TAMESIDE and GLOSSOP

Children and Young People's Emotional Wellbeing and Mental Health

TRANSFORMATION PLAN

2015 - 2020

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Section 1: Executive Summary

1.1 Children and young people's emotional and mental well-being is a high priority for all in Tameside and Glossop. From earliest development in pregnancy to early years, school age, teenage and into adulthood we aim to work with parents, carers to promote and support good emotional and mental health development and build resilience, providing children and young people with a great start in life and lifelong resilience. We also aim to ensure that, when it is required, children young people and their families have swift and easy access into evidence based specialist support.

1.2 The effective assessment of children's and young people's mental health needs is an early and crucial determinant of their subsequent pathway through an emotional wellbeing and mental health system, and their consequent use of resources.

1.3 Across Tameside and Glossop, there are concerns that open access to Child and Adolescent Mental Health Services (CAMHS) is not always being achieved in practice. Some children and young people still have to wait too long to be seen by services. Across a larger Greater Manchester footprint there is a geographical variation in access and service offer.

1.4 Some families and professionals find the procedures for accessing services unclear and confusing. Pathways into support services are not clear as demonstrated by the data from our provider of Tameside and Glossop CAMHS, where almost 40% of referrals to CAMHS are rejected (including over 50% of GP referrals).

1.5 Despite these barriers to getting the right timely support, demand for mental health services for children and young people in Tameside and Glossop is increasing with escalating presentations around anxiety, self-harm, eating disorders and new demands from Child Sexual Exploitation (CSE) and an increase in the Children Looked After population.

1.6 We recognise the evidence and compelling arguments for a focus on early intervention - preventing mental health problems escalating and becoming entrenched through joined up timely early help and support. Universal services, including primary care, health visitors, school nursing, Children's Centres, schools, colleges and youth services, play a key role in preventing and promoting emotional wellbeing and mental health. We will ensure CAMHS support this responsibility within their dual function in delivering direct help and treatment and providing information, advice and guidance (IAG) on how to

ensure good mental health and emotional wellbeing in children and young people, and how best to support those who care for them.

1.7 Juxtaposed with this position, we are faced with increasing financial pressures in public services and associated challenges in the third sector, resulting in reductions across all services.

1.8 Clearly if we are to improve and sustain access to services then this requires more than additional funds but rather a new whole system approach that includes the active participation of all partners and key stakeholders, notably parents and carers. We hold a view that CAMHS should be integrated within a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, Schools, Health Visiting, Youth Offending, Social Care and Third Sector provision (to name a few). It falls beyond the resources of a single provider to effectively promote and meet the emotional wellbeing and mental health needs of children and young people.

1.9 Therefore to address these mounting concerns and pressures we should act together, jointly, with a collective aim to improve access through a partnership approach to providing an emotional wellbeing and mental health system; improving partnership working to ensure children, young people and families have:

- Access to timely and appropriate information and support from pregnancy to adulthood
- Clearly signposted routes to support, including specialist CAMHS
- An 'open door' into a system of joined up support that holds a 'no wrong door' approach, which is easy to navigate
- Clear understanding of the service(s) offer (what support should be received and what the expected outcomes are)
- Timely access to this support that is as close to home as possible
- Integrated parent infant mental health provision from pregnancy across all partners

1.10 Our vision for children and young people is an emotional wellbeing and mental health system that is truly personalised, joined up, supports children and young people to stay well and provides the very best support and care, when and where they need it. For children and families, this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs and of those who care for them.

1.11 As such, the new approach will review and strengthen our referral pathways to make them more effective. It will deliver a clear offer to meet the emotional wellbeing and mental health needs of children and young people through

integrated partnership service delivery. This will require the development of pathways across an array of services, including school support services, health provision, social care and the third sector.

1.12 The plan seeks to be as ambitious as possible so that by 2020, the foundations for a sustainable system wide service transformation to improve children and young people's (including the most vulnerable such as looked after children, those connected to the criminal justice system or those who have learning difficulties) emotional wellbeing and mental health has been laid. This will lead to closing the treatment gap so that more children and young people with concerns about their mental health can access timely and high quality care coordinated and embedded within the other support they may be receiving.

1.13 The Government has committed to make children and young people's mental health and emotional wellbeing a priority. The government through the Children and Young People's Mental Health and Wellbeing Taskforce in early 2015 released the document Future in Minds, which highlighted the inconsistencies and challenges we face locally are nationally not uncommon. The document also articulated the way forward in addressing these anomalies.

1.14 Tameside and Glossop Clinical Commissioning Group (CCG) along with its partners, was selected as one of the pilot sites to respond to the challenges of children's and young people's emotional wellbeing and mental health. This response would be based on the guidelines articulated in the Future in Minds document. The transformation of the children and young people's mental health services in Tameside and Glossop is based on three key elements engagement, transparency and transformation through continual monitoring for improvement.

1.15 This Transformation Plan and strategy seeks to lay the foundations and aspirations for the ultimate vision for 2020 of having a system that is based on:

- The voice of the child - reforming care delivery based on the needs of young people, children and those who care for them;
- Developing resilience, prevention, early intervention and promoting good mental health and emotional wellbeing;
- Improving access to appropriate services that are as close to home as possible and at the right time that are implementing evidence based pathways;
- Promoting working across agencies leading to a clear joined up approach for the benefit of children and young people in Tameside and Glossop;
- Improved accountability, transparency and ownership of an integrated whole system; and
- Development of training programmes that lead to an appropriately skilled workforce across the whole system.

1.16 This is a five year programme of change and this transformation plan should be viewed as the first phase. The aims of this first plan are to reflect our collective vision and intention to work jointly, as a whole local system, over the next five years, building, refining and stretching our ambition as we progress. In readiness this plan establishes the baseline and builds system readiness to deliver the longer term sustainable system wide transformation envisaged locally and in the Future in Mind.

1.17 It is important that this plan should be viewed as a living document that will be refreshed as required and delivered through action plans for the 5 year life of this strategy. However, the vision of this transformation plan and strategy will remain the same - that is to ensure that children and young people's emotional wellbeing and mental health is 'Everyone's Business'. Throughout this document you will find examples and information as to why we need to do this.

1.18 Finally, we recognise that in producing this plan and agreeing the first phase of priorities that our focus is on mild to moderate mental health needs and specialist CAMHS provision. However to meet our aims of building resilient children, young people and communities, we will also focus and strengthen prevention, early intervention and promote good mental health and emotional wellbeing, aiming over time to develop a system in balance; ensuring a stronger focus on developing resilience, prevention, and early intervention.

Section 2: Introduction

Introduction

2.1 The seriousness of mental health issues, particularly around children and young people, is reflected by key statistics highlighted by the Office for National Statistics (2005) that one in ten children and young people aged 5-16 years old in the UK has a diagnosable mental disorder, of which five per cent have a diagnosable conduct disorder and four per cent have a diagnosable emotional disorder. Some researchers have suggested that nationally, close to 60 % of adults with a diagnosed mental illness would have been diagnosed with a mental disorder by the age of 15. The findings of the Children and Young People's Mental Health Taskforce have identified inconsistences and anomalies that have to be addressed with particular emphasis on transformation plans for mental health services being tailored to local needs, expectations and aspirations.

2.2 The recent report of the Children and Young People's Mental Health Taskforce, 'Future in Mind', establishes a clear defined and powerful consensus about how to make it easier for children and young people to access high quality mental health care when they need it.

2.3 In doing so Simon Stevens, CEO of NHS England commented in the report:

> *There is now a welcome recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked.*
>
> *Fortunately that is now changing. However, in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, over medicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I'm pleased to give it NHS England's full support".*
>
> Simon Stevens, 'Future in Mind' (March 2015)

2.4 Locally, Tameside and Glossop CCG with its partners was selected in November 2014 as 1 of the 8 Co-Commissioning National Pilots sites tasked with considering what changes and improvements are needed in the current system and identify innovative and effective solutions for achieving progress; feeding the findings into the work of the Children and Young People's Mental Health Taskforce.

2.5 Our findings locally at this time identified:

- The effective assessment of children's and young people's mental health needs is an early and crucial determinant of their subsequent pathway through an emotional wellbeing and mental health system, and their consequent use of resources.
- Concerns that open access to Child and Adolescent Mental Health Services is not always being achieved in practice. Across a larger Greater Manchester footprint there is a geographical variation in access and service offer.
- Some families and professionals find the procedures for accessing services unclear and confusing.
- Managing the emotional wellbeing and mental health of children is complex and challenging, requiring close working between multiple parties, including education. Children and young people's mental health and emotional wellbeing produce costs across the whole social system of Tameside and Glossop including Education.
- The complex fragmented nature of current CAMHS commissioning arrangements and lack of coordination between agencies held – and still does in certain parts - the potential for children and young people to fall though the net.
- Our partners, in particular but not limited to the third sector, face insecure and short term funding or have had to make cuts as a result of wider socio economic pressures and the impact of central funding reductions to local government.
- Despite these barriers to getting the right timely support, demand for mental health services for children and adolescents in Tameside and Glossop is increasing with escalating presentations around anxiety, self-harm, eating disorders and new demands from Child Sexual Exploitation (CSE).

