which we will look to develop within educational settings.

Resource mapping with schools

It is evident that schools are addressing some emotional health and wellbeing issues by procuring their own provision. A summary of this provision and identified issues by schools is provided in Appendix 6. It is clear that there is significant spend on emotional health and wellbeing within our school system. It is essential that we work more closely with schools as commissioners to collaboratively commission future provision to build capacity, whilst also ensuring that the current provision is consistent and quality assured across Kirklees. We have begun this process by the piloting of school and community hubs drawing together whole community approaches, to address needs of children and families earlier and using our collective resources to improve outcomes. This will include using community capacity and community assets including the voluntary and community sector.

This is about enabling schools to become community leaders. In particular, supporting schools, parents, school governors and the community to shape and influence services and resources to meet identified local need and utilise assets. As outlined in the needs assessment section, young people with low resilience often have multiple vulnerabilities, including being bullied, substance misuse, alcohol use and risky sexual behaviour. Therefore the integration of services for risk behaviours around the needs of the child should be a strategic priority through our learning and community hubs work.

Nurturing parent programme

Development of this programme is also an important priority - taking it forward throughout Kirklees will support the strengthening of the attachment and bond between parent and child. As part of this work we will redesign the healthy child programme for 0–5's which will further enhance support to increase parental bonding.

Perinatal mental health

We recognise the need for further developing our perinatal mental health provision, and understand that further guidance and planning processes will be forthcoming from NHS England in relation to this specific priority. Therefore the scope of the current Transformation Plan and funding arrangement does not currently include perinatal mental health.

What will our transformed provision look like?

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.

The following objectives will address our gaps and areas for development outlined in this section. This will ensure we are compliant with the Future in Mind recommendations, and meet the local identified needs highlighted by our local data and consultation with young people and families.

The priority objectives in year one will be to:-

1.1 Redesign and implement a school nursing service that is more focused on emotional health and wellbeing and provides an early intervention function across all educational settings. (2.4)

1.2 Implement clear joint working arrangements and clear pathways between schools and emotional health and wellbeing provision. The provision will be based on presenting need and linked to the Social, Emotional and Mental Health Difficulties (SEMHD) Continuum work that is being developed. (8.1, 8.2)

1.3 We will have emotional health and wellbeing provision that is collaboratively commissioned with educational settings. (2)

1.4 We will collaboratively design with young people peer education programmes for children and young people that promote resilience, and assist with early identification of emotional health and wellbeing issues. (11.1)

The following objectives will be addressed in the following years through the annual refreshing our of Transformation Plan:-

1.5 We will integrate our currently commissioned services for "risky" behaviours through our learning and community hubs, to help deliver a common set of outcomes improving emotional health and wellbeing. (2)

1.6 The nurturing parent programme approach will be delivered throughout early help services, children's centres and voluntary sector provision, to improve the maternal bond. (4)

1.7 To redesign and implement the healthy child programme 0-5, with increased focus on supporting the development of improved perinatal mental health provision and improving attachment. (1.4, 1.1)

1.8 We will Implement a comprehensive training programme to develop children and young people's resilience and raise their awareness of emotional health and wellbeing issues. We will embed this within the Personal, Social, Health, Citizenship and Economic education (PSHCE ed) curriculum. (2)

1.9 There will be a range of social media based interventions to provide support to children and young people and help build resilience. (11.1)

1.10 We will increase the range of innovative interventions available to children and young people to improve health and wellbeing.

1.11 Develop a training and support component regarding Emotional Health and Wellbeing for School Governors to be part of their ongoing training.

The above objectives will achieve the following outcomes in Kirklees:-

- **Improve 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.**
- **Children and young people having timely access to clinically effective mental health support when they need it.**
- **Improved 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.**
- **Mental health support will be more visible and easily accessible for children and young people.**
- **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.**

Theme 2. Improving access to effective support – a system without tiers.
Chapter 5 - Future in Mind

Ambition

We know that what counts has to be that children and young people can access the right support, at the right time and in the right place. We know that early intervention and access to the right service in a timely manner can make a real difference to improving mental health and wellbeing outcomes[9]; but also essential is managing crisis situations arising from mental health problems and reducing the impact of these crises.

Current service provision - strategic messages

Our self-assessment findings and current Tier 3 and Tier 2 data leave no doubt that we need to significantly transform our provision to improve access to effective support, timely support. Both our Tier 2 and Tier 3 providers are fully committed to working will us to address these issues, and have already made some progress in addressing areas for development. The number of commissioning intentions captured within this theme reflects the scale of this challenge.

Waiting Times

The current Tier 2 provision has an average waiting time of 12 weeks[10]. The Tier 3 provision offers a choice appointment within 5 weeks, but the average wait for the partnership appointment is an average of 4–6 months[11]. We acknowledge that some young people are seen much more quickly than this, based on presenting need, but the average wait is too long for children and young people to receive the help required.

Our Tier 3 provision received 1,657 referrals in 2014/15 and with 498 receiving treatment in that period. Our Tier 2 provision in the same period received 1,406 referrals, and the number of children and young people who received an intervention was 1,373; of whom 595 received direct support or therapy, and 778 receiving a group work intervention. The demand for both Tier 2 and Tier 3 provision locally is high, and both providers are working to manage demand, streamline processes and systems, and are committed to meeting the needs of children and young people locally. The historic under investment in service has also impacted on the waiting times in our local provision; we have begun the process of investment and are starting to see some improvement in waiting times.

[9] 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

[10] Chews monitoring data 2014/15

[11] SWYPFT quarterly dataset

The implementation of the anticipated waiting times standards is much welcomed and reducing the average waiting times and increasing capacity across the system are both seen as a significant priority to meet the standards.

Eating disorders

The current eating disorder service that is based within our Tier 3 provision in Kirklees has a caseload of 29 children and young people, and although is partially compliant with the Children and Young People Eating Disorder Service (CYPEDS) guidance, it requires further development and investment to meet the guidance.

In Kirklees, based on 2009 prevalence data, we would expect that around 51 young people would be receiving services for eating disorders.

Our Tier 2 provision has 64 young people currently in service for “eating difficulties”. This is usually linked to anxiety and low mood, and as a result there is either an increase or decrease in appetite. The majority of children and young people in service for “eating difficulties” (78%), received an intervention of counselling, group work or direct support and 3% of cases were directly referred into our Tier 3 eating disorder provision.[12]

The current average waiting time for Tier 3 eating disorder choice appointment provision is 4 weeks, but then 90 days for treatment to start, and our Tier 2 provision for “eating difficulties” is 12 weeks. Therefore, further investment is required to meet with CYPEDS waiting times and access standards.

The demographics of children and young people in our Tier 3 service show that the majority of those in current service are young women aged between 12 and 18 years old, with 22 resident in South Kirklees and 6 from North Kirklees. There are also currently 2 males receiving an eating disorder service across Kirklees[13].

The current staffing for our Tier 3 CYPED provision is attached as part of the workforce data in Appendix 7, which shows our current investment. The four CCGs will work collaboratively with the provider to explore the current provision stated. It is anticipated that the figures stated may not be an accurate reflection, due to provision being tied up in existing core CAMHS provision.

Kirklees, Calderdale, Wakefield and Barnsley have agreed to redesign service provision and we are working jointly to commission a CYPEDS compliant service using the Future in Mind eating disorder allocated funding. This allows our service to cover a population of 1,186,800 and deal with a minimum of 110 referrals per year.

The redesign of our provision will allow us to be compliant with the waiting time standards set out in the guidance. Working across Kirklees, Calderdale, Wakefield and Barnsley initially with the same mental health provider, will ensure that we mirror

[12] CHEWS data

[13] SWYPFT ED demographics

our acute footprint by working closely with Calderdale and Huddersfield Foundation Trust and Mid-Yorkshire Hospital Trust. This will assist in ensuring our model can easily link with paediatric and acute support pathways. We will develop an outcome based specification for the redesigned service, based on the guidance issued and support the principles of early intervention, care closer to home and choice. The allocated funding will give an overall budget of £646,379 for the new eating disorder provision. The proposed staffing and skill mix of the provision is attached as Appendix 8.

Crisis services

The arrangements for our current "crisis" services are currently being reviewed and re-specified in line with locally agreed investment. The parity of esteem funding has been prioritised locally to address our historic under-investment in CAMHS Tier 3 provision.

The crisis provision, on the whole, is delivered by close partnership working with our local Accident and Emergency departments and this is in line with the Crisis Care Concordat.

Alongside investing in our Tier 3 crisis function, we have recently re-designed our adult psychiatric liaison service to enable the lower age of eligibility range to be reduced to 16 years old, so that more young people can receive a crisis intervention when required. Our Tier 3 provision is receiving an average of 20 emergency referrals per month. Currently only 72% of emergency referrals are seen within 24 hours.

The reason for the young person not being seen within 24 hours may well be valid at times, for example if they are not well enough to be assessed - but we clearly need improvement in this area. Our investment within crisis provision will ensure we can implement a new target that children and young people are seen within 4 hours in a crisis, and will increase the percentage of those seen within this timeframe.

We will also develop, in line with recent NHS England funding, all age psychiatric liaison service provision, utilising the pump prime funding announced on 9/10/15. The detail of our plans will be developed in line with the "Core 24" specification for a 24 hours psychiatric liaison service to Accident and Emergency Departments, working closely with our local Systems Reliance Group from both CCGs and consideration will be given to the relevant footprint we will develop the model on.

The investment in our crisis provision and the new investment within the eating disorder provision will reduce pressure of the generic CAMHS Tier 3 service. This will enable some existing resources to be re-directed to reduce waiting times and support further prioritisation of crisis and self-harm provision. The resource that will be released will be equivalent to two whole time equivalent posts.

Learning disability, SEND and EHC

According to the January 2015 school census, there were 3,352 children with a primary or secondary Special Educational Need (SEN) of a learning difficulty, and 426 children with an Education Health and Care Plan (EHCP) or statement who had a primary or secondary need of "social, emotional and mental health"; this excludes those with a diagnosis of Autism Spectrum Disorder. Our Tier 3 provision has a caseload of 40 children and young people with a learning disability.

Due to the nature of our existing Tier 2 provision being time limited, and having lower threshold criteria, there is not a specific service offer for children and young people with a learning disability who also have mental health needs.

The data suggests that there seems to be an under representation of children and young people with a learning disability in our current provision. It appears there is a high level of need within of SEN provision for children with learning disabilities, and a high number of those children with an EHC plan have emotional and mental health needs.

Therefore, the need to augment our current joint arrangements in relation to Special Educational Needs and Disability (SEND) and Education Health and Social Care Plan (EHC) planning with CAMHS support, advice and consultation is a priority.

We also recognise that not all children with a disability will have an EHC plan; therefore the provision will also link in closely with wider provision for children with additional needs. The current specialist CAMHS learning disability provision for children and young people is disjointed in its design.

There is a lead role for learning disability that sits within the CAMHS provision whilst the specialist nursing support sits within the adult mental health provision. Neither of the specialist learning disability provisions is integrated within the council's children with a disability team which further compounds the lack of a cohesive offer for children and young people and their families.

Therefore one objective will be to re-design and re-specify the current learning disability provision to be an integrated, co-located offer, between the CAMHS provisions and Kirklees Council Children with a Disability Team. The offer will focus on a provision that incorporates diagnosis, behavioural support, nursing and family support.

Transition

Locally we know there are highlighted issues in relation to transitions for children and young people; this isn't confined solely to CAMHS provision but is an issue across wider provision. It is also worth noting that traditional views of transition relate to young people moving into adulthood. We recognise there are major transition points throughout young people's life's, including various school transition ages. Therefore, to address all stages we must include services that span a child's life course.

We have some good examples locally of services that have age ranges that are wider than the traditional young person/adult transition ages. For example, our early intervention in psychosis provision is for children and young people aged between 13 and 30, and our substance misuse provision for children and young people has an upper age limit of 25.

The Children and Families Act also requires that where there is an education component of an EHC plan that the processes and co-ordination of support can continue to age 25.

We will address transition points in our local CAMHS system in a number of ways including:-

- Linking CAMHS transitions into our all age disability strategy.
- Using our EHC transition planning sub-group to develop transition planning strategies that can be applied across the board.
- Continuing to explore the age boundaries between our CAMHS provision and Adult mental health provision in relation to crisis provision, IAPT provision and psychiatric liaison provision.
- To target key school transition age groups as part of our school link project to ensure smooth transitions are provided.

Tier 4 provision

There are no existing Tier 4 providers in Kirklees for children and young people's in-patient mental health. Therefore, any children and young people requiring inpatient care have to travel out of area, as do their carers and families. This can be distressing for those involved, we are working closely with our local mental health providers and specialised commissioning in NHS England to reduce the impact.

The co-ordination of children and young people's inpatient care have been highlighted locally as a gap, including lack of adequate Care Programme Approach (CPA) planning, local step down arrangements, care management functions and the provision of intensive home treatment approaches.

In Kirklees in 2014/15 we have had 13 children and young people admitted to Tier 4 provision, with a total number of bed days of 1,050 at a cost of £439,094[14]. There are also identified gaps in relation to the provision of Tier 4 placements for children and young people with a dual diagnosis of learning disabilities and mental health problems. Locally, there have been 3 cases that have required extensive work to ensure that Tier 4 settings were found to meet the needs of the children and young people involved. Two of the three cases resulted in serious incidents due to levels of concern and inappropriate places of safety found for the young people involved.

[14] Tier 4 data NHS England

In Kirklees there is no 136 suite as part of Mental Health legislation. (*This allows the police to move an individual who appears to be mentally unwell from a public place to a place of safety for up to 72 hours. The place of safety could be a police station or hospital and can be in a special section 136 setting*). We do have provision in Calderdale Royal Hospital for a place of safety in the Dales ward. This is primarily adult provision, but can be adapted to be appropriate for young people. We recognise the need to develop clearer pathways and protocols with West Yorkshire Police in relation to police cells not being used as a place of safety and to explore appropriate places of safety in Kirklees.

Collaborative Working with NHS England

The Yorkshire and Humber (Y&H) Mental Health Specialised Commissioning Team works closely with identified lead commissioners in each of the 23 CCG areas across the region to ensure that specialised services feature in their local planning. This work is done collaboratively through the Children and Maternity Strategic Clinical Network which includes all relevant stakeholders. There are a number of forums across the region where collaboration takes place; these include for example, the Y&H CAMHS Steering Group, Specialist Mental Health Interface Group and individual meetings between NHS England and local commissioners. This way of working ensures that the whole pathway is considered when developing services for children and young people.

Specialist Services

The National CAMHS Tier 4 Review identified Yorkshire and Humber as one of two areas nationally that are experiencing the most significant capacity issues. These issues are regularly discussed and reviewed locally and regionally. The national pre-procurement project reported in July 2015, recommendations in relation to procurement of Tier 4 services are due to be announced imminently.

Summary of current provision

In April 2015 the total number of available beds in Yorkshire and Humber was 90 (53 general adolescent and 37 other) – some of this capacity also provides for the population of East Midlands.

Services in Yorkshire and Humber currently includes:

- Leeds and York NHS Partnership Foundation Trust (York) - 16 general adolescent beds and deaf outpatient services.
- Leeds Community NHS Healthcare Trust (Leeds) - 8 general adolescent beds
- Riverdale Grange (Sheffield) - 9 CAMHS eating disorder beds.
- Alpha Hospitals (now part of Cygnet Hospitals) (Sheffield) - 15 general adolescent beds, 12 Psychiatric Intensive Care Units (PICU) beds.

- Sheffield Children's Hospital NHS Foundation Trust (Sheffield) – 14 beds for 14 to 18yrs, 9 beds for 10 to 14yrs, 7 beds for Learning Disabilities non-secure 8 to 18yrs and day-care 5 to 10yrs.

Provision required

Across the region we have considered in detail what provision is required. The following is a summary position; modelling work regarding bed numbers is ongoing and includes consideration of the natural patient pathways for young people from the East Midlands.

- Adequate capacity regarding general adolescent beds in appropriate geographical locations – there is a current lack of provision in West, North and East of Yorkshire and over provision in the South.
- Access assessment arrangements that reflect location of general adolescent services.
- Eating Disorders – North and South of the hub area.
- PICU – North and South of the hub area, co-located with general adolescent service.
- Children – regional central geographical location.
- Low secure - mixed gender – regional central geographical location.
- Low Secure and none secure learning disability and or ASD – regional central geographical location.
- Other services will continue to be provided on a regional basis, e.g. Medium secure or national basis, for example, in patient deaf services.

Other Issues Relating to In Patient Services

Since November 2014 access assessments arrangements have been formalised across the region to enable equity of access for all geographical areas and specialist provision required, ensuring that all access assessments are undertaken by Tier 4 clinicians.

These arrangements are underpinned by the National Referral and Access Assessment Process for Children and Young People into Inpatient Services (Specialised Mental Health Services Operating Handbook Protocol).

In addition Care and Treatment Reviews were developed as part of NHS England's commitment to improving the care of people with Learning Disabilities and/or Autism.

The aim is to reduce unnecessary admissions and lengthy stays in hospitals. Children and young people with a diagnosis of Learning Disabilities and/or Autism from the region had access to Care and Treatment Reviews whilst in hospital and often prior to referral to in-patient services.

In Summary

NHS England and local commissioners work collaboratively across the region to

ensure work is consistently undertaken with local commissioners to understand and address local issues that influence admissions to and length of stay within CAMHS inpatient services.

The variation of CAMHS provision across the region is monitored through local and hub wide data to help identify trends/themes. The Regional Mental Health Specialised Commissioning Team have positive relationships with local commissioners across the region, this is a significant determinant ensuring local pathways work effectively to provide a whole system approach. The work undertaken with local commissioners as part of their Transformation Plan development looks to ensure that the right services are in the right place, accessed at the right time and based on local population need.

Through the Transformation Plan all opportunities for collaborative commissioning have been explored. Good examples of these opportunities are in CAMHS Eating Disorder and Intensive Community Provision.

Tiered services-changes needed and whole service redesign

Through consultation with children, young people and their families, we know that the current tiered system of provision provides barriers to timely effective intervention, and feels like a complex system that is difficult for patients and referrers to be able to understand or access. It is clear from our baseline data that on average children and young people wait too long for an intervention and to receive help.

The lack of an integrated comprehensive system of CAMHS support across the current tiers impacts on our children and young people's emotional health and wellbeing, and also their families and carers. Parents are very clear that trying to navigate a complex system, when trying to obtain help for their child, increases the distress and impact of their child's illness. Parents also tell us that this distress impacts on their own health, other siblings in the family and their employment arrangements and finances.

Therefore providing a more comprehensive, easy to access and user friendly model for our whole CAMHS system is essential. We will develop our whole system model of intervention to adopt a tierless approach, which is accessible and integrated, in which children and families only have to tell their story once. Our provision will be enabling and collaborative to help improve children's emotional health and wellbeing.

Thrive model

The model that we will develop will be based and integrated into our local continuum of support offer developed by the Learning Service in collaboration with schools. We will also draw upon the new "Thrive" model developed by the Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust. This would cluster the support young people require into four groupings:-

- Signposting, self-management and one off intervention.
- Goal focused, evidence informed and outcome focused intervention.
- Extensive treatment.
- Risk management and crisis response.

In effect these four “functions” will form the basis for an outcome based redesign of the whole CAMHS system. The other principles that will underpin this model are having a holistic provision that accommodates a whole family support model.

The redesign of the whole CAMHS system is going to be a long term aim of our Transformation Plan, and we will pilot the models and approach though our school link pilot.

Single Point of Access

In the interim, we must formalise a Single Point of Access (SPA) arrangement to reduce the complexity of referrals and navigation of the system for children young people and families. We know at times children; families and professionals feel overwhelmed by the current system.

We will aim to provide a seamless, one stop shop offer of care to children, young people and professionals, co-ordinating information and provision across the system. This will mean parents, school, primary care and all refers can easily access advice and support from a single place in relation issues young people are experiencing. The single point of access will provide co-ordination of appropriate interventions and service for young people and families regardless of levels of need. The provision of care co-ordination and communication with referrers and parents will also be managed through the Single Point of Access. We will build on existing good practice systems between our Tier 2 and Tier 3 providers, where weekly meetings escalate and de-escalate cases.

In the interim, this should reduce the high level of inappropriate referrals, offer a central point for advice and consultation, and ensure children and young people’s needs do not fall between the tiers of provision. It will also allow children and young people to tell their story once, instead of multiple assessments by multiple professionals.

Through consultation with referrers including, schools, primary care and parents, it is clear that locally there is a gap in understanding what each current tier of provision provides, and the differences between universal provision, targeted provision and specialist provision. Through consultation with primary care and schools we also know that the lack of a Single Point of Access and advice and support means they are often seeing referrals made being passed between tiers of provision, and those involved are experiencing lack of communication. This is particularly concerning as schools and GP referrals are the top two referrers to both Tier 2 and Tier 3 provision. Primary Care is often the first point of contact for parents, and where parents return

to whilst waiting for a lengthy period, after the referral has been made and are waiting for interventions to start. There needs to be more education, support, information re-services and clearer pathways, not just around referral into specialist services, but also around Tier 1 Universal Services.

A joint pathway between Tier 2 and Tier 3 has been developed to assist in this clarification of function. In be able to implement this pathway successfully, there is a need to implement training across Kirklees to improve knowledge and skills in relation to children and young people's mental health and the services that can address needs.

The priority objectives outlined below reflect our local needs as described above, whilst also reflecting the Future in Mind recommendations highlighted as priorities in our self-assessment document. Appendix 4.

What will our transformed provision look like?

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.

The following priority objectives will address our gaps and areas for development outlined in this section. This will ensure we are compliant with the Future in Mind recommendations, and meet locally identified needs highlighted by local data and consultation with young people, families and professionals.

The priority objectives in year one will be to**:**

2.1 To re-design the specifications for Tier 2 and Tier 3 CAMHS provisions, transforming services to provide a "tier free" new service model that is based on the "Thrive" approach. (6)

2.2 Increase front line capacity within Tier 2 and Tier 3 provisions to reduce waiting times and improve access for children and young people. (17)

2.3 Provide a comprehensive eating disorder service across Kirklees, Calderdale, Wakefield and Barnsley in line with best practice and guidance issued. (13)

2.4 Implement Tier 2 and Tier 3 CAMHS Link Workers to directly liaise with and support schools, primary care and other universal provisions. (8.1, 8.2)

2.5 Implement a joint training programme to support the link roles within primary care, schools, Tier 2 and Tier 3 CAMHS provisions and to support joined up working across services. (9)

2.6 Have in place a Single Point of Access model for advice, consultation and assessment and co-ordination of provision. (7.1)

2.7 Provide a one stop shop approach providing advice and support, that has been collaboratively commissioned with the voluntary and community sector. (7.1)

2.8 Provide a local crisis model that ensures assessment within 4 hours and is in line with the Crisis Care Concordat and utilises our re-designed psychiatric liaison service. (12.5, 12.3)

2.9 To work with our local Systems Resilience Group to Design and implement all age psychiatric liaison provision in line with the "Core 24" service specification. Where appropriate we will work on a regional basis across acute footprints to develop collaborative approaches.

The following priority objectives will be addressed in the coming years through the annual refreshing our of Transformation Plan. We will:-

2.10 Implement an Intensive Home Treatment model, preventing admission to Tier 4, assisting with transition back to community setting and with clear comprehensive pathways. (12.4)

2.11 Develop our local Tier 4 markets collaboratively with NHS England supporting the development of LD/ CAMHS inpatient provision. (13.2)

2.12 Provide a case management function that coordinates care and discharge for those young people in Tier 4 settings and those requiring a "step down" placement. (13.1)

2.13 Establish a CAM HS link role to support Learning Disability, SEND and assessment for the EHC planning process. (10)

2.14 Establish an integrated team for children with learning disabilities between specialist CAMHS and Kirklees Council Children with a Disability Team.

The above objectives will achieve the following outcomes in Kirklees:-

- **Care is built around the needs of children, young people and their families.**
- **Children and young people will have timely access to clinically effective mental health support when they need it.**
- **Increased use of evidence-based treatments with services rigorously focused on outcomes.**
- **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.**
- **Mental health support is more visible and easily accessible for children and young people.**

Theme 3 - Caring for the most vulnerable.
Chapter 6 - Future in Mind

Vulnerable children and young people

The need to provide both targeted and specialist mental health interventions to children most at risk of developing poor mental health is an essential aspect of any CAMHS system. The need to provide a flexible approach to this provision which engages the most vulnerable is vital to ensure engagement and retention of children and young people in CAMHS provision. These children often experience multiple vulnerabilities and can lead chaotic lifestyles, living in families where there are also multiple parental vulnerabilities.

The main vulnerable groups we have agreed to focus on in Kirklees are Looked After Children (LAC), children subject to a child protection plan, young people involved in the youth justice system and those at risk of or experiencing child sexual exploitation. We know particularly for these groups of children having a lead professional approach, where communication and engagement are paramount will help improve treatment outcomes.

We also know that take whole life course approaches and providing support to children and families at the earliest possible opportunity will help to tackle the development of factors that are precursors for children and young people becoming part of the vulnerable groups outlined below. Therefore the success of this section of the plan is co-dependent on theme one priorities including, the implementation of the nurturing parent programme to improve maternal bonds and perinatal mental health, and developing a cohesive healthy child programme offer from 0-19 years old to intervene early and improve outcomes across a range of indicators.