2.6 Clearly if we are to improve and sustain access to services, then this requires more than additional funds but rather a new whole system approach that includes the active participation of all partners and key stakeholders. We hold a view that CAMHS should be seen as part of a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, Schools, Health Visiting, Youth Offending, Social Workers and Third Sector provision (to name a few). It falls beyond the resources of a single service or provider to effectively meet the emotional wellbeing and mental health needs of our children and young people. Therefore to address these mounting concerns and pressures, we recognise the need to act together, jointly, with a collective aim to improve access through a partnership approach to providing an emotional wellbeing and mental health system; improving partnership working to ensure children, young people and those who care for them have better outcomes.

2.7 The Tameside and Glossop Children and Young People's Emotional Wellbeing and Mental Health Programme Board was formed in February 2015. The

Programme Board is a partnership to lead the shared mission, vision and the ambition to improve access and support within an integrated approach to providing an emotional wellbeing and mental health system. See Appendix 1 for the Terms of Reference for the Programme Board.

2.8 Our Local Transformation Plan has therefore been developed through a strong partnership approach and the active involvement of all stakeholders, specifically children, young people and those who care for them. Further to this is the development of the participation and engagement agenda and a commitment at both the commissioner and provider level to involve children, young people and those who care for them in the emotional wellbeing and mental health service design, delivery, monitoring and evaluation.

Images 1: Ensuring young people's views from Consultation Workshops held August, 2015.

2.9 We recognise to deliver the vision and ambition set out in the plan, the CCG and its partners are committed to ensuring that the Emotional Wellbeing and CAMHS Transformation Plan is embedded within a whole system of change and development.

Connected Programmes of Work

2.10 The following programmes and have been identified that are interdependent in delivering our vision and ambition by 2020.

a) ***Child and Adolescent Mental Health Service and Schools Link National Pilot Scheme*** – Tameside and Glossop CCG and its partners were delighted to have been selected by NHS England and the Department for Education as a national pilot to improve joint working between school settings and NHS funded Child and Adolescent Mental Health Services (CAMHS).

b) ***Care Together*** – approved by Monitor in September 2015, NHS Tameside and Glossop CCG, Tameside Hospital Foundation Trust, Tameside Metropolitan Borough Council, Derbyshire County Council and NHS England are all committed to reducing demand on more intensive health and social care services by focussing on community based prevention and early intervention initiatives.

As organisations we have come together fundamentally to address the health and social care challenges faced by our population. We have created a “Care Together Programme” to redesign and realign health and care services to provide joined up care to the population of Tameside and Glossop. This will ensure that people get the right care in the right place from the most appropriate professional and within the resources available. Care Together aims to introduce a new form of provision into the Health and Care economy namely a fully Integrated Care Organisation spanning primary, community, mental health, social and local hospital based care.

c) ***Tameside Public Service Reform Hub*** – strategic vision to radically reform public services in Tameside to improve outcomes for families and residents as well as tackle issues of increased demand. *The Public Service Hub is a pooled resource from across a range of services, bringing together skills, expertise and knowledge that will:*
   - *Identify and respond to risk of harm*
   - *Prevent escalation to complex dependency*
   - *Support people to live well and be self-reliant*

   CAMHS Practitioners are embedded within the Hub and we are exploring options to develop this further into a single point of entry into all children’s services to ensure there is no wrong door.

d) ***Greater Manchester (GM) Devolution*** – the twelve GM CCGs, ten Councils and all health and social care providers have a long history of working effectively together and the Devolution Agreement brings new opportunities to do this. The CAMHS elements that we hope to progress include:

   - GM Commissioning of in-patient beds and alternatives to admission
   - GM Commissioning of Specialist Perinatal Mental Health Inpatient and Community Provision, including alternatives to admission
   - GM Self Harm and Suicide Prevention Strategy
   - GM Crisis Care Concordat updated to strengthen crisis support to children and young people, and develop consistent access to age appropriate crisis support
   - GM Starting Well Strategy including the Early Years New Delivery Model – aims to continue to roll out this evidence based approach to services in pregnancy and early years to promote the capacity of families to ensure their children are ready for school. Parent Infant Mental Health is at the heart of this model.

e) ***The GM Transforming Care for People with Learning Disabilities Fast Programme*** – we have been a partner in the development of the Greater Manchester Transforming Care Fast Track Programme and are committed to including the need of children, young people and their families as well as those of adults. Within our CAMHS Transformation Plans we have included an Early Intervention Project for children with challenging behaviours, looking at how we can use our resources within CAMHS, schools, children’s services and the community more effectively in

childhood to improve outcomes and reduce the numbers requiring high cost out of area health and social care placements. This includes ensuring that our At Risk Register and Plans includes consideration of children and young people as well as adults.

f) ***Tameside Early Years New Delivery Model (EYNDM)*** - aim is to provide integrated early years services delivered by health, education, early help, social care, private and voluntary service partnerships to improve outcomes and school readiness for the under 5's

g) ***Pennine Care Commissioning Footprint*** – the six CCGs who commission CAMH provision from Pennine Care NHS Foundation Trust work closely together with the Provider to co-commission quality CAMH services. We are currently working together to jointly commission Specialist Community Eating Disorder services in line with NHSE Standards.

h) ***CQUINs*** - Commissioning for Quality and Innovation (CQUINs) payments framework encourages NHS healthcare providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. We are utilising this framework to reward excellence, by linking a proportion of NHS healthcare providers' income to the achievement of local quality improvement goals. CQUINs have been established that seek:
- Improved access and partnership working delivering improved/stretched waiting times targets or CAMHS; and
- Children's integrated care pathway delivering integrated pathways for children with long term conditions / complex needs, which is delivering an integrated Self Harm pathway, from the Emergency Department to admission onto the paediatric ward of the Tameside Hospital Foundation Trust.

i) ***Local Safeguarding Children's Board (LSCB)*** – Tameside LSCB have established their priorities below for 2015-18. They have been developed based on the needs identified through quality assurance activities and case reviews during 2014/15 and from the TSCB Annual Report 2014/15.

- Domestic Abuse - To develop and deliver an educational awareness programme to universal services
- Child Sexual Exploitation - To ensure that a tiered package of support is available for victims of CSE and increase awareness of CSE amongst children and young people, parents and community
- Self-Harm – To develop and promote a self-harm and preventing suicide policy in conjunction with a package of self-harm and suicide training and support and work with the Emotional Wellbeing and Mental Health Board to develop the referral pathways and service offer for CAMHS.

j) ***NHS England Mental Health Access and Waiting Time Standards*** – children and young people's needs are being taken into account within our local plans to meet the new/emerging standards for:

- ***Liaison Psychiatry*** – within our review of RAID services in our local acute Trust we are reviewing access to CAMH specialists with a view to ensuring parity of esteem for children and young people. This includes 7 day access to crisis support, direct pathway into CAMHS, avoiding A&E and CAMHS support to our Street Triage programme.

- ***Early Intervention in Psychosis*** – we are ensuring that our EIP developments take into account the NICE Ante and Post Natal Mental Health recommendations and that our Integrated Parent Infant Mental Health Pathway is effective for all EIP service users.

- ***Improving Access to Psychological Therapy*** – Healthy Minds, our local IAPT service, has a Babies Can't Wait policy so all pregnant women or those with an infant under the age of two, and their partners have direct access to a range of psychological therapies. The IAPT service works with young people from the age of 16, including supporting those in colleges.

- ***Eating Disorders*** – we are working with other CCGs and the provider to establish a specialist eating disorder service for all young people up to the age of 18 in line with NHSE Standards. We are also aiming, with additional CCG investment, to extend the age range to 25 years for those who need it, to ensure that there will be no need for a transition at the age of 18.

- ***Perinatal Mental Health*** – we are refreshing our Integrated Parent Infant Mental Health Pathway in line with the Antenatal and Postnatal Mental Health NICE Guidance and are preparing to work in partnership within Greater Manchester to meet the imminent NHS England Perinatal Mental Health Standards.

k) ***Parity of Esteem*** – the CCG is committed to continuing to aim for more equal distribution of resources between physical and mental health disorders and ensuring the association between the two are supported in all commissioning.

l) ***SEND Reforms*** - places duties on local authorities and other services in relation to both disabled children and young people and those with Special Educational Needs (SEN). As part of the reforms the CCG is seeking to expand the offer of a personal health budgets, from April 2016, wider to those children and young people with Education Health and Care Plan (EHC Plan).

Section 3: Future in Mind - Our Vision and Ambition

Our Vision

3.1 The vision for Tameside and Glossop is for a children and young people's emotional wellbeing and mental health system that is truly personalised, joined up, supports all children and young people to stay well and provides the very best support and care when and where they need it. For children, young people and those who care for them this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs.

3.2 We want to create an integrated system where every child and young person in Tameside and Glossop receives the best, consistent, care and support; delivered as locally as possible - in our communities - with services designed in a joined up way so that they are seamless. This requires us to establish a comprehensive system wide approach to providing support and care, which puts children, young people and those who care for them first and to ensure a better understanding of all of a child or young person's needs. This is what we understand is to be truly holistic and person-centred, which necessitates the child and those who care for them being at the heart of our approach.

3.3 Currently we know there are inconsistencies in the way support and care is planned, commissioned and delivered across the many partners involved. Children, young people and those who care for them tell us that they experience time delays, duplication, fragmentation and a lack of clarity and uncertainty. With growing demand and rising expectations, the current system is generally seen as unfit for purpose and it is not sustainable. We need to develop a coordinated and integrated approach to children and young people's emotional wellbeing and mental health to improve experiences and achieve better outcomes.