We are also working closely with members of Kirklees Safeguarding Children Board in relation to our local CAMHS provision. In order to improve and transform our provision for vulnerable children and young people the Safeguarding Board have agreed to fund a piece of research. It has been agreed that we will commission a "deep dive" into children and young people's experience of the CAMHS system and safeguarding, to ensure we have the child's voice at the heart of any new re-designed provision.

Looked After Children (LAC)

Young people coming into the local authority care system will already have had trauma and difficulties over and above those experienced by most of their peers.

Most will have suffered abuse or neglect, or experienced bereavement, disability or serious illness in one or both parents. Many are from disadvantaged backgrounds. Being looked after can involve major and sometimes traumatic upheaval. Some young people, especially if they have been moved from their own home, may find it hard to settle and may feel torn or even guilty at being removed from their family,

however abusive or neglectful (although some may feel a sense of relief because of their changed circumstances).

Changes and a lack of permanence in the arrangements for many looked-after children are unsettling and can hamper effective work by professionals. The stigma of being looked after and the unhappiness that young people may feel – for example, because they have had to leave their family home – may inhibit their asking for help or wanting to use any facilities or services on offer. Social care staff often have difficulty in finding appropriate placements that meet basic emotional, physical and cultural needs of looked-after young people. Research shows that more looked-after children have more mental health problems than other young people, including severe and enduring mental illness. But their mental health needs are frequently unnoticed and unmet.

As part of the ongoing assessment of LAC needs, the Strengths and Difficulties assessment is undertaken and staff respond to scores which indicate concerns.

When completing the self-assessment in relation to the Future in Mind recommendations, it is evident that our local system for caring for the most vulnerable needs significant redesign. In Kirklees we had 612 LAC as of August 2015 with children placed both within Kirklees and with other local authority areas. We know from national research that 60% of LAC and 72% of those in residential care have some level of emotional health and wellbeing problem[15].

This means that there are significant numbers of looked after children who could potentially need a CAMHS intervention. In accordance with responsible commissioner guidance where a child placed out of area requires CAMHS interventions; both Greater Huddersfield and North Kirklees CCG's procure this provision from a local provider. Currently this spend locally is relatively low, but could rise to £240,000 due to payment protocols being development regionally. Ensuring good quality and comprehensive CAMHS provision is available for out of area LAC is a strategic priority and will be addressed by exploring regional approaches to the procurement of regional out of area provision. We also recognise that we need to better improve the identification of LAC placed in Kirklees by other authorities and their CAMHS needs.

In 2014/15 we witnessed 24 LAC presenting at out crisis provision from other local authority areas, and we need to ensure that under the responsible commissioner guidance that provision has been organised by the placing authorities.

Historically in Kirklees the Tier 2 and Tier 3 provision for LAC has not offered a discrete provision and has been provided at a low level through mainstream contracts. The lack of comprehensive provision for LAC in Kirklees can also be argued to have caused the need for more therapeutic placements being made out of

[15] REPORT OF THE CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM – MENTAL HEALTH SUB-GROUP

area. The lack of a local comprehensive CAMHS offer to LAC, residential staff and foster carers has often been cited as the cause of placement breakdowns, as appropriate interventions and support has not been available in a timely manner.

Local data tells us that we currently have 5 LAC in Tier 2 provision[16], although there is a focused pilot to increase access for LAC using pupil premium funding. There are currently 8 LAC in service within our Tier 3 provision[17].

We recognise that the data only reflects direct interventions and not consultation, advice and support with fosters carers, residential staff and others. It is clear there is a significant under representation of our LAC in our CAMHS provision.

Therefore, an important priority is to increase the number of LAC receiving interventions through our CAMHS provision. We are currently piloting a Team Around the Child approach for LAC which involves educational psychology, the social care placement team, our Tier 2 and Tier 3 providers, the lead LAC Nurse and our Virtual Head for LAC. The learning from this pilot will inform the re-design of a flexible multi-disciplinary approach meeting the needs of vulnerable groups including LAC. This will ensure they will have access to evidence based interventions including:

- Play therapy
- Psychotherapy
- Multisystemic Therapy (MST)
- Dialectical Behaviour therapy
- Cognitive Behavioural Therapy (CBT)
- Work to address attachment disorders and early childhood trauma.

We have been developing the pillars of parenting programme throughout local residential care to support residential staff to meet the emotional and behavioural needs of the children placed with them. To complement access to the above individual interventions we will roll out the approach to foster carers and other relevant professionals working with LAC, in the first instance taking a consultation and support approach. We will develop and implement the specialist link model throughout our vulnerable children's provision where professionals already engage with children such as Youth Offending Team staff, social workers and others, to develop a level of expertise in relation to delivering CAMHS interventions with vulnerable groups.

We are also working closely with Council Children's Social Care to support the use of the adoption support fund for adopted children and their parents to access a range of discrete provision in relation to their emotional health and wellbeing needs. The development of local family drug and alcohol courts is a recent development in Kirklees and the model of national good practice requires that an adult and children's

[16] CHEWS LAC report

[17] SWYPFT LAC report

mental health input into the weekly review meetings involved in the process.

We have recently established our local Multi Agency Safeguarding Hub (MASH) arrangements in Kirklees which involve children's social care, police, health visitors, school nurses, attendance and pupil support officer and adult mental health provision. We plan to include CAMHS provision within the current arrangements to meet the support needs of children and young people and their families who are receiving support and co-ordination from the MASH arrangements.

Working with Stronger Families

The expanded criteria for our Stronger Families Programme now include children affected by poor mental health along with other wider measures. The extended Stronger Families Programme has identified 619 families in 9 months to the end of September 2015. 195 (31%) of these families have at least one person with a known mental health problem including 76 (12%) of these were young people. We would expect to work with over 460 families who had at least one child experiencing poor mental health between now and 2020. The multiple vulnerabilities experienced by some parents as part of the Stronger Families Programme can also affect the emotional health and wellbeing of children in the family. For example we know that poor outcomes for children who have a parent in prison include the development of mental health issues in later life; boys are particularly[18] at risk of this. We also know that one third to two thirds of children whose parents have mental health problems will experience problems themselves[19].

The expanded criterion gives us an opportunity to develop closer links and joint working between our local CAMHS provision and the Stronger Families Programme. We aim to increase the speed of access to CAMHS provision for those children involved in the Stronger Families Programme, whilst offering advice, support and consultation to the wider group of practitioner's professionals working with the family. The workforce also require training to be able to deliver low level interventions such as basic counselling techniques training and use of Strengths and Difficulties Questionnaire (SDQ) scales and other diagnostic tools.

We will work closely with the extended Stronger Families Programme to incorporate learning from the approach incorporated into our assertive outreach provision.

Youth Offending

When considering other vulnerable groups in Kirklees, there were 69 young people aged 10-14 who entered the criminal justice system in 2013/14. This rose to 87 in the 15 year old age group, 83 in the 16 year old age group and 132 in the 17 year

[18] Barnardo's 2009

[19] ODMP 2004

old age group. There were around 400 orders in 2013/14 imposed on young people under 18 supervised by the Kirklees Youth Offending Team[20]. It is important to note that a third of children in contact with the youth justice system, are also Looked after Children.

At least 43% of children and young people on community orders have emotional health and wellbeing problems and the rate increases when children are in custody[21]. Therefore, there is a minimum of 185 children within the youth justice system who require a level of CAMHS intervention. Additionally, around 25% of those in the youth justice system have an IQ below 70, so have additional needs[22].

Our current provision within Kirklees Youth Offending Team includes a nurse who is a Multisystemic Therapy trained practitioner and a specialist Learning Disability nurse. Whilst this provision goes some way towards meeting the emotional health and wellbeing needs of those in the youth offending system, there needs to be further work to develop a clear multi-agency CAMHS offer for those within that system. Local data suggests that there are very few if any referrals from the Youth Offending Team to CAMHS Tier 2 or Tier 3.

Forensic CAMHS (F CAMHS)

Children referred to FCAMHS may be involved with the youth justice system or be at high risk of being so in the future. They are likely to present with behavioural problems like violence and aggression towards others, harming themselves, fire setting or engaging in sexually inappropriate behaviour. Forensic CAMHS work collaboratively with other agencies in the youth justice system; there should be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring protection of the public.

Challenges in service delivery include;

- The time of highest risk for children is during transition between different elements of the pathway – it is essential this transition is managed safely and effectively. This is particularly the case for the transition from secure accommodation to increased independence and responsibility in the community. There is a need for children on release from the secure estate to be referred to a community forensic CAMHS if they have been assessed within the estate as needing a service, but the sentence has been too short to start or complete an intervention.

[20] ChiMAT Data 2015

[21] Turning young lives around: How health and justice services can respond to children with mental health problems and learning disabilities who offend. A briefing paper by Robert Newman with Jenny Talbot, Roger Catchpole and Lucie Russell

[22] Turning young lives around: How health and justice services can respond to children with mental health problems and learning disabilities who offend A briefing paper by Robert Newman with Jenny Talbot, Roger Catchpole and Lucie Russell

- The principle of 'equivalence of care' established that people (including children) in prison should have the same standard of care that is available to the wider (non-imprisoned) population. The three secure establishments for children in Yorkshire and the Humber are; HMYOI Wetherby, Aldine House and Adel Beck. Secure Children's Homes all have access to FCAMHS, but there is often no community service providing treatment or follow up support.

Currently we procure forensic assessments and interventions as and when they are requested though children's service provision. These requests presently come mainly from our Looked after Children and Youth Offending teams. We need to explore the development of forensic provision within our local CAMHS service, to have a sustainable provision for those requiring a service, and provide a wraparound provision for those children released from the secure estate or secure accommodation.

Child Sexual Exploitation (CSE)

Addressing the core emotional needs of the victim and those around them is critical in order to increase protective factors and reduce risk of further CSE.

The cause and effect relationship in terms of CSE is also very important. Building a professional relationship with someone to understand the root causes of behaviours or feeling is much harder, but a very important role.

Scope of therapeutic interventions for CSE victims

As discussed there are a number of issues with current therapeutic support arrangements. Issues around accessibility, appropriateness and eligibility generate their own barriers for victims or those at risk of CSE. Making sure the right sort of support is available in the right place and delivered by the right professional are at the centre of the Child and Adolescent Mental Health Transformation Plan.

A gap in the current offer is around victim recognition support. The vast majority of cases reviewed featured a victim who was seen as such by everyone but themselves. A therapeutic process that enables this realisation and disclosure would be a major step in the recovery and reconciliation process. There are a myriad of processes ready to start once disclosure is made, but there is little to help the individual to reach that point themselves.

The act of disclosure is the start of a therapeutic journey. In terms of treatment, the literature regarding the therapeutic process after disclosure is limited and no specific treatment model is suggested. The NICE guidance offering any advice for on treatment is around the management of post-traumatic stress disorder (PTSD) in adults and which was issued in 2005.

NICE – PTSD Children and young people - children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development.

Cognitive behavioural therapy (CBT) is a form of psychotherapy that teaches skills that retrain behaviour and style of thinking to help victims deal with stressful situations. Psychodynamic (psychoanalytic) psychotherapy helps victims become aware of meanings or patterns in behaviour that are linked to the sexual exploitation.

There are other frequently used approaches to trauma are EMDR (Eye Movement Desensitisation and Reprocessing) and TIR (Traumatic Incident Reduction). When abuse occurs the trauma affects how the brain store memories of the abuse. Both EMDR and TIR work by freeing up and releasing traumatic memories so that victims can gain a clearer picture and understanding of what actually happened and what impact it has had on them as CSE victims.

There will be occasions where more complex mental health support will be required by victims. The same victim recognition and understanding of root causes need to feature in these interventions. Therapeutic professionals must work with the relationship role above to understand case complexity, offering advice and guidance to others in the CSE support system on lower level and preventative interventions. They must also understand the reasons behind victim's propensity to disengage because of the damage caused by CSE and its related risks factors.

Scope of relationship rebuilding support

A relationship rebuilding offer across age and case complexity will reconnect the victim or at risk individual to family, carers and friends who have been pushed away. This is a two sided process, each party needs insight into the motivations and decisions of the other.

This offer - being either an early intervention or part of the recovery process - will support a range of case complexity. Some will need short term advice and coping strategies. Other cases will need counselling and longer term support.

A crucial part of early intervention is around how parents or carer can support the at risk individual into making positive choices. This will help carers develop supportive and authoritative parent techniques. There also needs to be support for carers about how to have a conversation constructively so that it does not end in chaos or a child going missing or absent.

Scope of prevention and diversionary interventions

Developing or modifying the range of interventions to increase engagement with those at risk of CSE is important. The target audience for this sort of intervention will be at the lower end of the risk spectrum or displaying risks such as absenteeism and poor emotional wellbeing. The sorts of activities need to stimulate the same feelings of independence, maturity and risk that the grooming process creates.