3.4 We believe that emotional wellbeing and mental health is not about feeling positive all the time or solely focusing on providing treatment following assessment or diagnosis, but having the resilience and ability to cope from an early age through childhood and into adulthood. We recognise that mental health is as important as physical health, indeed it is the foundation of physical health. We acknowledge that it is not the responsibility of one agency or profession but about all organisations genuinely working together to meet the needs of the child, young person and those who care for them. We must have services that are accessible to all children, young people and those who care for them regardless of background or make up. We need to take active steps to reducing the barriers to support. Our children's emotional wellbeing and mental health is everyone's business.

3.5 To deliver our vision we must take a truly joined approach to commissioning and service delivery that ensures stakeholder engagement at all times. To underpin the transformation of the system we are committed to placing children, young people and those who care for them at the heart of change. To achieve this we will look to sustainable creative and innovative ways to make this happen.

Our Principles

3.6 Our principles are based on participation and collaboration. To help create and underpin our vision and ambition we have listened – and will continue to do so - to children and young people who have told us what they want and what we will aspire to deliver. Their voice provides us a set of quality standards (KPIs), which will be seen as the right of any child or young person who maybe experiencing emotional wellbeing and/or mental health issues. See Appendix 2 for the voice of the child full findings.

The Voice of the Child	
1.	I should be listened to, given time to tell my story and feel like what I say matters
2.	I want my situation to be treated sensitively and I should be respected and not feel judged
3.	I want the professionals that I come into contact with to be kind and understanding and realise that I need to trust them if they are going to help me
4.	I should always be made to feel safe and supported so that I can express myself in a safe environment
5.	I should be treated equally and as an individual and be able to shape my own goals with my worker
6.	I want my friends, family and those close to me to understand the issues so that we can support each other
7.	I want clear and up to date detailed information about the services that I can access
8.	I want to get the right type of help, when things first start to be a problem, at the right time in the right place and without having to wait until things get worse
9.	I want to feel that services are shaped around my needs and not the other way round, but I also want to know that I am not alone in how I am feeling
10.	I want my support to feel consistent and easy to find my way around, especially if I need to see different people and services

Our Ambition

3.7 Our vision requires the following aims to be achieved:

- To improve access and partnership working to bring about an integrated whole system approach to promoting emotional well-being and resilience and meeting the emotional wellbeing and mental health needs of children and young people.

- To ensure children, young people and families have:
  - Access to timely and appropriate information and support from pregnancy to adulthood
  - Clearly signposted routes to support, including specialist CAMHS
  - An 'open door' into a system of joined up support that holds a 'no wrong door' approach, which is easy to navigate
  - Clear understanding of the service(s) offer (what support should be received and what the expected outcomes are)
  - Timely access to this support that is as close to home as possible

- To maintain a commitment to promotion of emotional wellbeing and mental health prevention of problems developing through whole system approaches and aligned strategic programmes, such as:
  - Continued roll out of the Early Years New Delivery Model for all families including those with High Needs.
  - Integrated parent infant mental health provision from pregnancy across all partners.

3.8 We recognise our aims to improve access and partnership working through an integrated whole system approach to meeting the emotional and mental health needs of children and young people holds a number of inherent challenges. We know that delivering better coordinated care and support centred on the child or young person's needs is challenging and there are barriers at national and local level. The fragmented nature of current CAMHS commissioning arrangements, lack of coordination between agencies and explicit organisational boundaries holds the potential for children and young people to fall though the net, which has been highlighted in several recent national reports and, sadly, serious case reviews. As such the new approach will increase capacity of the whole system to promote emotional and mental well-being while at the same time, also strengthening our specialist services and referral pathways to make them more effective and accessible. It will deliver a clear offer to meet the emotional wellbeing and mental health needs of children and young people through partnership service delivery. This will require the on-going development of skills, knowledge and support plus pathways across an array of services including schools, health, social care, third and public sectors.

3.9 In addition, we recognise the increasing evidence and compelling arguments for a focus on early intervention - preventing mental health problems escalating and becoming entrenched through joined up timely early help and support. We

will ensure the early effective assessment of children's and young people's emotional wellbeing and mental health needs by providing access to the 'experts' across the system; particularly placing them where children and young people are most vulnerable so that there are no gaps through which they can fall. Where children and young people require support we will equip all front line staff to be able to identify and respond to mental health issues within an agreed framework for intervention providing clear pathways and access supported by an assertive consultation, information, advice and guidance (IAG) model.

3.10 Through these steps our fundamental ambition is to improve access so that children and young people have easy access to the right support from the right service at the right time and this is as close to home as possible. This includes implementing clear pathways for community based care and crisis intervention to avoid unnecessary admissions to hospital and inpatient care. Where children and young people are cared for based on their needs and not through a system on how agencies organise '*their*' services. Our ambition requires the voice of child to be held at the heart of change. We will ensure meaningful involvement of children, young people and those who care for them. They are the experts by experience.

3.11 We recognise this is a five year programme of change and our challenge and successes to date should be viewed as the start of a longer planning process with subsequent updated action plans to follow; ensuring a phased approach that address not just system changes, but also develops the culture for sustainability and learning. Our ambition and vision set out in this plan has been decided at a local level in a co-production between children, young people and those who care for them, our commissioner and providers.

3.12 Our journey is very much aligned to the Governments aspirations for 2020 and the key themes and recommendations outlined in the 'Future in Mind'. As such in this plan we bring together the local vision and ambitions reinforced and expand upon them, with the key themes and recommendations from the 'Future in Mind'.

In summary, the themes are:

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

Future in Mind recommends that by 2020 Government wishes to see:

1. Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people. Also where there is less fear, and stigma and discrimination are tackled.
2. In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.

3. Moving away from a system defined in terms of the service organisations provide (the ‘tiered’ model) towards one built around the needs of children, young people and their families.
4. Increased use of evidence-based treatments with services rigorously focused on outcomes.
5. Making mental health support more visible and easily accessible for children and young people.
6. Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.
7. Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.
8. A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.
9. Improved transparency and accountability across the whole system, to drive further improvements in outcomes.
10. Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

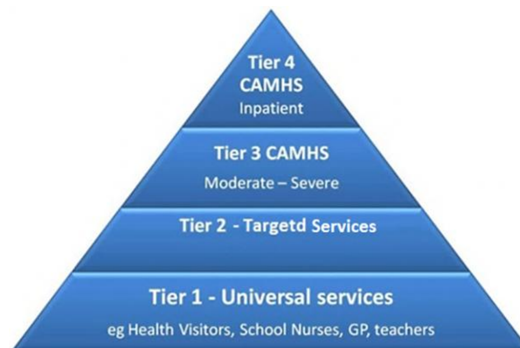
Section 4: Where Are We Now?

4.1 In this section we summarise where we are in 2015, as regards the current delivery, in relation to the emotional wellbeing services for children, young people and those who care for them. We provide an overview on the transformation that has occurred to date and the investment that goes into these services.

Phase 1 (2015-16) CAMHS Redesign - Moving to a system without tiers.

4.2 At the beginning of 2015, we embarked upon Transforming CAMHS with the mandate outlined in our vision and ambition set in Section 3. In response the Stepped Care Framework for Children's Emotional Well-being Mental Health in Tameside and Glossop initiated the start on the redesign of CAMHS, moving the service from the Tiers of Need model, shown in *figure 1* below to a new model for CAMHS. The Tiers of Need was developed as part of the first national review of CAMHS in 1995. The tiered model for CAMHS provided at the time a useful means for helping differentiate between the forms of support that might be available to children and young people. However it is now increasingly criticised for providing barriers to getting help and support; through its denoted thresholds and the escalator journey required to getting the 'expert' help at the end of the journey and not the start.

Figure1. CAMHS Tiered Model (NHS HAS 'Together We Stand' 1995)



4.3 The new framework in 2015, shown below (*Figure 2*), was innovative by nature and focuses on a community based, Stepped Care approach promoting prevention, early intervention and supporting the Early Help agenda across Tameside and Glossop. The model is based on the notion of 'Flexible Rigidity'. This concept offers some key principles around consultation and liaison, brief intervention and clear pathways for sentinel conditions i.e. ASD, ADHD and long term conditions, which are flexible enough to be tailored to, and meet the needs of different children, young people and families, communities and neighbourhoods.

Figure2: The Stepped Care Framework for Children's Emotional Well-being Mental Health (Pennine Care Foundation Trust, 2015)

4.4 The stepped care model is heavily focused on helping workers within Universal and Early Help services, GP's and other children's services to develop skills to support the promotion and management of children's emotional health within communities. The service model seeks to support staff in children's services e.g. Youth Offending Teams, Primary Care Health Services and Children's Social Care, as well as GP's and schools to develop the required skills by the provision of consultation, liaison and training offers delivered by workers from what is currently known as the specialist CAMHS service. These consultations offer and serve as gateways for children's emotional health pathways at higher steps of the model, with the exception of the urgent care pathway. At steps 2 and 3, assessments, limited individual brief intervention and a group offer should be available and the goal is for capacity to be developed in other agencies following this year's non recurrent investment provided by the CCG to deliver these interventions. At step four, a time limited, goal and outcome focused CAMHS pathway will be available and delivered predominately by CAMHS clinicians. Partnership engagement will be essential to achieve full implementation of this way of providing emotional wellbeing and mental health services in the medium to long term.