Did Not Attend (DNA)

Our local did not attend rates for Kirklees are 43% for Tier 3 and for Tier 2 provision is 16%. We know particularly through consultation that our most vulnerable groups and families in Kirklees are more likely to have high DNA rates for a variety of reasons. Follow up and support to these families is extremely important and as such the need to develop assertive outreach approaches is also a vital priority.

What will our transformed provision look like?

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.

The following priority objectives will address our gaps and areas for development outlined in this section. This will ensure we are compliant with the Future in Mind recommendations, and meet the local identified needs highlighted by our local data and consultation with young people and families.

The priority objectives in year one will be to:

3.1 To invest in and implement a flexible multiagency team to address the emotional health and wellbeing needs of looked after children, children in the youth offending team, children experiencing CSE and children on child protection plans. (28, 26, 24)

3.2 To provide the CAMHS link and consultation model within the range of provision across Kirklees for the most vulnerable children. (28.1, 28.3)

3.3 Ensure rapid access to CAMHS interventions for those children who are part of the Stronger Families programme. (22)

3.4 To provide cohesive CAMHS provision on a regional basis for LAC who are placed within the 10 CC (West Yorkshire Clinical Commissioning Groups, Commissioning Collaborative) footprint. (28)

3.5 To work with Kirklees Safeguarding Child Board to undertake a "deep dive" into the way in which vulnerable children and young people experience the CAMHS system and use the learning to inform the development of our

discrete provision for vulnerable children.

The following priority objectives will be addressed in the following years through the annual refreshing of our of Transformation Plan. We will:

3.6 Include Specialist CAMHS provision in local MASH (Multi-Agency Safeguarding Hubs) arrangement, alongside adult mental health service provision. (25)

3.7 To provide an assertive community outreach model through our CAMHS provision that actively engages children, young people and families. (20)

3.8 Provide CAMHS support to the new Drug and Family Court model in Kirklees. (25)

3.9 To ensure that local provision is available for those children and young people requiring forensic CAMHS provision. (26)

The above objectives will achieve the following outcomes in Kirklees:

- **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.**
- **Increased use of evidence-based treatments with services rigorously focused on outcomes.**
- **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.**

Theme 4. To be accountable and transparent.
Chapter 7 - Future in Mind

Clarity of provision and progress

In order to transform our local service provision, deliver better quality care, improve standards and achieve the best outcomes for children and young people, accountability and transparency is vital.

Commissioning responsibility, budgets, performance activity and monitoring often sit with different organisations within the commissioning system. This can cause confusion in relation to accountability for the whole CAMHS system.

Integrated commissioning

Our aim is to achieve accountability and transparency by building on the integrated commissioning programme and priorities already in place across both CCGs and Kirklees Council. A focus on integration across the commissioning system for children's mental health is one of the high level agreed priorities already agreed across the system, by (COG) Chief Officers Group in June 2015. We have a good history of integration across the children's commissioning system in Kirklees as a result of our Children's Trust arrangements. This means we have an established Integrated Commissioning Group with representation from health, social care and education, amongst others.

The high level outcomes agreed within our Integrated Commissioning Group are based on the every child matters outcomes:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing

Our specific target populations within these outcomes are :

Children and Young people experiencing or at risk of:-

- Being "looked after"
- Abuse or neglect
- Child sexual exploitation

Children and young people with care needs including:-

- A significant need or disability
- Significant health problems

Children and Young People experiencing or at risk of:

- Low achievement

- Poor employability
- Low levels of emotional wellbeing
- Lack of effective/ positive parenting

We have in place a Joint Commissioning Manager for children and young people across both CCG's and Kirklees Council. This post is jointly funded and manages themes and staff across the system including Kirklees council commissioning managers.

The Joint Commissioning Manager currently oversees :-

- CAMHS Tier 2 and Tier 3
- Substance misuse commissioning
- Youth Offending Team health provision and commissioning
- LAC health team based in Kirklees
- Pupil referral unit health provision
- Looked after Children CAMHS health needs
- Children with a disability provision
- Collaborative commissioning with schools

Therefore, this extensive oversight across the commissioning systems enables the Joint Commissioning Manager to further integrate CAMHS provision across the partnership. The Joint Commissioning Manager for children and young people will be the lead commissioner for the Kirklees Transformation Plan.

As such, this post will be responsible for the whole system transformation plan delivery, the budgets relating to CAMHS activity in Kirklees, and be accountable to the Integrated Commissioning Executive and Kirklees Health and Wellbeing Board.

Evidence based approaches and Outcomes

We will ensure that the provision and approaches funded and supported through our Transformation Plan are evidence based approaches. We will also ensure that local innovative approaches are evaluated to contribute to "what works" in relation to CAMHS provision. Through our close working with Public Health colleagues and adherence to NICE guidelines we will redesign and review all provision in line with NHS and Public Health outcome frameworks and NICE guidelines as detailed in Appendix 9. We will also utilise session by session outcome monitoring across our targeted and specialist provision as part of the implementation of our IAPT programme.

We recognise the need to ensure governance arrangements in place closely monitor the whole system of CAMHS provision. This will ensure services are evidence based, NICE guidance compliant and have rigorous performance and outcomes measures. The responsibility for monitoring these aspects of the provision will be

discharged at our Integrated Commissioning Group for children and families, who will oversee a comprehensive performance report on the key performance indicators (KPIs) relating to the commissioning intentions in the Transformation Plan. The group will oversee the pooled budget arrangement and monitor spend, receive regular monitoring reports in relation to the Transformation Plan KPI's and receive quality and data dashboards for the CAMHS provision across Kirklees.

Challenge and external oversight and learning

We will invite NHS England to regularly attend our Integrated Commissioning Group, to collaboratively commission clear pathways into the Tier 4 and step down provisions.

Risks will be monitored through performance reporting which will include reporting on a quality dashboard on a monthly basis.

We are exploring membership of CORC (Child Outcomes Research Consortium) to assist the development on sound outcomes measures and quality reporting to review provision across the system. The implementation of the CAMHS minimum dataset will provide a framework for closely monitoring our Tier 3 performance, as will the new waiting times standards. Above and beyond this we will conduct regular walkabouts in services to understand the challenges faced by front line workers and monitor the experiences of children, young people and families. Children and young people will be involved in regular reviews of service provision including mystery shopping approaches using our young advisors programme in Kirklees.

Governance

Our governance structures are outlined in Appendix 10, but ultimately the Health and Wellbeing Board will be the accountable statutory body receiving quarterly performance reporting from the Integrated Commissioning Group; this will commence in April 2016 reporting on agreed key performance indicators across our CAMHS provision. The Health and Wellbeing Board will closely monitor the progress of our Transformation Plan and the outlined commissioning intentions.

Local needs

We are committed to fully understanding the needs of our population on an ongoing basis in line with our locally agreed commissioning cycle.

Therefore, we will regularly be refreshing our local data sets, and dashboards alongside undertaking regular Joint Strategic Needs Assessment data refresh and local schools surveys. We will embed children and young people service user feedback within our new governance arrangements to redesign the CAMHS provision in line with children and young people views.

In this area of our self-assessment we had a number of green actions and completed actions, although we acknowledge there is further work to do to fully meet the ambitions outlined in Future in Mind. The commissioning intentions reflect the areas we need to prioritise to work towards being compliant with Future in Mind by 2020.

What will our transformed provision look like?

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.

The following priority objectives aim to address our gaps and areas for development outlined in this section. This will ensure we can achieve the Future in Mind recommendations, and meet local identified needs highlighted by local data and consultation with young people and families.

The priority objectives in year one will be to:

4.1 To implement the lead commissioning arrangement for all CAMHS provision covered within the Transformation Plan, discharged through the Joint Commissioning Manager jointly funded by North Kirklees, Greater Huddersfield CCGs and Kirklees Council. (30, 30.1)

4.2 Use the Transformation Plan as the basis for our commissioning priorities over the next 5 years. (30.3)

4.3 Embed the responsibility for overseeing the commissioning intentions within the Health and Wellbeing Boards work plan and oversight function. (30.5)

4.4 Ensure the Integrated Commissioning Group is overseeing the implementation of the Future in Mind detailed operational commissioning plan. Ensuring that commissioned services are evidence based and that NICE guidelines are implemented throughout the service provision. (30.1, 33)

4.5 Ensure the Integrated Commissioning Group closely monitor the CAMHS minimum dataset and waiting time standards, whilst developing a rigorous outcome based dataset to monitor and improve performance across the systems. (35.2, 36)

4.6 Implement clear and transparent outcome monitoring supported by membership of CORC, (CAMHS Outcomes Research Consortium) and the implementation of session by session outcome monitoring across CAMHS provision. (37)

4.7 Receive quarterly service feedback from children, young people and families in all performance reporting to the Integrated Commissioning Group. (30.3)

The following objectives will be addressed in the annual refreshing our of Transformation Plan, we will:

4.8 Have a single pooled budget for CAMHS provision across Kirklees and to publish the investment figures on local offer website along with referral rates and waiting times. (30.2, 38)

4.9 Collaboratively commission with NHS England to ensure clear and smooth care pathways in relation to Tier 4 provision. (32)

4.10 Be committed to continuous improvement and monitoring of all of our emotional health and wellbeing provision, using the commissioning cycle to understand, plan, do and review. (39)

The above objectives will achieve the following outcomes in Kirklees:

- **Improved transparency and accountability across the whole system, to drive further improvements in outcomes.**
- **Increased use of evidence-based treatments with services rigorously focused on outcomes.**
- **Children and young people having timely access to clinically effective mental health support, when they need it.**

Theme 5. Developing the workforce.
Chapter 8 - Future in Mind

Commissioning narrative

It is our aim that everyone who works with children, young people and their families is ambitious in making sure every child and young person achieves 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.

Workforce

To deliver our ambitions in transforming the CAMHS provision across the Future in Mind themes, it is essential that we have a workforce with the skills, competencies, values and qualifications to achieve this.

A comprehensive CAMHS workforce strategy will be developed in partnership with our local Children's Trust, including schools, primary care, Tier 2 and 3 providers, children, young people and their families.

Our self-assessment in relation to workforce development highlights gaps that are intertwined throughout the other themes and commissioning priorities. It is clear that through our proposal to develop the schools link and vulnerable children schemes that a comprehensive programme of training needs to be developed to support this. It is also essential that when developing our specialist model for vulnerable children that a crucial competent to support this will be the training of "experts" within strategic health and social care positions such as social workers, substance misuse workers and others working directly with children and young people.

Improving Access to Psychological Therapies - IAPT

Within our targeted and specialist provision we have gaps in training in relation to the Children and Young People IAPT programme. Although our Tier 2 provision is using session by session outcome monitoring, and our Tier 3 provider is a member of the North West (NW) collaborative for services in Wakefield and Barnsley, we are yet to realise our ambition in relation to fully implementing CYP IAPT.

Therefore, we are supporting both our Tier 2 and Tier 3 providers to join the North West collaborative for Kirklees, and in 2015/16 for their participation in the IAPT "light touch" training for IAPT which incorporates management training.

This will then be followed with full IAPT participation being agreed for 2016/17. This will ensure our targeted and specialist workforce are utilising IAPT approaches and

evidence based interventions, including the use of session by session outcome monitoring. This will allow for closely monitoring the impact of interventions on treatment outcomes for children and young people.

Our CAMHS workforce development strategy will also include comprehensive training for health and social care staff to develop the workforce to deliver a range of evidence based interventions. For example through our consultations with schools they feel that some interventions could be delivered by school support staff given the correct training and support.

We have good examples of this already within our Youth Offending Team, where a practitioner is Multisystemic Therapy trained, and within our placement support service where we have specialist practitioners able to deliver some CAMHS intervention. The training programme will also be underpinned by equality and diversity training through Kirklees.

What will our transformed provision look like?

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.

The following priority objectives aims to address our gaps and areas for development outlined in this section. This will ensure we are compliant with the Future in Mind recommendations, and meet the local identified needs highlighted by local data and consultation with young people and families.