Phase 2 (2016-17) CAMHS Redesigned - THRIVE model for CAMHS

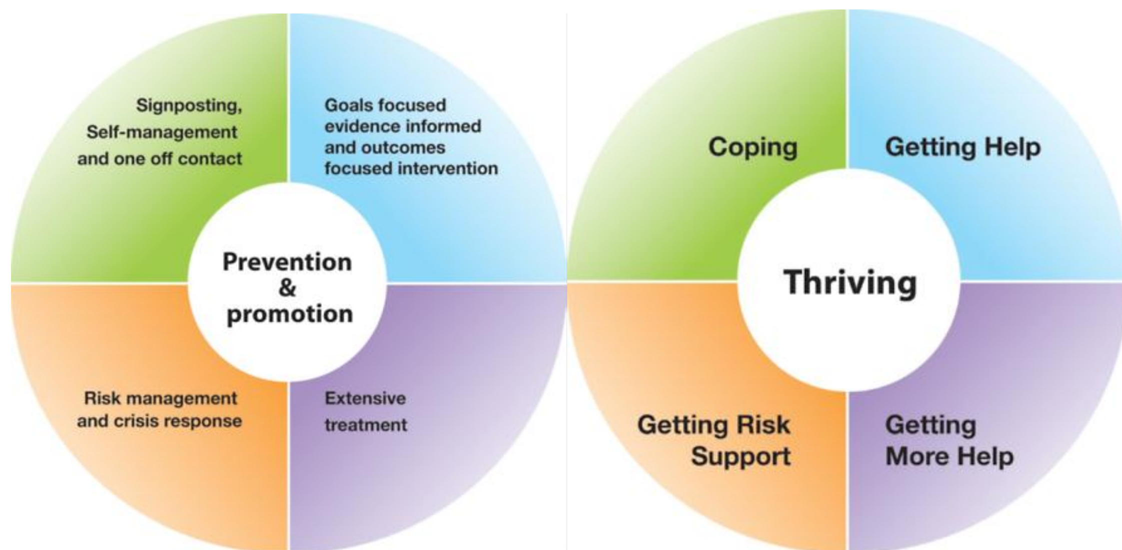
4.5 In the back drop to our initiated local CAMHS redesign, the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre have been collectively and individually considering what CAMHS could and should look like for some time. In 2014, they formed a consortium to further develop and refine a new model for CAMHS based on shared thinking in this area: this is now known as the THRIVE model. The Thrive Model is growing in support to replace the previous CAMHS tiered model with a conceptualisation that is aligned to emerging thinking on multi agency partnership working, providing timely support not based on diagnosis but to meet the emotional wellbeing and

mental health needs of the child or young person. It seeks to ensure that the most experienced professionals with expert knowledge of children and young people's mental health are accessible from the start and not at the end of a journey based on escalation. The model outlines groups of children and young people and the sort of support they may need and draw a clearer distinction between treatments on the one hand and support on the other.

4.6 Rather than an escalator model of increasing severity or complexity, they suggest a model that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices. The Thrive model below (*figure 3*) conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community.

4.7 The image below to the left describes the input that is offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service use.

Figure3: The Thrive Model for CAMHS (The Tavistock and Portman NHS Foundation Trust the Anna Freud Centre November 2014)



In our approach we will deliver a phased change in how care is provided – moving away from a system defined in terms of the services' organisational structures towards one built around the needs of children, young people and their families. Our emphasis is on building resilience, promoting good mental health and wellbeing, prevention and early intervention and ensuring timely treatment support; through cohesive multiagency and integrated working.

The Current Local Offer (September 2015)

4.8 In this following subsection an overview is provided on current local services, in 2015-16, providing interventions to build resilience and to reduce risk around emotional wellbeing and mental health. The Local Offer is produced here under four domains: Local NHS services, Local Authority, Third Sector and Schools.

Local National Health Service (NHS)

Children and Adolescent Mental Health Service (CAMHS) *(Pennine Care Foundation Trust)*

4.9 Tameside & Glossop child and family therapy service (CAMHS) supports families and professionals who are concerned about children and young people who may be experiencing mental health difficulties. They see young people at all levels of ability. Some of the difficulties this team can help with include:

- Depression
- Self- Harm
- Anxiety Disorders (including phobias)
- Obsession/Compulsive disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Eating Disorders
- Trauma, including Post-Traumatic Stress Disorder (PTSD)
- Psychosis
- Bi-Polar disorder

The service is made up of a team of mental health professionals, staffed by child and adolescent psychiatrists, clinical nurse specialists, psychologists, family therapists and mental health practitioners. There are staff who specialise in working with young people with a learning disability.

The team can offer short term consultation and intervention to parents/professionals. They work individually with young people and their families. They offer urgent same day consultations to professionals worried about a child's risk via a duty system. The length of support offered is based on the child's and family's needs.

The service is working in partnership with the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) as part of a Learning Collaborative. Currently staff have and are receiving training in psychological therapies that are NICE approved. In addition the service offers a broad range of interventions, Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Interpersonal Psychotherapy (IPT), Family Therapy and medication (prescribing).

Any professional involved with a young person is able to refer to CAMHS with the appropriate consent. Referrals are screened daily; at this point some referrals will be re-directed to a more appropriate service (for service accomplishment see 4.65).

Inpatient (Tier 4/Getting Risk Support) Children and Adolescent Mental Health Service (CAMHS) *(Pennine Care Foundation Trust)*

4.10 Pennine Care Foundation Trust provides Tier 4 services in two inpatient units. The Hope Unit is an acute unit which provides short term crisis intervention to young people aged 13 – 18 years whose mental health needs cannot be managed safely in the community. Typically the length of stay in this unit is 6 – 8 weeks with the aim of formulating mental health needs, identifying appropriate support and intervention pathways, stabilising a young person's mental state and managing risk. The Horizon Unit is also a unit for young people aged 13- 18 with more complex and enduring mental health needs. Typically the length of stay in this unit is 9 months plus in order to provide treatment and rehabilitation to young people and their families.

The North West as a region can be seen as well-resourced in terms of inpatient provision with other inpatient units available that are provided by other NHS Trusts.

Early Attachment Service (EAS) *(Stockport NHS Foundation Trust, Pennine Care NHS FT and Home Start).*

4.11 Led by a CAMHS Consultant Clinical Psychologist, the Tameside and Glossop Early Attachment Service (EAS) was established in 2007. It is based on a unique model that is comprehensive, cost-effective and sustainable. It aims to meet the needs of parents, including those who need a high level of professional expertise and skill to help them, as well as those who would benefit from simpler information and support. The overarching principle of the Tameside and Glossop Early Attachment Service (EAS) is "holding the baby in mind", from a universal level to targeted individual parent-infant relationships, from the antenatal to postnatal period, across services, and with all professionals and families; placing the baby at the centre of everyone's thinking in the community. The service works with families from pregnancy through to the child's third birthday; the small core staff team working in close partnership with midwifery and health visiting, who are trained and supervised in parent-infant mental health, enabling them to become proficient in the use of a range of universal interventions, and also in early identification when problems emerge. An embedded Home Start worker also supports parents.

Healthy Minds (Improving Access to Psychological Therapy Service) *(Pennine Care Foundation Trust)*

4.12 Provides a Tier 2 and 3 Improving Access to Psychological Therapy (IAPT) Service to people from the age of 16, offering support and treatment for those who are experiencing symptoms such as difficulty sleeping, low mood / depression, stress, worry or anxiety, feelings of hopelessness or panic attacks.

The team also helps those dealing with the effects of a long-term health problem or chronic pain, Post Natal Depression, Obsessive Compulsive Disorder, phobias, or eating difficulties.

School Nursing Service *(Stockport NHS Foundation Trust)*

4.13 Children who are happy and healthy achieve more at school. The School Nursing Service aims to promote optimal health, well-being and opportunities for all children and their families within Tameside and Glossop. The service works closely with children and their families and carers, schools and other agencies to provide a child focused flexible, accessible service to meet their health needs.

The School Nursing Service aims to provide:

- Named school nurse for each high school
- Drop-ins at all high schools
- Support all school aged children and young people to attain good emotional, physical, sexual and mental health
- Healthy Child Programme: 5-19 years
- Supporting children, young people and families to navigate the health and social care services to ensure timely access and support;
- Promoting emotional wellbeing through the school-age years working alongside children and young people to support those with emotional and mental health difficulties, referring to CAMHS where appropriate;
- Care and support to keep children and young people healthy and safe within their community.
- Early identification of children, young people and families where additional evidence based preventive programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing;
- Working in partnership with primary and secondary care colleagues to support children and young people with long term conditions or complex needs and facilitate appropriate management of health conditions to ensure hospital admissions are kept to a minimum;
- Provide advice and support to parents and carers to enable them to address their needs and those of their children
- Work collaboratively with colleagues and with other professionals in order to deliver the best possible service to children and young people
- Educate school staff in the management of children and young people with long term conditions

Health Visiting *(Stockport NHS Foundation Trust)*

4.14 The service works to keep parent and child healthy and provide advice and support to parents and carers until children reach school age. They offer support to all new mothers around all aspects of childcare, infant feeding and post natal depression. Health Visitors work with partner agencies to offer

support and work with families as required protecting vulnerable children and families, with particular emphasis on early intervention. They offer consultation and advice on immunisation, contraception, smoking cessation, alcohol consumption and all aspects of childcare.