The priority objectives in year one will be to**:**

5.1 Ensure Tier 2 and Tier 3 providers are fully participating in CYP IAPT core curriculum in 2016/17. (43)

5.2 Ensure that Tier 2 and Tier 3 provider managers are involved in the introduction to CYP IAPT in 2015/16. (43)

5.3 Ensure that where required staff and parents receive appropriate training and continuing development opportunities to enable them to deliver relevant evidence based interventions. (40)

5.4 Develop a comprehensive workforce development strategy for CAMHS across Kirklees. The strategy will inform and direct how workforce

development will be supported and implemented. (43.2, 43.3)

The following objectives will be addressed in the annual refreshing our of Transformation Plan, we will:

5.5 Ensure that health and social care staff receive appropriate training in order for them to deliver the appropriate evidence based interventions. (40)

5.6 To support school based staff, parents and Tier 1 providers to deliver interventions at a universal level to increase resilience in children and young people and families. (43)

5.7 To support Workforce development programmes that assist in young people's transition into adulthood before they reach 18 years old, targeted at post 16 support services, further education and outside of school provisions. (43)

The above objectives will achieve the following outcomes in Kirklees:-

- **Increased use of evidence-based treatments with services rigorously focused on outcomes.**
- **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.**
- **Children and young people having timely access to clinically effective mental health support when they need it.**
- **Making mental health support more visible and easily accessible for children and young people.**

Annex 1: High level summary - Local Transformation Plans for Children and Young People's Mental Health

Q1. Who is leading the development of this Plan?

North Kirklees CCG is the lead accountable commissioning body for children and young people's mental health. The lead commissioner for Future in Mind across Kirklees is a joint post across Greater Huddersfield CCG, North Kirklees CCG and Kirklees Council. This ensures that although North Kirklees CCG is the accountable body, there is, and will be close collaboration across the partnership in the development and delivery of our Transformation Plan.

There is Chief Officer support for our local Transformation Plan priorities from Kirklees Council, North Kirklees CCG and Greater Huddersfield CCG, through the Health and Wellbeing Board and support from lead portfolio elected members.

We have in place a number of arrangements that also include strategic planning and involvement with a number of partners across Kirklees. Through both our Children's Trust and Health and Wellbeing Board arrangements, we have strong partnerships in place with the voluntary and community sector, police, probation, CCGs, across council departments, a range of providers, parents and children and young people.

The development of the local Transformation Plan has been a testament to the partnerships in place. This has ensured that the plan has an ambition that involves whole system redesign to improve emotional health and wellbeing, that all partners understand their role in transforming provision in Kirklees, are fully committed to the objectives of the plan and we will hold each other accountable for the delivery.

Any queries in relation to the application should be directed to:

Tom Brailsford
Joint Commissioning Manager
Tom.Brailsford@northkirkleesccg.nhs.uk
Tom.Brailsford@Kirklees.gov.uk

Q2. What are you trying to do?

The scope of the Kirklees CAMHS Transformation Plan brings together core principles and requirements, considered fundamental to creating a system that supports the emotional wellbeing and mental health of children and young people in Kirklees.

The plan covers the whole spectrum of services from health promotion and prevention work, to support and interventions for those with existing or emerging mental health problems, as well as transitions between services. This will make it easier to access the support they need, when and where they need it, by providing a continuum of care.

This means our offer will ensure that:-

- Children, young people and their families/carers can access the right support at the earliest possible opportunity to prevent escalation of emotional health and wellbeing issues.
- The right support is offered quickly with reduced waiting times, and is in the right place for children, young people and families first time.
- Support is offered based on needs, and eligibility criteria and tiers of provision do not get in the way of access to the right continuum of support.
- Universal provision including schools and primary care will have closer working relationships with wider CAMHS provision, as well as a good understanding of emotional health and wellbeing issues. This will ensure universal provision can support children, young people and families in a co-ordinated timely manner.
- Support offered will be evidence based, collaboratively commissioned and cohesive. This will include clear specifications, monitoring and accountability from the lead commissioning organisation.
- The most vulnerable children will have discrete multi-agency CAMHS support to meet their needs and reduce the impact on their emotional health and wellbeing.
- Staff will be trained in delivering evidence based interventions through the IAPT programme, and wider health, social care, education staff and parents/carers will be trained to deliver appropriate care and support.

Q3. Where have you got to?

In Kirklees we have made some progress towards developing our local offer in line with the Future in Mind recommendations. We have developed our Transformation Plan Year 1 priorities based on our self-assessment against the 49 recommendations and have a clear commitment to the delivery of our commissioning intentions. To date we have:-

- Redesigned our psychiatric liaison provision reducing the upper age limit from 18 to 16 years old.
- Invested significantly in our local Tier 3 crisis CAMHS provision in order for children and young people to receive rapid access to support and assessment in line with the crisis care concordat.
- Undertaken a review of our CAMHS LAC provision for those children and young people out of area, with a clear commissioning recommendation to address the presenting needs.
- Invested in some discrete provision locally for LAC using pupil premium funding.
- Developed and implemented the pillars of parenting programme for our local children's home residential staff and are now extending this to our local foster carers.
- Undertaken a review of those children experiencing or at risk of CSE and the emotional health and wellbeing support they need. This has resulted in resource being dedicated locally to meet this need.
- Agreed and started to implement a model of Social, Emotional and Mental Health Difficulties (SEMHD) Continuum of need across our local schools on which our CAMHS offer will also be based.
- Started to develop a single point of access model between our Tier 2 and Tier 3 provision locally.
- Ensured that the development our local integration arrangements between CCGs and Kirklees Council have the integration of emotional health and wellbeing provision as a core priority.

Q4. Where do you think you could get to by April 2016?

Following the assurance process in October 2015, some of the changes that we will implement by April 2016 have been cross referenced with elements of our tracker Local Priority Stream (LPS) numbers which show partial implementation and working towards progressive longer term KPI completion.

- Capacity will have been increased in our current Tier 2 and Tier 3 provision to reduce waiting times for intervention. (LPS6)
- We will have started the delivery of our new eating disorder provision across Kirklees, Calderdale, Wakefield and Barnsley. (LPS7)
- We will have in place a single point of access between our Tier 2 and Tier 3 provision. (LPS10)
- We will have re-specified our Tier 2 and Tier 3 provision in line with a tier-less approach based on the thrive model. (LPS5)
- We will have re-specified our healthy child programme 0-19 to be more integrated and focused on emotional health and wellbeing. (LPS1)
- We will have in place discrete provision for the most vulnerable children in Kirklees. (LPS17)
- We will be piloting the CAMHS link model with a number of schools in Kirklees and primary care, despite being unsuccessful in our bid to NHS England. (LPS2)
- Our governance arrangements and reporting arrangements will be in place in relation to the delivery of our Future in Mind objectives. (LPS21)
- We will have drafted a pooled budget arrangement for emotional health and wellbeing funding across Kirklees. (LPS21)
- We will have begun collaborative commissioning with schools in relation to emotional health and wellbeing provision. (LPS3)
- There will be identified CAMHS link workers to liaise with schools and primary care. (LPS8)
- We will have started to design and implement an all age psychiatric liaison provision in line with the “Core 24” service specification on a regional basis. (29)

Q5. What do you want from a structured programme of transformation support?

In Kirklees, our programme of transformation is wide reaching and ambitious and we will need support locally for all our partners, but will also require support from NHS England in a number of areas. This will include:-

- Support to develop and implement the delivery of a tier-less CAMHS system across Kirklees. Good practice examples and specifications in this area would be particularly welcome.
- Access to training both for commissioners and providers in relation to evidence based practice and outcome monitoring.
- Challenge and oversight in relation to progress on the identified local objectives in our Transformation Plan.
- Improved datasets nationally in relation to national outcomes monitoring for CAMHS provision and improved data reporting eg based on the substance misuse provision model.
- Early indication of supportive best practice evidence to enable appropriate implementation of the right mix of specialist community health services which will enable staff to have the relevant skills and support the development of a tier less triage model.
- Clarity of funding beyond year two to support longer term planning to 2020.
- Examples of effective collaborative arrangements between educational establishments in pyramids and clusters.
- Support for change programme across the system to embed new and different ways of working in support of the transformation (getting people to think and work together to deliver the change).
- Provide other infrastructure support with aspects such as IT systems and interfaces between systems and organisations.

Plans and trackers should be submitted to your local DCOs with a copy to England.mentalhealthperformance@nhs.net within the agreed timescales

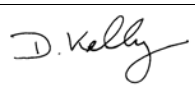
The quarterly updates should be submitted in Q3 and Q4. Deadline dates will be confirmed shortly and are likely to be shortly after quarter end. These dates will, where possible, be aligned with other submission deadlines (eg for the system resilience trackers, or CCG assurance process).

DCOs will be asked to submit the trackers to england.camhs-data@nhs.net for analysis and to compile a master list.

Annex 2: Self-assessment checklist for the assurance process

Theme	Y/N	Cross reference in Kirklees Local Transformation Plan
Engagement and partnership		
Please confirm that your plans are based on developing clear co-ordinated whole system pathways and that they:	**Y**	10, 19, 43, 57, 60 and 64
1. have been designed with, and are built around the needs of, CYP and their families.	**Y**	11-12, 14-16, 17-19 and 77-78
2. provide evidence of effective joint working both within and across all sectors including NHS, Public Health, LA, local Healthwatch, social care, Youth Justice, education and the voluntary sector.	**Y**	3, 32, 34, 50, and 77-81
3. include evidence that plans have been developed collaboratively with NHS E Specialist and Health and Justice Commissioning teams.	**Y**	9, 37-44, 50-52, 61 and 78-79
4. promote collaborative commissioning approaches within and between sectors.	**Y**	4-6, 10, 29-30, 33-34, 37, 41-43, 46, 51, 54, 57-58, 60-61,65, 67-68
Are you part of an existing CYP IAPT collaborative?	**N**	57 and 61
If not, are you intending to join an existing CYP IAPT collaborative in 2015/2016?	**Y**	7, 9, 40, 57, 61, 62 and 65. Tracker files 3.0 and 3.1
Transparency		
Please confirm that your Local Transformation Plan includes:		
1. The mental health needs of children and young people within your local population.	**Y**	11-28
2. The level of investment by all local partners commissioning children and young people's mental health services.	**Y**	74-77 - CYP IAPT funding mechanism changing in year. MOU & values unknown so not included in tracker
3. The plans and declaration will be published on the websites for the CCG, Local Authority and any other local partners.	**Y**	60 (4.8) and Annex 3.0 and 3.1 tracker files for Greater Huddersfield and North Kirklees CCG's.
Level of ambition		
Please confirm that your plans are:		
1. based on delivering evidence based practice.	**Y**	6-7, 9-10, 31, 49, 57-63, 65-68 and 86

2. focused on demonstrating improved outcomes.	**Y**	4-7, 30, 33, 34-35, 45-46, 54-55, 59-60, 62-63 and 86.
Equality and Health Inequalities		
Please confirm that your plans make explicit how you are promoting equality and addressing health inequalities.	**Y**	10-12 and 62
Governance		
Please confirm that you have arrangements in place to hold multi-agency boards for delivery.	**Y**	50, 55, 77-79 and 86
Please confirm that you have set up local implementation / delivery groups to monitor progress against your plans, including risks.	**Y**	6-7, 43, 57, 60-61,77-79 and 86
Measuring Outcomes (progress)		
Please confirm that you have published and included your baselines as required by this guidance and the trackers in the assurance process.	**N**	60 (4,) and Annex 3.0, 3.1 Tracker files include web address for publication upon Assurance Approval
Please confirm that your plans include measurable, ambitious KPIs and are linked to the trackers.	**Y**	Annex 3.0 and 3.1 tracker files for Greater Huddersfield and North Kirklees CCG's
Finance		
Please confirm that:		
1. your plans have been costed.	**Y**	74, 76, 82-84, Annex 3.0 and 3.1 tracker files for Greater Huddersfield and North Kirklees CCG's.
2. that they are aligned to the funding allocation that you will receive.	**Y**	Annex 3.0 and 3.1 tracker files for Greater Huddersfield and North Kirklees CCG's.
3. take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem).	**Y**	Annex 3.0 and 3.1 tracker files for Greater Huddersfield and North Kirklees CCG's.



Dr David Kelly
Deputy Chair of Kirklees Health and Wellbeing Board
signed off Plan on behalf of local partners

'Local decision by NHS Specialised Commissioning (Y&H hub) for LTPs to be signed off at the Assurance Panel'

Name signature and position of person who has signed off Plan on behalf of NHS Specialised Commissioning.