Health Visitors aim to provide:

- All children 0-2 have a named Health Visitor
- All Parents receive an 6-8 week Edinburgh Postnatal Depression Scale assessment
- New born Behavioural Observations (NBO) and Neonatal Behavioural Assessment Scale (NBAS) provided
- Listening visits - for parents with emotional issues
- Out of the Blues groups run by HVs
- Family Health Mentors

Integrated Service for Children with Additional Needs (ISCAN) *(Stockport NHS Foundation Trust and TMBC)*

4.15 This multi-disciplinary team comprises of Occupational Therapy, Physiotherapy, Speech and Language Therapy Learning Disability Nursing, Complex Needs Nursing, Social Workers and Nursery Nurses. The Integrated Service provides:

- Nurses and therapists that work as lead professionals for parents with children with identified disabilities.
- Packages of care provided for children, young people and their families to ensure healthiest outcomes are achieved in the areas of physical, cognitive and emotional development.
- Speech therapists work with children with communication needs and neurological disorders such as Autism. Therapy focusses on improving communication environments and developing skills (Children with language disorders more likely to have mental health issues).
- Family Therapy to support parents to manage communication deficits.
- Speech and Language Therapy providing interventions for young people within the youth justice team.
- Provides evidence based therapy and nursing interventions within schools, homes and other settings.
- Trains parents, teachers and other professionals around the needs of the child.

Paediatrics Services *(Tameside Hospital Foundation Trust)*

4.16 The children's ward comprises of a 21 bedded inpatient unit, 8 bedded day case unit. They provide nursing care for children aged between 0 to 16 years of age (in secondary education) with a variety of medical, surgical, orthopaedic, ENT, dental and gynaecological problems. On the unit they are able to provide care for children and young people requiring a higher dependency of care. The team comprises of experienced paediatric nurses and auxiliaries who provide

holistic family centred care 24 hours, 7 days a week. The team works closely with all members of the multi-disciplinary team in order to deliver evidence based care to a high standard which ultimately empowers children, young people and those who care for them in preparation for discharge.

Referrals are accepted from General Practitioners, Accident and Emergency Department, the Observation and Assessment Unit and other health professionals. Patients are not able to self-refer to this service.

Primary Health Care (GPs)

4.17 Primary Health Care provides the first point of contact in the health care system. In the NHS, the main source of primary health care is general practice. Across Tameside and Glossop there are 41 GP practices that offer for registered patients appointment times for medical advice, examinations and prescriptions. GPs also provide an out-of-hours service via contact the practice directly.

The aim is to provide an easily accessible route to care, whatever the patient's problem. Primary health care is based on caring for people rather than specific diseases. This means that professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social problems, rather than specialists in any particular disease area.

Local Authority Offer (TMBC)

Behaviour for Learning and Inclusion Service (BLIS) *(TMBC)*

4.18 BLIS plays an important supporting role, providing schools with support which is both preventative and also directly supporting children with emotional, behavioural and social difficulties (EBSD). It offers:

- Supports students with Education Health Care Plans where EBSD is a priority need.
- Provides six day cover for Primary excluded pupils.
- Provides support for Key Stage 1 pupils at risk of a permanent exclusion/permanently excluded.
- Supports the identification of pupils with BESD adopting offering an overview of need through a comprehensive in depth assessment process ensuring a multi-agency approach response and building capacity in school.
- Offers advice, support and training to schools, their pupils, parent/carers and governors in the promotion of positive behavioural, emotional and social development (BESD) and the effective management of behaviour.
- Supports through training, advice and sharing of good practice the promotion of an ethos which encourages and facilitates positive BESD including the recognition of the link between good teaching and

learning and an emotionally healthy school where pupils are able to achieve.

- Where appropriate acts as a critical friend in terms of identifying and supporting the needs of children and young people and monitoring and evaluating school interventions.
- Facilitates, where appropriate, referral for further assessment/involvement of other professionals and access to support through a multi-agency approach.
- Supports identification of pupils at risk of exclusion and support for reintegration of those who have been excluded.

Communication Language and Autistic Spectrum Support Service (CLASS) *(TMBC)*

4.19 This service enables pupils with Social Communication Difficulties including Autistic Spectrum Disorders (ASD) or with Specific Language Impairments (SLI) to reach their maximum academic and social potential in an inclusive educational environment. It offers:

- Support for pupils with an Education Health Care Plan where ASC is a priority need
- Advice and support for school staff on specific and appropriate targets and strategies for pupils with diagnosis of Autistic Spectrum Disorder (ASD), Asperger Syndrome or with Social and Communication Difficulties
- Liaison with professionals, parents and carers
- Monitoring and review of progress
- Support for transitions, especially KS2 to KS3 and KS4 to KS5
- Provision of recommendations regarding future placements and support
- Training is provided on particular skill development:
- General ASD awareness
- Delivery of Social Skills Programmes (KS1, KS2 KS3 and KS4)
- Pupil focused sessions for all staff

Children's Social Care *(TMBC)*

4.20 The main responsibility of the service is to safeguard and promote the welfare of 'Children in Need'. Children subject to protection plans remain vulnerable to mental health issues; they remain living in family environments where neglect or abuse has been identified. This is often due to parental substance misuse and or mental health impacting on parenting ability and in turn on the emotional wellbeing and mental health of the child.

The Government sets standards that Children's Social Work has to meet. These include:

- The child and family assessment must be completed within 45 working days.

- Families are usually entitled to have a copy of the assessment.
- Families will be given clear information about the services which are available as a result of the assessment.
- Children are at the centre, their wishes, views and voice will be heard and will inform the assessment and plan.
- Social workers must work in partnership with parents.

Tameside Youth Offending Team *(TMBC)*

4.21 The Youth Offending Team is made up of professionals from several different organisations in Tameside, working with young offenders aged 10 -17 and their families within the borough.

The main aim of the team is to prevent children and young people from offending. The team provides the following services:

- Working with young offenders who receive Out of Court disposals (formerly Police Cautions).
- Providing a variety of services to the Tameside Youth Court including - writing Pre-Sentence Reports; the supervision of Court Orders.
- Restorative justice work as part of the above orders.
- Supervision of young offenders during and after custody.

Service for Children with Disabilities and their Families

4.22 Jubilee Gardens is a resource centre for children with disabilities and their families. They work directly with families to look at needs and identify appropriate support where needed. The Centre's facilities include:

- Play sensory room, SNOEZELEN® Room, filled with special lights, soothing music, a variety of textures, mirrors and sounds. The floors and walls are cushioned and there are special chairs that are placed for relaxation.
- Staff from the ISCAN (Integrated Service for Children with Additional Needs) are based at the centre.

Third Sector

4.23 The following provides details of third sector offers and the organisations who are delivering emotional health and wellbeing services and activities across Tameside and Glossop. The organisations featured here are delivering targeted services under the Thrive model of Coping to Getting Help. There is a wider group of third sector organisations who deliver emotional health and wellbeing work as a part of their positive activities offer, these organisations are currently being mapped and a service directory will be available from the CVAT website by the end of 2015.

42nd Street

4.24 It is a regional charity that provides services to young people under stress. They work with young people between the ages of 11-25 living in parts of Greater

Manchester, providing a range of services including one to one counselling, therapy and psycho-social support. They also offer targeted and needs led group work and offer a growing creative programme. Currently in Tameside and Glossop a 42nd Street counsellor is seconded to CAMHS to provide 2 days of counselling per week for aged 16+ in Tameside College, Hyde Clarendon and Ashton 6th Form supporting transition.

The Anthony Seddon Fund

4.25 It is a Tameside Charity involved in raising funds for mental health & wellbeing projects in our local area. The charity is passionate about helping people who are living with mental illnesses and the effects. The charity aims to raise awareness and challenge the stigma, discrimination and lack of resources endured by those with mental health issues in our community. The Antony Seddon Fund work in partnership with other agencies to provide therapeutic services to young people at risk of suicide or associated issues (self-harm, low mood, low confidence etc.). Services provided through the following groups/projects are:

- Rethink Mental Illness Family & Friends Group - Suitable for people who provide support to someone with a mental health diagnosis, age 18+
- One-to-one Counselling Sessions age 13 – 28 years
- Therapeutic Art-based Project age 7 – 11years Sunshine Social Group – a peer led drop-in group – suitable for people with low level mental health issues
- Time to Change - LGBT Youth Group – starts in July 2015

Off the Record (OTR)

4.26 Delivers the Emotional Wellbeing Service in Tameside for Young People aged 10 to 25. OTR currently provides:

- A person centred counselling service based in Hyde and at other young person friendly venues, including; supported accommodation projects and with partner organisations, e.g. the Anthony Seddon Trust and Cavendish Mill.
- Two drop-ins for young people 'in immediate crisis', offering brief interventions. In November 2015 there will be an additional internet based Skype Drop-In.
- Schools based counselling service, with counsellors based in 6 primary and secondary schools in Tameside.
- The 'Time-2-Talk' projects offering specialist counselling provision for young people who are the victims of Domestic Abuse or Child Sexual Exploitation. These projects are funded through Comic Relief and the Step Up Programme.
- A new internet based service to be launched in November 2015 – www.wtfaffirmation.co.uk. Young people and their families will be able to access advice and guidance through a message board and a range of 'self-serve' tools called Affirmations.

- The ‘What Makes You Tick?’ is an accredited personal development training programme. The training programme targets the victims of domestic abuse, CSE and young people working with YOT.

Tameside Oldham and Glossop Mind

4.27 It is a mental health charity covering Tameside and Glossop (*and Oldham*), providing counselling and therapeutic group work and activities.

- Currently providing emotional wellbeing and mental health awareness assemblies in all secondary schools in Tameside.
- Providing resilience building workshops in all secondary and 30 primary schools.
- Part of National Department for Education pilot in 5 Tameside schools offering workshops and facilitated self-help services.
- Counselling, Therapeutic courses and solution focused therapy also provided in Oldham schools and self-funding Tameside schools.

Lifeline

4.28 It is a national charity which in Tameside is providing a Tier 3 young people’s substance use treatment service, working with young people up to the age of 25 that also includes family support and interventions.

- A TMBC Public Health project in conjunction with the Child Sexual Health team is planned from September 2015, focusing on Year 8 pupils identified with risky behaviours.
- Strengthening Families (parenting programme for families with alcohol or substance misuse) project is funded until July 2015.
- Hidden Harm project supporting Young Carers.

Papyrus

4.29 It is a national suicide prevention charity focussing on young people and young adults

- It has a project in Tameside training a group of 20 young people to provide support in the community for self-harm and potential suicide.

Making a Difference Tameside

4.30 Provides fully trained workers in mental health and coaching skills provide individually tailored practical support to people in their own homes including household management, cooking and budgeting. Volunteers and fellow members from the workshop also help with decorating and maintenance work. Working towards goals and needs identified by the person themselves their support workers assist, enable and empower them to be more confident and independent. The workshop is a dynamic, supportive yet challenging centre which seeks to develop self-esteem and relationship skills through a range of

social and vocational activities. The approach is built on befriending, participation and the ethos of a “therapeutic community”.

Home Start

4.31 Home-Start is a family support charity that works with families who are suffering from stress and who have at least one child under the age of five. They are an early intervention charity that aims to support parents to give their children the best possible start in life, to improve the ability of parents to care for their children, and to prevent family crisis and breakdown by ensuring the health and social needs of families are met. They do this by recruiting, training and supporting volunteers (who are all parents themselves) to go into family homes for a few hours on a weekly basis to offer practical help and much needed emotional support. Home-Start has a dedicated Parent Infant Mental Health worker who is a member of Tameside’s Early Attachment Service and who works primarily with families with children in the 0-2 period.

4.32 Many of the families supported by Home-Start are affected by mental health issues, including post natal depression, as well as other mild to moderate mental health issues that affect a parent’s confidence, self-esteem and motivation. Through the support and reassurance of their volunteer, families are enabled to widen their support networks, to gain confidence and self-esteem and to establish routines that lead to a more settled home life. Parents consistently report feeling more able to cope as a result of Home-Start support and the emotional wellbeing of parent and child is greatly enhanced.

Crossroads - Harmony Home

4.33 Harmony Home is a refuge for women aged 16-24 that provides transitional housing for women who are in the process of recovery providing a number of programmes of support/Interventions from substance abuse treatment, to psychological assistance, domestic abuse. It operates a support group for children aged 5 – 15 who have experienced domestic abuse.

Life You Choose

4.34 Life You Choose is a Community Interest Company (“CIC”), which is required to use its profits and assets for the benefit of the community rather than for private gain. It was set up to create and discover opportunities within the Glossop community for people with learning disabilities. It provides a social group focussing on media related activities for those with learning disabilities.

Hidden Gems - Glossop Autism Support Group

4.35 The aim of the group is to provide support, guidance, encouragement and inclusion for families and their children who are affected by ASD and all related conditions. They promote a safe, relaxing and non-judging environment where children and their parents, carers can meet to share advice and for all the family to make new and local friends. They offer support for children aged 4 - 15 years old and their siblings. The group is open to parents, relations and carers and their children who have Autism Spectrum Disorder, Attention Deficit

Hyperactive Disorder, DAMP, SPD, Dyspraxia and all related conditions including behavioural issues and delayed development. Families awaiting a diagnosis for their child are also welcomed.

4.36 Taking the term ‘emotional wellbeing’ in its widest sense to mean being happy and confident, able to build good relationships with others and have the emotional strength required to be resilient, then the following range of activities in the third sector, which could be classed as supporting wellbeing, may be relevant:

- Sports Clubs: There are a wide range of sports clubs across Tameside and Glossop.
- Uniformed Groups e.g. brownies, guides, rainbows, beavers, cubs, scouts, explorers, army cadets. There are packs in Hadfield and Glossop plus an army cadet base in Glossop.
- Youth Groups: Millennium Cellar, Simmondley Youth Projects Group, Youth Café at Jericho Café, Gamesley. Also a number of Church based groups for children and young people e.g. Methodist Church, St Lukes, St Andrews.
- Drama Groups: Partington Players.

Schools Offer

4.37 The Future in Minds proposes that there is a dedicated named contact point in targeted or specialist mental health services for every school that seeks to improve communication and access. Tameside and Glossop CCG and its partners are working with NHS England and the Department for Education to test the named lead approach and training programme. The CAMHS and school link scheme will support the promotion of mental health awareness, thus empowering staff within education to more confidently identify mental health difficulties, leading to more timely assessments and more effective interventions at the ‘getting help’ stage of the Thrive Model. NHS England and the Department for Education have recruited a training organisation to develop and deliver a joint training programme that aims to:

- Raise awareness and improve knowledge of mental health issues amongst school staff;
- Improve CAMHS understanding of specific mental health and well-being issues within schools; and
- Support more effective joint working between schools and CAMHS.

We expect the training to be undertaken in the autumn term 2015 and spring term 2016.

4.38 The following provides details of individual school offers that have been received during the schools mapping programme prior to the national pilot scheme outlined above. These individual school offers build upon and/or liaise with the service offer’s outlined in paragraphs 4.18 and 4.19 (BLISS and

CLASS services). In addition the CCG, Tameside and Glossop CAMHS and the ADHD Foundation have ensured training to over half of the schools' teachers who hold the function of Special Educational Needs Co-ordinator (SENCO's) in around ADHD and its application within a school setting.

Astley Sports College / A + Trust Schools

4.39 Work directly with Pennine Care NHS Foundation Trust CAMHS offering the school trust an enhanced emotional wellbeing and mental health service. They offer a broad range of school-based counselling, therapy and parenting support services with a single point of access. Services can be tailored to the needs of individual schools.

The offer is committed to providing high standards of care and governance and will link into other universal, targeted and specialist support services provided in your school and community, for example school nursing and health visiting. The schools work in Partnership with CAMHS:

1) To improve students' emotional wellbeing

2) To help overcome barriers to learning

3) To enable students to maximise their education and fulfil their potential

Hawthorns

4.40 It provides 'A Quiet Place', a 6 week programme within an AQP environment, for pupils led by trained Hawthorns staff. Manage emotions, breathing, anger management, and explore personal issues. In addition, a children's counsellor works one day a week in the school (available for staff at lunchtime).

- Family and Multi-agency link worker- supports families
- Key workers - support child in school and family where needed
- Educational Psychology advice
- ISCAN support
- Behaviour team support
- BLIS
- CLASS
- MIND Resilience sessions for Year 6 to help with transition.
- Resilience training for staff
- School nurse

White Bridge College

4.41 Provides SENCO, Key Teacher and Pastoral Support with Educational Psychologist input. Liaison with a variety of agencies including CAMHS, MAAT, YOT, The Phoenix Team, Branching Out, Off The Record, Inspire and MST.

Yew Tree

4.42 They provide a SENCO and pastoral supervisor, who works with children who are emotionally vulnerable e.g. dealing with bereavement, members of family in prison and/or social care issues. Receives input from an Educational Psychologist and BLIS support team, who offer support for those children who are finding it difficult to cope in the mainstream classroom. They offer advice and practical guidance and support for teachers, including coaching.

4.43 CLASS also provide invaluable support for those children on the Autistic Spectrum. In addition they work with external services to gain advice on particular situations.

St Damien's

4.44 Provides a student support officer, pastoral/attendance officer and behaviour and guidance support manager. In addition to its SENCO, T.A.'s and carers also has: Peer Mentors; Father (Priest).

The school works with Off the Record, CAMHS and the Tutor Trust. Receives support from BLIS Intervention CLASS support and School Nurse plus Health Mentors.

St Paul's RC

4.45 TA and Class Teachers provide pastoral support to pupils with emotional and mental health issues, although they have received little/no training in relation to this.

Russell Scott

4.46 Provide the social and emotional aspects of the Learning (SEAL) programme, Teacher and TA support and School Nurse – with advisory capacity. Learning Mentor – Individual programmes of work e.g. self-esteem, anger, friendship etc. They receive input from an educational psychologist and is supported by BLIS support.

Fairfield

4.47 Provides KS3 and KS4 Learning Mentors, individual programmes for students for anger management and self-esteem, Young Carers, Friday Friendship and Peer Mentoring (SHINE) groups. Receives support and input from C.L.A.S.S., Tameside Young Carers Project and Early Help, School Nurse, Health Mentor, SALT and Educational Psychology

In addition provides:

- Relateen (7hours per week)
- Hilary Quigley (exam techniques, relaxation strategies)
- Home Tutor linked to LAC students
- Behaviour buddies (provided by Teaching Personnel)

Copley

4.48 Learning Support and Behaviour Support units provide a school nurse and weekly health mentor, counselling (weekly sessions run by ‘off the record’) and ‘relateen’. They receive input from Education Psychology.