Annex 2a: Self-assessment initial action checklist

Extract from guidance - Section 4	Y/N	Reference to relevant pages in Transformation Plan
have been designed with, and are built around the needs of, CYP and their families	**Y**	Addressed in Annex 2
are based on the mental health needs of children and young people within your local population	**Y**	Addressed in Annex 2
provide evidence of effective joint working both within and across all sectors including NHS, public health, LA, social care, youth justice, education and the voluntary sector	**Y**	Addressed in Annex 2
include reference to other improvement initiatives such as the Crisis Care Concordat	**Y**	5, 9, 38, 46, 66, Annex 3.0 and 3.1
include evidence that plans have been developed collaboratively with NHS England Specialised and Health and Justice Commissioning teams	**Y**	Addressed in Annex 2
promote collaborative commissioning approaches within and between sectors	**Y**	Addressed in Annex 2
clarify status within the CYP IAPT programme	**Y**	Addressed in Annex 2
include the level of investment by all local partners commissioning children and young people's mental health services for the period April 2014 to March 2015	**Y**	76
include spend on services directly commissioned by NHS England on behalf of the CCG population	**Y**	76
will be published on the websites for the CCG, Local Authority and any other local partners	**Y**	Addressed in Annex 2
are based on delivering evidence based practice and focused on demonstrating improved outcomes	**Y**	Addressed in Annex 2
make explicit how you are promoting equality and addressing health inequalities	**Y**	Addressed in Annex 2
will be monitored by multi-agency boards for delivery supported by local implementation / delivery groups to monitor progress against your plans, including risks	**Y**	Addressed in Annex 2
include baseline information for April 2014-March 2015 on referrals made, accepted, and waiting times	**Y**	74, 82-83
include workforce information, numbers of staff including whole time equivalents, skills and capabilities	**Y**	75
include measurable, ambitious KPIs	**Y**	Attached at Annex 3.0 and 3.1

have been costed and are aligned to the funding allocation that you will receive	**Y**	Addressed in Annex 2
take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem)	**Y**	Addressed in Annex 2
a self-assessment checklist	**Y**	Addressed in Annex 2

Data Collection Template

Appendix 5

Data

CCG Area Covered	North Kirklees CCG AND Greater Huddersfield CCG	
Child Population in area:	107,402	
Lead Organisation:	**NHS North Kirklees Clinical Commissioning Group**	
Main Contact for the Lead Organisation:	**Full name:**	Tom Brailsford - Joint Commissioning Manager / CAMHS Transformation Lead
	Email Address:	Tom.Brailsford@northkirkleesccg.nhs.uk
	Telephone Number:	
Details of the person completing the toolkit:	**Full name:**	Tom Brailsford - Joint Commissioning Manager / CAMHS Transformation Lead
	Email Address:	Tom.Brailsford@northkirkleesccg.nhs.uk
	Telephone Number:	
Date completed:	Oct-15	

Collection Template - Activity

Draft content	Number of referrals into service between April 14 and March 15	Number of CYP accepted into service during 14/15	Average waiting time to assessment/ first contact	Average waiting time between assessment and intervention - (if appropriate)	Number of active cases as at March 31st 2015	Total number of face to face appointments offered during 2014/15
School based/ education cluster based services						
School Nursing	**8,516**	**403**	*Cannot report on this*	**Not appropriate**	**1099** Behavioural & Emotional wellbeing Care Plans	*Cannot report on offered appointments*
Locally authority based services						
Services targeted at other vulnerable children YOT	**153**	**86**	**3 - 10 working days**	**5 working days**	**62**	**337**
Services targeted at other vulnerable children LAC	*Not available*	*Not available*	*Not available*	*Not available*	*Not available*	*Not available*
Services targeted at other vulnerable children PRS	**136**	**81**	**35 days**	**Not appropriate**	*No currently available new reporting methods to be adopted Nov 2015*	
Learning SEMH provision	*Not available*	*Not available*	*Not available*	*Not available*	*Not available*	*Not available*
NHS based services						
NHS Provider CAMHS service	**1,657**	**498**	**5 - 6 weeks**	**6 - 9 months**	**834**	*Not currently available*
Looked after children CAMH service	**24**	**11**	*Not available*	**Not appropriate**	**11**	*Not available*
Third sector provided services (use as many rows as necessary for individual third sector agencies (Include name of agency in 1st column)						
ChEWS CAMHS service - area based (used to be referred to as 'Tier 2' services).	**2,190**	**1,406**	**7 days**	**12.7 weeks**	**158**	**1,373**
Totals	**4160**	**2082**			**1065**	**1710**

Data Collection Template - Workforce

Draft content	Total number (WTE) of practitioner/clinical staff **on the establishment** as at June 15	Total number (WTE) of practitioner/clinical staff **in post** as at June 15	Total number (WTE) of **non practitioner/clinical staff** supporting clinical staff on establishment as at June 15 (include admin staff and managers etc.)	Use this column to provide more detail or to signpost to other documents that provide more detail
School based/ education cluster based services				
School Nursing	**31.2**	**31.2**	**Not known**	
Locally authority based services				
Looked after children CAMH service	**1**	**1**	**1**	
Services targeted at other vulnerable children YOT	**1**	**1**	**Not known**	
Services targeted at other vulnerable children LAC	**2.8**	**2.8**	**5**	1 LA F/T BSO, 2 P/T & 1 F/T admin for Safeguarding and LAC at Batley health centre, 1 F/T admin at CHFT to support Designated Doctor
Services targeted at other vulnerable children PRS	**2**	**2**	**Not known**	1x 0.89 band 7 + 1x 0.2 band 5.
Learning SEMH provision	**60% of EP Time**	**Not Known**	**Not known**	
Health based services				
NHS Provider CAMHS service	**32.05**	**24.28**	**7.7**	
Health visiting	**95**	**95**	**Not known**	Recruiting more staff September 2015
School Nursing	**31.2**	**31.2**	**Not known**	
Third sector provided services (use as many rows as necessary for individual vol. orgs.				
ChEWS CAMHS service - area based (used to be referred to as 'Tier 2' services).	**9.5**	**9.5**	**3.1**	
Totals	**174.55**	**166.78**	**16.8**	

Data Collection Template - Investment

Expenditure type Draft content	LA funding spend 'in house'	LA funding allocated to third sector or private agencies	North Kirklees CCG funding contribution	Greater Huddersfield CCG funding contributions	CCG funding allocated to NHS agencies	CCG funding allocated to other providers	Funding provided by other agencies (e.g. by school clusters, by Grant giving Trusts, by Central Government etc.) Please indicate amount and source of funding -			
							Amount	Source	**Total budgets**	
Services directly at individual children/ families										
ChEWS - Early intervention emotional health services (non school based) - working with individual children /families - (used to be referred to as Tier 2 services)		**£360,000.00**	**£42,240.00**	**£53,760.00**		**£96,000.00**			**£456,000.00**	
School Nursing	**£1,504,437.00**								**£1,504,437.00**	*This is whole budget and yet to quantify amount of resource for EHWB*
Health Visiting	**£6,098,000.00**							Includes FNP	**£6,098,000.00**	
Emotional health/ CAMH Services based in school settings -							**£339,561.22**		**£339,561.22**	
Services targeted at other vulnerable children YOT					**140,000.00**			CCG funded	**£140,000.00**	
Services targeted at other vulnerable children LAC		**£65,800.00**			**120,000.00**			CCG Funded	**£65,800.00**	
Services targeted at other vulnerable children PRS			**£29,397.00**				**£29,397.00**	School clusters/CCG	**£58,794.00**	
Learning SEMH provision		**£420,000.00**							**£420,000.00**	
NHS provided specialist CAMHS service - area based (used to be referred to as 'Tier 3' services) If there is a merged Tier 2/3 service - include it within this row)			**£758,226.00**	**£976,845.00**	**£225,496.00**				**£1,960,567.00**	*Column F includes non-recurrent - recovery of service 1 April 14 to 31 Dec 14.*
NHS provided intensive home treatment/crisis response service			*within the Tier 3 contract*						*within the Tier 3 contract*	
NHS England funded Tier 4 activity in area (Further Guidance to be produced on how to calculate this figure) Use final column for this amount.			**£309,220.00**	**£121,874.00**					**£431,094.00**	
Spot purchased 'mental health' out of area placements funded by the local area	*Spend not available*		*Information not currently available*						*Information not currently available*	
Any other areas of services directed at individual children/families- not included above										
CAMHS support provisions independently provided in schools to support early intervention and prevention							**£546,021.38**	Primarily Pupil Premium and School Budgets	**£546,021.38**	*Figures at 7 October 2015. Relates to 39 schools (20% of all Kirklees schools) from 93 responses who bought in additional support in 2014/2015). Provides baseline estimate only*
	£7,602,437.00	**£845,800.00**	**£1,139,083.00**	**£1,152,479.00**	**£485,496.00**	**£96,000.00**	**£914,979.60**		**£12,020,274.60**	

Engagement and consultation

Appendix 6

The following details consultation process and activities undertaken to support the co-production of the Kirklees CAMHS Transformation Plan.

1. **Transformation Plan consultation and engagement event**

   This was held on September 4th 2015 and involved inter-agency partners, senior managers from Council, both CCGs, parents from PCAN (Parents of Children with Additional Needs) group, councillors, schools, voluntary and community sector and service providers. Children and young people's views were represented by member of the engagement team as well as inclusion in themed outcomes. NHS England also attended. The meeting discussed national requirements and the Kirklees initial priority outcomes. Comments and contributions from the session and post event discussions were integrated into the draft plan. Feedback was in support of the priority outcomes which had been drawn up using wide range of existing knowledge and feedback.

2. **Research**

   National and local research and data was used to draft out the initial priority outcomes and develop the text of the plan. This included the Young Minds presentations from the regional Future in Mind event held March 2015.

3. **Transformation Plan Strategy Group**

   Co-ordination and strategic oversight provided by senior leads from partnership.

4. **Children and Young People**

   Kirklees' children and young people's views have been collated from work that has taken place over a number of years and more recently by the specialist team, Involving Young Citizens Equally (IYCE) to set out young people's views and expectations. This included planned activities, reports presented to strategic managers regarding Emotional Health and Wellbeing as well as working with individuals. Young people's contributions were also included in the tendering arrangements for the current Tiers 2 and 3 provisions. Feedback from service users is collated by providers as routine information. The lead Future in Mind commissioner has spoken to two current service users and included feedback in relation to their experiences into our commissioning priorities.

5. **Parents**

   Ongoing discussions with PCAN have been maintained around the plan and general issues over the past two years. This has included individual discussions, contributions from parent representatives on the Disabled Children Strategy and Local Offer (Children and Families Act) and engagement with parents regarding the Care Act and other areas of development such as ASD and ADHD.

6. Schools

Early discussions were held about the proposed Transformation Plan from July 2015 with school representatives on the Children's Trust Board (these are representatives from Infant/Primary Schools, High Schools and Pupil Referral Units), identified school leaders as part of emotional health and wellbeing work and school leaders who are part of the Learning and Community Hubs programme. The hubs work has also been included in regional ADCS systems leadership development. In addition, reference made to previous information from school leaders regarding emotional health and wellbeing and discussions held at the Children's Trust Board.

All learning establishments have been contacted regarding identification of CAMHS lead and current spend and wide range of feedback shared which has influenced the Plan. This work is ongoing, see annex (i) of this report for more detail.

7. CCGs

Detailed reports and draft plans taken to all appropriate Boards at both North Kirklees and Greater Huddersfield CCGs which includes Quality and Performance Committees, Clinical Strategy Groups and Governing Bodies. Reports taken between July and October 2015.

8. Dialogue with providers

This has been ongoing and included in regular dialogue, contract monitoring and specific discussions regarding issues/data for the text of the Plan. Early drafts sent to both providers and comments noted and included where appropriate.

9. General practitioners

Main engagement through clinical governance structure. The Lead GP for North Kirklees CCG for mental health has been very involved in the drafting of the Plan and also in service walkabouts which included meeting service users.

10. Voluntary and Community Groups

In addition to inclusion in engagement event in September and circulation of draft Plans as members of strategic groups, there have been detailed discussions with Third Sector leaders who also ensured that a draft was shared with Kirklees based organisations. Healthwatch have also been involved in a number of discussions and had input into the Transformation Plan.

11. Yorkshire and Humberside Regional Consortium

Ongoing discussions to encourage the development of standardised approaches across the region. This has included the planning arrangements to establish a regional Eating Disorder Service.

Formal Planning and Oversight

1. **Portfolio Holders**

   Lead councillors have been briefed and discussed the draft plans in addition to contributions to formal sign off process.

2. **Elected members**

   Briefing held with lead for Adults Scrutiny and Transformation Plan part of agenda for current Children and Families' ad hoc Scrutiny panel. The Plan was discussed in detail at the first meeting and will be subject to detailed work by the panel over the coming months.

3. **SEND Children's Strategy Group**

   This is a multi-agency group and includes parent representatives. Updates and discussion as part of group's work.

4. **Integrated Commissioning Group - Children and Families**

   One of the groups working to plan, deliver and monitor integrated commissioning between Council and both CCGs. The ICG has been updated and had detailed discussions regarding the text and detailed aspects of the Plan and priority outcomes and connections with commissioning.

5. **Health and Wellbeing Board**

   Briefing regarding the requirements for the Plan taken in July 2015 and formal sign off of priority outcomes at meeting held September 2015.

6. **Children's Trust Board**

   This is the strategic body for the partnership with wide ranging membership and has received reports over period of years regarding emotional health and wellbeing, CAMHS and recently the Transformation Plan. The draft plan has been seen by all members and relevant comments incorporated.