4.49 Students can access stress management, Young Carers support and emotional wellbeing support from the Pastoral Team – has one trained Counsellor leading intervention. 1:1 or small group. They also provide relaxation sessions and anxiety reduction sessions with students. They also work with parents about how to support their families.

Longdendale

4.50 Longdendale provides SEAL intervention from their Pastoral Team 1:1 and a small group of identified students and also receive input from Education Psychology.

4.51 Available is support for students who are coping with stress in an unsafe way - self harm coping strategies, working in alignment with CAMHS professionals - 1:1 support by trained counsellor for vulnerable and at risk students. There are family sessions in school with trained counsellors – emotional support for families in conflict. Self-esteem and body image sessions – booking sessions from the ‘Dove’ project.

4.52 Longdendale work with MIND to provide sessions for students – targeted small groups and assemblies – focus: strengthening resilience. MIND offers evening workshops to parents re: building resilience with their families and focus: strengthening community resilience. LHS is one of the Centres for this project working with MIND.

Mossley Hollins

4.53 The Learning Support Unit provides access to a school nurse and health mentor (weekly). Receive input from Educational Psychologist BLIS, Early Help Team and You think. They access advice and support from CAMHS and make referrals to CAMHS as required.

Canon Burrows

4.54 Provides pastoral support from teachers, TAs, SSA and SMT and a school nurse as required.

- SEALs taught through PSHE sessions.
- Peer support – buddy systems.
- Targeted interventions e.g. anger management, self-esteem, friendship building etc.
- Reward systems to encourage success and positive self-esteem.

Receive input from BLIS, CLASS, Educational Psychologist, Early Help Team, and Inspire.

Moorside

4.55 Moorside provides a small team who support children and parents with their emotional wellbeing and some issues relating to mental health. They receive input from BLIS – social groups and 1:1 support.

Silver Spring

4.56 Provides a Family and Community Engagement Co-ordinator, trained in therapeutic play techniques, bereavement support, sexual exploitation awareness and supports learners in KS2. They support those children with the most complex needs with Play Therapy and compliment this with Family Therapy for parents. This is provided by IntraQuest.

4.57 The School has established effective links with MIND, Social Care, CAMHS, Neighbourhood Teams, Early Help, the Children's Centre team and Inspire and the implementation of "Strengthening Families, Strengthening Communities". All classroom based staff in the school and Welfare Assistants have been trained in Attachment Theory and Practice on which Family Mechanics is built.

4.58 A qualified teacher provides Nurture Group support for a group of six children with emotional and behavioural needs each afternoon in KS1. One of their HLTAs delivers Hotshots. The head teacher, SENCO and two other teachers have specialist training in supporting challenging behaviour.

St Raphael's

4.59 Provides a Class teacher, SENCO, SLT and Family liaison officer/safeguarding.

Ravensfield

4.60 Provides two learning mentors in school that have accessed a range of training to enable emotional support (self-esteem, friendships, anger management, nurture and massage, bereavement, relationships, managing feelings, attachment disorders). In addition provides Art Psychotherapy – purchased by the school.

4.61 Delivers: SEAL programme and their own SEALs wheel modelling of situations. Commando Joe - respect, aspiration and self-control resilience cooperation. Early identification of feelings through their own Feelings Register. They facilitate every 8 week referral meetings to assess developing need and discussion with pastoral and leadership team for accessing further intervention of support. Available is a learning support unit to provide internal exclusion, and focus emotional support and access to BLIS for advisory support or assessment and 1-1 work with individuals or groups.

The Heys

4.62 Provides learning mentors, one to one support with key workers, SENCO support, and Play Therapy. They receive input from Educational Psychologist,

BLIS, School Nurses and CAMHS. They also deliver the Social and Emotional Aspects of the Learning (SEAL) programme.

Leigh

4.63 Support is given via the school's inclusion team. A new Welfare Officer/Mentor is to be appointed during the summer term. At present the school accesses Inspire to support some identified families.

Our Investment in 2015/16

4.64 This subsection seeks to provide an overview of the 2015-16 emotional wellbeing and mental health services for children, young people and those care for them investment - by the CCG and its partners.

Figure 4: Tameside and Glossop Emotional Wellbeing and CAMHS 2015-16 Investment

Tameside and Glossop Emotional Wellbeing and CAMHS 2015-16 Investment				
Funded From	**Service**	**Pay**	**Non Pay**	**Total**
		(Note 1)		
TMBC Public Health	Off The Record		91,670	91,670
TMBC Public Health **(Note 2)**	Parenting Programmes		41,663	41,663
TMBC Public Health **(Note 3)**	Perinatal / Infant Mental Health		238,544	238,544
TMBC Public Health	School Based Programmes		16,000	16,000
		0	**387,877**	**387,877**
NHSE	Specialised Commissioning (Inpatient)		1,268,990	1,268,990
NHSE **(Note 4)**	Tameside Youth Justice Liaison & Diversion Scheme	50,500	7,100	57,600
		50,500	**1,276,090**	**1,326,590**
TMBC **(Note 5)**	BLIS		125,000	125,000
LA Maintained Primary Schls	BLIS		443,000	443,000
Academies & LA Maintained Secondary Schls	BLIS		65,000	65,000
		0	**633,000**	**633,000**
DfE - Dedicated Schools Grant	CLASS		721,000	721,000
		0	**721,000**	**721,000**
CCG **(Note 6)**	CAMHS (excluding CQUIN) - PCFT	1,607,194	530,822	2,138,016
CCG	Young Persons Alcohol Nurse - THFT		48,000	48,000
CCG	Inreach/ Outreach Team - PCFT		62,165	62,165
CCG	42nd Street		32,240	32,240
CCG	Homestart (Parent Infant Menatl Health)		40,299	40,299
CCG	ISCAN - SFT		14,105	14,105
		1,607,194	**727,631**	**2,334,825**
	TOTAL	**1,657,694**	**3,745,598**	**5,403,292**

Note 1: Where financial breakdown and analysis does not enable pay and non pay separation all funding is applied under non-pay

Note 2: TMBC Public Health parenting programmes consists of Solihull Approach and parenting training and manuals £21,529; Incredible Years parenting training and manuals £18,344; Mellow parenting training £1,790

Note 3: TMBC Public Health Perinatal - Infant consists of Early Attchment Service £225,734 (An additional £145,080 has been invested from Oct15, therefore a part year effect for 15/16); & Neonatal Behaviour Assessment Scale training £1,800; Neonatal Behaviour observation training (links to parenting attachment/bonding) £11,010

Note 4: Tameside Youth Justice Liaison & Diversion Scheme funded from NHSE directly pays for a 0.4wte AfC band 6 Mental Health practitioner is will end 31.03.16

Note 5: From the total service costs of £633k for 2015-16, £125k is funded via TMBC budgets, however with the remaining balance of £508k this is income generated funding by a combination of schools budgets.

Note 6: CCG CAMHS Investment 2015-16 includes £200k non-recurrent funding

4.65 The CCG investment in Tameside and Glossop CAMHS, outlined in Figure 4, enables the following CAMHS service composition summarised in table 1

below. The composition is of the 1st October 2015 and reflects the transformation to date. It does not reflect the new Allocation of Mental Health Funding to CCGs and the proposed expenditure outlined in section 7.9 Table 1.

Table 1: Tameside and Glossop CAMHS Service Composition as of the 1st October 2015.

Tameside and Glossop CAMHS Service Composition		
Whole Time Equivalent (W.T.E)	Role / Designation	Narrative
2.7	Consultant Psychiatrist	Contribute to the management and core CAMHS delivery; leading on Transitions (16-18 years), ASD and Learning Disability
0.7	Band 8C Psychologist*	2 x posts 0.5 holds caseload of complex cases and contributes to the management team. 0.2 Hold a case load within the Early Attachment Service
2.5	Band 8a Psychologist	Contribute to ASD, LD, paediatrics and core CAMHS. Between them they hold specialist skills in CBT, IPT, DBT, and Parenting. They offer supervision and teaching on the IAPT courses
1	Band 8a Operational Manager	Responsible for day to day management of the CAMHS team
4.1	Band 7 Senior Mental Health Practitioners (0.5 of which is a specified family therapist)	Hold management responsibility in their roles as well as taking leads on multi-agency pathways, delivering specialist mental health interventions to complex clients. The post holders have additional skills in NMP, parenting, DBT, CBT and Family Therapy. 2 of the band 7's have been on the initial IAPT in 2012 and are accredited in parenting and CBT. They continue to offer supervision support to current IAPT attendees and contribute to wider system peer supervision amongst the agencies
6.7	Band 6 Mental Health*Practitioners	These staff offer assessment/ interventions/ consultation/duty cover. They work across the pathways, supporting the leads. Most staff have additional skills in the areas of CBT, DBT, and Family therapy. 1 member of staff completed the SFP training on IAPT in 2014 and another is due to complete the CBT IAPT in December 2015. 1 member of staff is on the EEBP IAPT and due to complete in January 2016.
1	Band 4 Practitioner	Offers support to the team in supporting group interventions, specialist play work and is also completing the EEBP IAPT,
1	Band 4 Service Administrator *	Administrative lead
3	Band 3 Secretaries	Offer admin support across the service
1	Band 2 Receptionist	Provides reception duties and inputs data

* Note: From the CCG £ 200k non recurrent investment, funded till March 31.03.2016, relates to 0.3 of a 8C Psychologist time that sits in the management CAMHS team, plus a band 6 and a band 4 admin time

(Source: Adapted from Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015)

4.66 CAMHS Prescribing is undertaken by the Consultants outlined in the above table. The service holds 1 Nurse prescriber (Non Medical prescribing (NMP)). Prescriptions are done on FP10's if needed, but preferably none urgent GP advice forms, all with-in shared care protocols. The service only prescribes within NICE recommendations, for depression, anxiety, OCD, Psychoses, Severe challenging behaviour in LD if behaviour interventions fail, sleep deprivation, ADHD, TICs, emotional dysregulation with quasi psychotic symptoms.