Kirklees Schools' Feedback

Annex i

There are 195 educational establishments in Kirklees. To assess current needs and provision in schools a short piece of research was undertaken. Its results are detailed in this section, based on the first 59 schools that responded. This work is ongoing with 95 responses having being received so far which will inform a revision of the following content.

Respondent Profile

Respondents	Total Establishments	Responses	Response Rate
Primary Schools	147	46	31%
High Schools	26	11	42%
Special Schools	7	2	29%
Other Schools and FE establishments	15	0	0%
Total		59	30%

Spending

The responding establishments spent £339,561 during 2014/2015. The profile of that spending is detailed below.

Primary Schools	High Schools	Special Schools	Total Spend
£ 77,905	£256,156	£5,500	£339,561
23%	75%	2%	

Within the schools surveyed, 70% had made some sort of funding allocations towards mental health and emotional wellbeing spending in the next financial year. However, 1 in 5 schools did not have the funding available to make such a commitment.

(The submitted tracker shows and revised minimum spend of £546,021.38 which relates to the 95 schools who have submitted responses to date.)

Emotional and Mental Health support needs identified by Schools

Notwithstanding the evidence about individual need elsewhere in this document, there are a number of need areas that schools have identified through the research that are detailed below.

The greatest need area was around prevention and early intervention activities, 90% of respondents saw the need and value of this support. The feedback from schools was that they need to be able to support children who are struggling but not in a "crisis" that would require an intervention. Schools felt the need to be supported in this process, half of schools wanted training to for staff that would equip them with

the skills needed to support children and prevent them entering a crisis and needing more complex support.

Schools also identified the need to be more involved in cases where children were in receipt of ChEWS or CAMHS services, there are likely to be things that can be done in school to add value to therapeutic interventions or mitigate the likelihood or deterioration. However, 5 in 7 (71%) schools were often excluded from care management discussions.

Just over half (56%) of schools identified the need for information and guidance, this was more around access to professional advice about the needs or specific children than general condition information. Linked with the training of staff discussed above there is a potential opportunity to enable schools to intervene early and effectively if they have the right skills and professional support.

Schools also identified the need to be part of the holistic support for the family. This was both in cases of a child with mental and emotional health needs and also supporting children of parents who have mental and emotional health needs. This again connects with supporting schools to offer an immediate response to children in need.

Schools realise there are cases where professional intervention was needed, 2 in 3 (68%) schools wanted to offer counselling in schools - this increased to 82% in high schools. Over half (53%) of schools were willing to make dedicated space available to outside professionals so that this sort of support could be delivered.

Specific Issue Support

In high schools, two specific issues were identified as needing increased support. These were self-harm where 1 in 4 (27%) of high schools needed support, and eating disorders where 1 in 5 (18%) of high schools needed additional support.

Service Accessibility

As discussed elsewhere service accessibility in terms of eligibility, referral delays and waiting times for services continue to be picked up as major issues by schools.

Schools waited easier access to former Tier 2 services (ChEWS) - this was the case in 85% of respondents, and this increased to 91% in high schools. Similarly 78% of respondents wanted easier access to former tier 3 (CAMHS) services - 78% of respondents felt this and again this increased to 91% of respondents in high schools.

Where children were able to access support, schools felt waiting times were a major issue. 3 in 4 (75%) schools wanted action on waiting times. Also for children who were accessing support 1 in 4 (24%) of schools wanted that support to last for longer. When thought of alongside schools wishing to be part of the support there are significant joint opportunities that might be available.

Eating Disorders – Current staffing

Appendix 7

BARNSLEY, CALDERDALE, KIRKLEES AND WAKEFIELD EATING DISORDER SERVICE PROVISON (CURRENT AND FUTURE)

Barnsley Current Service

	Band	Pay Point	Head count	WTE	Pay	NI	Pen	Total	
Medical Staff	8a	38	1	0.10	4,756	544	680	5,980	Assumed band 8a - could be very different
Lead Nyurse	8a	38	1	0.20	9,512	1,089	1,360	11,961	
CBT/Family Therapist	7	34	1	0.20	8,193	907	1,172	10,271	
Psychologist	8a	38	1	0.10	4,756	544	680	5,980	
MH Practitioner	6	29	1	0.50	17,438	1,353	2,494	21,284	
Consultant Psychiaterist			1	0.30				37,500	Based on approximate £ 124999
			6	**1.40**				**92,977**	

Wakefield Current Service

	Band	Pay Point	Head count	WTE	Pay	NI	Pen	Total	
CBT	7	34	1	0.50	20,482	2,267	2,929	25,678	
Family Therapy	7	34	1	0.50	20,482	2,267	2,929	25,678	
Dietician	6	29	1	0.40	13,950	1,082	1,995	17,028	
Consultant Psychiaterist			1	0.30				37,500	Based on approximate £ 124999
Crisis	7	34	1	0.50	20,482	2,267	2,929	25,678	
Admin	4	17	1	0.40	8,894	556	1,272	10,723	
			6	**2.60**				**142,283**	

Calderdale and Kirklees Current Service

	Band	Pay Point	Head count	WTE	Pay	NI	Pen	Total
Pathway Lead	7	34	1	1.00	40,964	4,534	5,858	51,355
Specialist Nurse	7	34	1	0.40	16,386	1,813	2,343	20,542
Dietician	6	29	1	0.40	13,950	1,082	1,995	17,028
CBT	7	34	1	1.00	40,964	4,534	5,858	51,355
-	6	29	1	1.00	34,876	2,706	4,987	42,569
Support Worker	4	17	1	1.00	22,236	1,391	3,180	26,807
Specialist Nurse	7	34	1	1.00	40,964	4,534	5,858	51,355
			7	**5.80**				**261,012**

Combined Level of Current Services	19	9.60	496,272
Recommended Service Level (using workforce calculator)		23.70	1,718,368
Difference between levels of provision			1,222,096

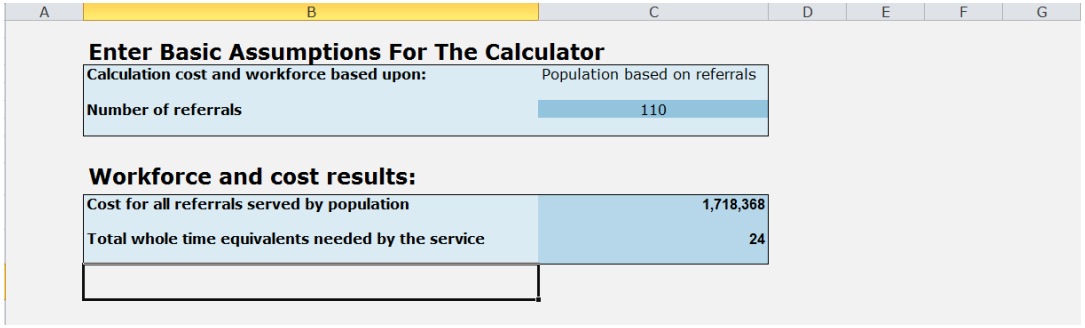
Eating disorders - Pay schedule

PAY				EMPLOYERS NI						EMPLOYERS PENSION	TOTAL
Band	Pay Point	Pay Point	Pay	EPW	NI Taxable	NI Rebate	13.80% ENI	3.40% ENI Rebate	NI Contribution	14.30% Amount	
		1	0						0	0	0
Band 1	Point 2	Point 2	15,100	290	134	178	964	-315	649	2,159	17,908
	Point 3	Point 3	15,363	295	139	183	1,001	-324	676	2,197	18,236
Band 2	Point 2	Point 2	15,100	290	134	178	964	-315	649	2,159	17,908
	Point 3	Point 3	15,363	295	139	183	1,001	-324	676	2,197	18,236
	Point 4	Point 4	15,786	304	148	192	1,059	-339	720	2,257	18,764
	Point 5	Point 5	16,210	312	156	200	1,118	-353	764	2,318	19,292
	Point 6	Point 6	16,633	320	164	208	1,176	-368	808	2,379	19,820
	Point 7	Point 7	17,179	330	174	218	1,251	-386	865	2,457	20,501
	Point 8	Point 8	17,800	342	186	230	1,337	-407	930	2,545	21,275
Band 3	Point 6	Point 6	16,633	320	164	208	1,176	-368	808	2,379	19,820
	Point 7	Point 7	17,179	330	174	218	1,251	-386	865	2,457	20,501
	Point 8	Point 8	17,800	342	186	230	1,337	-407	930	2,545	21,275
	Point 9	Point 9	17,972	346	190	234	1,361	-413	948	2,570	21,490
	Point 10	Point 10	18,468	355	199	243	1,429	-430	999	2,641	22,108
	Point 11	Point 11	19,027	366	210	254	1,506	-449	1,057	2,721	22,805
	Point 12	Point 12	19,461	374	218	262	1,566	-464	1,103	2,783	23,346
Band 4	Point 11	Point 11	19,027	366	210	254	1,506	-449	1,057	2,721	22,805
	Point 12	Point 12	19,461	374	218	262	1,566	-464	1,103	2,783	23,346
	Point 13	Point 13	20,147	387	231	275	1,661	-487	1,174	2,881	24,202
	Point 14	Point 14	20,844	401	245	289	1,757	-511	1,246	2,981	25,071
	Point 15	Point 15	21,477	413	257	301	1,844	-532	1,312	3,071	25,860
	Point 16	Point 16	21,692	417	261	305	1,874	-540	1,335	3,102	26,128
	Point 17	Point 17	22,236	428	272	316	1,949	-558	1,391	3,180	26,807
Band 5	Point 16	Point 16	21,692	417	261	305	1,874	-540	1,335	3,102	26,128
	Point 17	Point 17	22,236	428	272	316	1,949	-558	1,391	3,180	26,807
	Point 18	Point 18	23,132	445	289	333	2,073	-588	1,484	3,308	27,924
	Point 19	Point 19	24,063	463	307	351	2,201	-620	1,581	3,441	29,085
	Point 20	Point 20	25,047	482	326	370	2,337	-654	1,683	3,582	30,312
	Point 21	Point 21	26,041	501	345	389	2,474	-687	1,787	3,724	31,552
	Point 22	Point 22	27,090	521	365	409	2,619	-723	1,896	3,874	32,860
	Point 23	Point 23	28,180	542	386	430	2,769	-760	2,009	4,030	34,219
Band 6	Point 21	Point 21	26,041	501	345	389	2,474	-687	1,787	3,724	31,552
	Point 22	Point 22	27,090	521	365	409	2,619	-723	1,896	3,874	32,860
	Point 23	Point 23	28,180	542	386	430	2,769	-760	2,009	4,030	34,219
	Point 24	Point 24	29,043	559	403	447	2,888	-789	2,099	4,153	35,295
	Point 25	Point 25	30,057	578	422	466	3,028	-824	2,204	4,298	36,560
	Point 26	Point 26	31,072	598	442	486	3,168	-858	2,310	4,443	37,825
	Point 27	Point 27	32,086	617	461	505	3,308	-893	2,416	4,588	39,090
	Point 28	Point 28	33,227	639	483	527	3,466	-932	2,534	4,751	40,513
	Point 29	Point 29	34,876	671	515	559	3,693	-988	2,706	4,987	42,569
Band 7	Point 26	Point 26	31,072	598	442	486	3,168	-858	2,310	4,443	37,825
	Point 27	Point 27	32,086	617	461	505	3,308	-893	2,416	4,588	39,090
	Point 28	Point 28	33,227	639	483	527	3,466	-932	2,534	4,751	40,513
	Point 29	Point 29	34,876	671	515	559	3,693	-988	2,706	4,987	42,569
	Point 30	Point 30	35,891	690	534	578	3,834	-1,022	2,811	5,132	43,835
	Point 31	Point 31	37,032	712	556	600	3,991	-1,061	2,930	5,296	45,257
	Point 32	Point 32	38,300	737	581	625	4,166	-1,104	3,062	5,477	46,839
	Point 33	Point 33	39,632	762	606	650	4,350	-1,149	3,200	5,667	48,500
	Point 34	Point 34	40,964	788	632	0	4,534	0	4,534	5,858	51,355
Band 8a	Point 33	Point 33	39,632	762	606	0	4,350	0	4,350	5,667	49,649
	Point 34	Point 34	40,964	788	632	0	4,534	0	4,534	5,858	51,355
	Point 35	Point 35	42,612	819	663	0	4,761	0	4,761	6,094	53,467
	Point 36	Point 36	44,261	851	695	0	4,989	0	4,989	6,329	55,579
	Point 37	Point 37	46,164	888	732	0	5,251	0	5,251	6,601	58,017
	Point 38	Point 38	47,559	915	759	0	5,444	0	5,444	6,801	59,804
Band 8b	Point 37	Point 37	46,164	888	732	0	5,251	0	5,251	6,601	58,017
	Point 38	Point 38	47,559	915	759	0	5,444	0	5,444	6,801	59,804
	Point 39	Point 39	49,968	961	805	0	5,776	0	5,776	7,145	62,890
	Point 40	Point 40	52,752	1,014	858	0	6,160	0	6,160	7,544	66,456
	Point 41	Point 41	55,548	1,068	912	0	6,546	0	6,546	7,943	70,038
	Point 42	Point 42	57,069	1,097	941	0	6,756	0	6,756	8,161	71,986
Band 8c	Point 41	Point 41	55,548	1,068	912	0	6,546	0	6,546	7,943	70,038
	Point 42	Point 42	57,069	1,097	941	0	6,756	0	6,756	8,161	71,986
	Point 43	Point 43	59,016	1,135	979	0	7,025	0	7,025	8,439	74,480
	Point 44	Point 44	61,779	1,188	1,032	0	7,406	0	7,406	8,834	78,019
	Point 45	Point 45	65,922	1,268	1,112	0	7,978	0	7,978	9,427	83,327
	Point 46	Point 46	67,805	1,304	1,148	0	8,238	0	8,238	9,696	85,739
Band 8d	Point 45	Point 45	65,922	1,268	1,112	0	7,978	0	7,978	9,427	83,327
	Point 46	Point 46	67,805	1,304	1,148	0	8,238	0	8,238	9,696	85,739
	Point 47	Point 47	70,631	1,358	1,202	0	8,628	0	8,628	10,100	89,359
	Point 48	Point 48	74,084	1,425	1,269	0	9,104	0	9,104	10,594	93,782
	Point 49	Point 49	77,850	1,497	1,341	0	9,624	0	9,624	11,133	98,606
	Point 50	Point 50	81,618	1,570	1,414	0	10,144	0	10,144	11,671	103,433
Band 9	Point 49	Point 49	77,850	1,497	1,341	0	9,624	0	9,624	11,133	98,606
	Point 50	Point 50	81,618	1,570	1,414	0	10,144	0	10,144	11,671	103,433
	Point 51	Point 51	85,535	1,645	1,489	0	10,684	0	10,684	12,232	108,451
	Point 52	Point 52	89,640	1,724	1,568	0	11,251	0	11,251	12,819	113,709
	Point 53	Point 53	93,944	1,807	1,651	0	11,845	0	11,845	13,434	119,223
	Point 54	Point 54	98,453	1,893	1,737	0	12,467	0	12,467	14,079	124,999

Workforce Modelling Tool

Appendix 8

EATING DISORDERS – BASIC ASSUMPTION FOR BARNSLEY, CALDERDALE, KIRKLEES AND WAKEFIELD SERVICE



Enter Basic Assumptions For The Calculator

Calculation cost and workforce based upon:	Population based on referrals
Number of referrals	110

Workforce and cost results:

Cost for all referrals served by population	1,718,368
Total whole time equivalents needed by the service	24

AfC Band (if relevant)/medical grade	WTE	Average salary	On-costs	Capital and facilities	Overtime and allowances	Total per capita pay costs 2013/14	Total per capita pay costs uplifted to 15/16	Overheads per capita	Total per capita	Total	Comments
Consultant Psychiatrist	1.29	£89,175.00	£23,729.00	£4,891.00	£29,873.63	£147,668.63	£153,932.14	£69,186.00	£223,118.14	£288,625.62	PSSRU 2014
Consultant (Medical)	0.24	£87,060.00	£23,141.00	£4,891.00	£29,165.10	£144,257.10	£150,375.91	£67,530.00	£217,905.91	£52,533.10	PSSRU 2014
8b	0.36	£55,237.00	£13,809.25	£4,338.00	£3,977.06	£77,361.31	£80,642.67	£33,849.23	£114,491.91	£41,576.51	PSSRU 2014
8a	1.45	£46,013.00	£11,729.00	£4,338.00	£3,312.94	£65,392.94	£68,166.64	£35,384.00	£103,550.64	£150,413.22	PSSRU 2014
Registrar	1.74	£37,378.00	£9,329.00	£3,935.00	£17,380.77	£68,022.77	£70,908.02	£28,621.00	£99,529.02	£173,104.01	Registrar, PSSRU
7	7.42	£38,345.00	£9,598.00	£3,687.00	£4,869.82	£56,499.82	£58,896.31	£29,378.00	£88,274.31	£655,366.81	Assumed therapis
6	0.56	£31,943.00	£7,818.00	£3,687.00	£4,056.76	£47,504.76	£49,519.72	£24,366.00	£73,885.72	£41,379.90	Community nurse
6	1.69	£30,998.00	£7,749.50	£5,767.00	£2,231.86	£46,746.36	£48,729.15	£17,733.00	£66,462.15	£112,386.19	PSSRU 2014
4	1.98	£19,730.00	£4,932.50	£1,255.00	£2,505.71	£28,423.21	£29,628.81	£12,090.54	£41,719.35	£82,420.01	Assumed assistan
4	2.87	£21,244.00	£5,311.00	£1,255.00	£0.00	£27,810.00	£28,989.59	£13,018.32	£42,007.91	£120,562.71	Average salary fo
										£1,718,368.09	

Public Health Framework and NICE Guidance

Appendix 9

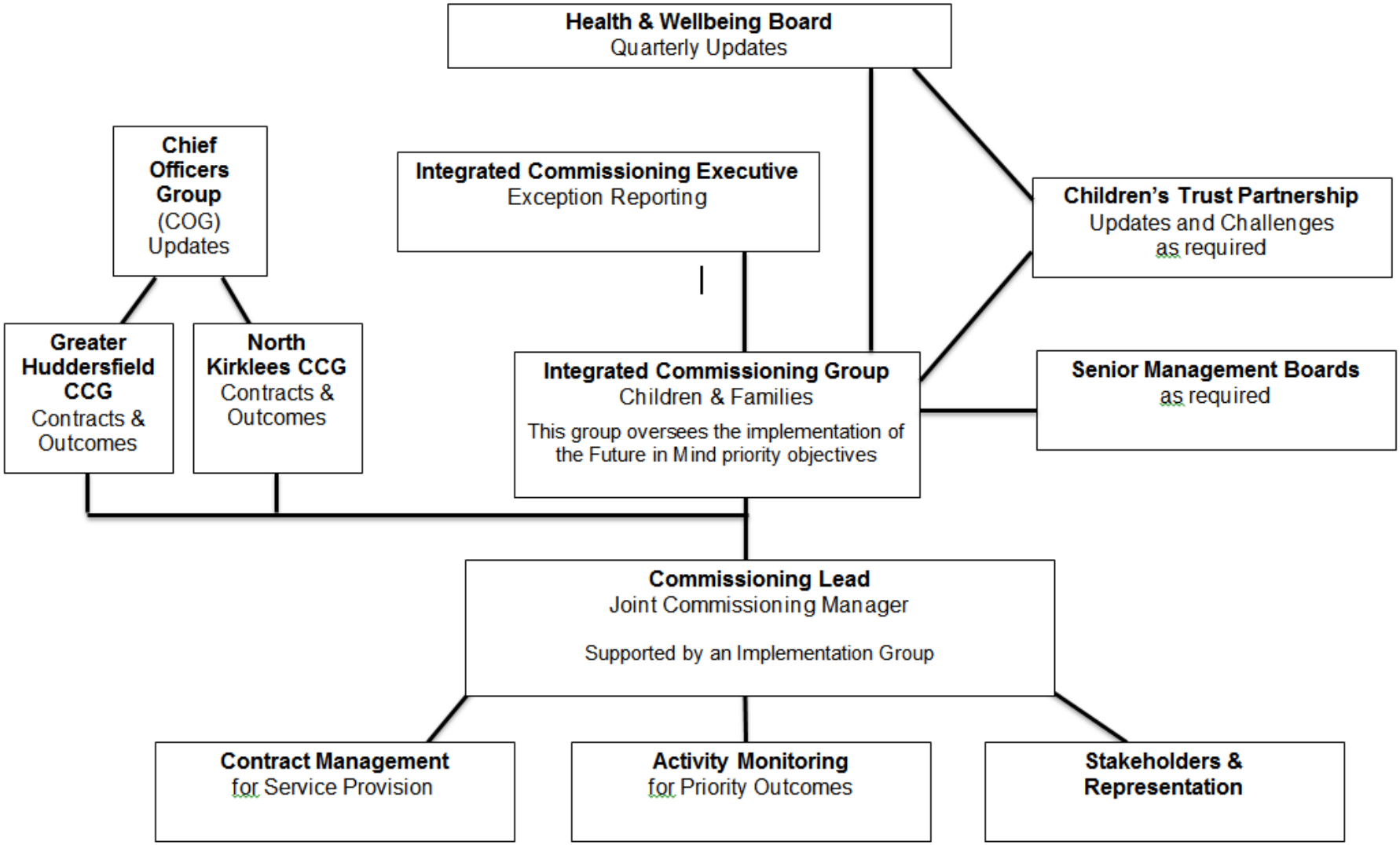
Guidance	Link
Antisocial behaviour and conduct disorders in children and young people	http://www.nice.org.uk/Guidance/CG158
Attention deficit hyperactivity disorder in children, young people and adults	http://www.nice.org.uk/Guidance/CG72
Autism: management of autism in children and young people	http://www.nice.org.uk/Guidance/CG170
Depression in children and young people	http://www.nice.org.uk/guidance/CG28
Looked-after children and young people	http://www.nice.org.uk/Guidance/PH28
Psychosis and schizophrenia in children and young people	http://www.nice.org.uk/Guidance/CG155
Antenatal and postnatal mental health: clinical management and service guidance	https://www.nice.org.uk/guidance/cg192
Social and emotional wellbeing: early years	http://www.nice.org.uk/Guidance/PH40
Social and emotional wellbeing in primary education	http://www.nice.org.uk/Guidance/PH12
Social and emotional wellbeing in secondary education	http://www.nice.org.uk/Guidance/PH20

System Level Outcomes

Domain	Potential outcomes
NHSOF: Preventing people from dying prematurely	Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services
NHSOF: Enhancing quality of life for people with long term conditions	Enhancing quality of life for people with mental illness
NHSOF: Helping people to recover from episodes of ill health or following injury	Improved outcomes from planned treatments, including psychological therapies.
NHSOF: Ensuring that people have a positive experience of care	Improved experience of healthcare for people with mental illness, including community mental health services
NHSOF: Ensuring that people have a positive experience of care	Improving children and young people's experience of healthcare, including inpatient services
PHOF: Wider determinants of health	School readiness
PHOF: Wider determinants of health	Pupil absence
PHOF: Wider determinants of health	First time entrants to the youth justice system
PHOF: Wider determinants of health	16-18 year olds not in education, employment or training
PHOF: Wider determinants of health	Re-offending levels
PHOF: Wider determinants of health	Statutory homelessness
PHOF: Health improvement	Hospital admissions caused by unintentional and deliberate injuries in children and young people
PHOF: Health improvement	Emotional wellbeing of looked after children
PHOF: Health improvement	Average Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score
PHOF: Healthcare and premature mortality	Suicide rate

Governance Structures

Appendix 10



Glossary and Acronyms

CAMHS	**C**hild and **A**dolescent **M**ental **H**ealth **S**ervice
CCG	**C**linical **C**ommissioning **G**roup
Core 24	Specification for 24 hours psychiatric liaison service to Accident and Emergency Departments
CSE	**C**hild **S**exual **E**xploitation
CYP IAPT	**C**hildren and **Y**oung **P**eople's **I**mproving **A**ccess to **P**sychological **T**herapies programme
NICE	**N**ational **I**nstitute for Health and **C**are **E**xcellence
Tier 2	Historical description for practitioners who are CAMHS specialists working in community and primary care settings
Tier 3	Historical description for a multi-disciplinary service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team includes child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.
Y & H	**Y**orkshire and **H**umber Region
ChiMAT	**C**hild and **Mat**ernal Health Observatory
JSNA	**J**oint **S**trategic **N**eeds **A**ssessment
ChEWS	**Ch**ildren's **E**motional **W**ellbeing **S**ervice
PCAN	**P**arents of **C**hildren with **A**dditional **N**eeds
PSHCE ed	**P**ersonal, **S**ocial, **H**ealth, **C**itizenship and **E**conomic **ed**ucation
CYPEDS	**C**hildren and **Y**oung **P**eople **E**ating **D**isorder **S**ervice
CBT	**C**ognitive **B**ehavioural **T**herapy
10CC	Group of **10 CC**G;s in a West Yorkshire Clinical Commissioning Collaborative
DNA	**D**id **n**ot **a**ttend
SEN	**S**pecial **E**ducational **N**eeds
SEND	**S**pecial **E**ducational **N**eeds and **D**isability
EHC (P)	**E**ducation **H**ealth and **C**are (**P**lans)

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS
North Kirklees
Clinical Commissioning Group

Kirklees
COUNCIL