Section 5: Our Needs - Local Needs Assessment

5.1 This section seeks to provide a description of the current mental health and wellbeing needs of Tameside and Glossop's children and young People. These needs have been used to inform and target service provision in tackling health inequalities and along with other findings, inform the Transformation Plan recommendations. The findings contained in this section draw upon the Tameside Joint Strategic Needs Assessment (JSNA) 2015/16, the National Child and Maternal Health Intelligence Network and an epidemiological literature review.

Tameside and Glossop Children and Young People

Age

5.2 Children and young people under the age of 20 years make up 23.8% (n=57,042) of the population of Tameside and Glossop.

Table 1: Tameside and Glossop CCG population 2014, Age distribution

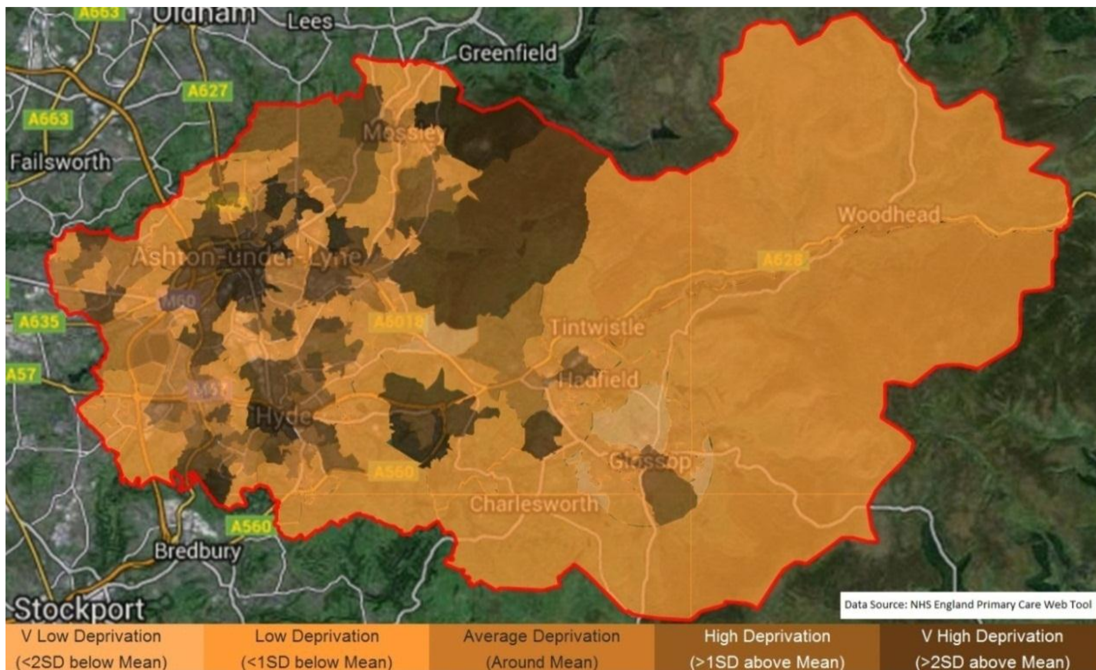
Age	Male	Female	Persons
0 – 4 years	7,775	7,482	15,257
5 - 9 years	7,284	6,921	14,205
10-14 years	6,680	6,503	13,183
15-19 years	7,423	6,974	14,397
20+	89,996	92,272	182,268
Total	119,158	120,152	239,310

(Source: ONS, 2015)

Deprivation

5.3 Some major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems evidences that such problems are more common among children and young people who are have fewer educational qualifications, have been looked after or accommodated, are in a low income families or have a low standard of living. When considering inequalities in mental health and wellbeing, it is therefore important to consider deprivation as a driver. Just over a third of the Tameside population lives in areas that fall within the most deprived 20% of areas nationally, with just 3.2% of the Tameside population living within areas that fall within the least deprived 20% of areas nationally. In Glossopdale, the Gamesley residential area falls in the most deprived 10% of areas nationally. This means that based upon the level of deprivation in Tameside and Glossop health inequalities would be expected to exist between Tameside and Glossop and England as a whole.

Map 1: Deprivation in Tameside and Glossop (IMD 2010)



(Source: NHS England Primary Care Web Tool)

Child Poverty

5.4 Child Poverty is currently defined by the national child poverty measure: the percentage of children who live in families in receipt of out-of-work benefits or in working families with income less than 60% of the median national income. The wider determinants of poverty include a range of social and economic factors and are currently being reviewed under the banner of ‘life chances’ and ‘social mobility’. The consequences of allowing a child to grow up in poverty are severe, not only for the child but for the family, for society and for the wider economy as well. For a child, consequences can be wide ranging and can affect health, education, employment, behaviour, finance, relationships and their well-being.

5.5 A child growing up in poverty has a greater likelihood of experiencing health problems from birth and of accumulating physical and mental health problems throughout their life. Poverty and inequalities proportionately increase the chances that someone will develop a disability or life limiting illness and ultimately decrease their life expectancy. Though poverty can affect anyone, a number of groups are more at risk than others. These include, children in care, teenage parents, asylum seekers, single parents and particular ethnic groups. The levels of child poverty in Tameside are higher than both the North West and England (national Child Poverty Data from 2011). Local data had indicated that the levels of poverty had increased over the past 4-5 years. Local data is no longer comparable due to welfare changes. National data from HMRC continues to be available but in arrears. This data indicates a relatively static position in the percentage of children living in poverty in Tameside.

Ethnicity

5.6 Ethnicity has a major impact on a person’s mental health (Persuad, R. 2007). It is important to consider the ethnic breakdown of the local area when planning

services, given that different ethnic groups have differing needs. There may be barriers to accessing services in some ethnic communities due to limited knowledge of English. Research on the risk factors for young people developing mental health problems has highlighted that those from black and ethnic minority groups may be disproportionately affected, as indicated by the numbers excluded from school, being looked after, in local authority accommodation or being homeless (Young Minds, 2005). Services hold a duty to ensure that they accessible to all.

5.7 The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7%, 2.2% and 2% of the Tameside population respectively. Glossopdale is one part of the High Peak area, which has a predominantly white population with less than 3% of residents from black and minority ethnic (BME) groups. The overall white British population is considerably higher in Tameside at 88.5% compared to the England average of 79.8

At Risk and Vulnerable groups

Pregnancy and early years

5.8 Pregnancy and early years lay the foundations for health, wellbeing, cognitive development and economic security throughout one's life. The transition through pregnancy, birth and early parenthood is a vital window of opportunity. A baby born into a home with parents that are well educated and financially comfortable has a better chance of living longer (and without disease and disability) than a baby born into poverty. This is in a large part because the social and economic inequalities in our society are reflected in and help to determine our health and wellbeing outcomes.

Looked After Children

5.9 Evidence from literature reviews reflect that looked after children are more likely to experience mental health problems than the general population. It has been highlighted that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such anxiety or depression, and 7% were hyperkinetic (Meltzer, H. et al 2003). As such it should be viewed as all looked after children are vulnerable hence a reasonable expectation that appropriate services should be in place. Failure to meet the needs of those most vulnerable impacts not just on their childhood but also on their adulthood and on their ability to parent and the cycle continues.

Table 2: Looked after children in Tameside and Glossop

Total number of Looked After Children (LAC) in Tameside and Glossop	766
Number of LAC placed in Tameside and Glossop (from other areas)	467
Number of LAC placed in other areas by Tameside and Glossop	136

(Source: NHS Tameside and Glossop CCG, September 2015)

The number of Tameside and Glossop children who are looked after is higher than the England average.

Youth Offending

5.10 There is a considerable agreement that levels of mental health problems among young people connected to any part of the criminal justice system are higher than in the general population. Literature reviews indicate the prevalence rates of mental health problems to be at least three times as high for those within the criminal justice system as within the general population (Leon, L. 2002). A recent evaluation of the Youth Justice Liaison and Diversion pilot scheme (Haines, A. et al. 2012), found that 80% of young people had between one and five vulnerabilities, which range from mental health issues, behavioural issues, and social problems.

5.11 In Tameside, between April 2014 to March 2015, 112 children entered the youth justice system for the first time. This is a 21.7% increase compared with (n=92) the previous equivalent 12 months. Although this gives a similar rate to the England average for young people receiving their first reprimand, warning or conviction. Tameside Youth Offending Team (YOT) use Asset as their assessment tool, the nationally recognised assessment framework for young people involved in the criminal justice system. Asset aims to look at the young person's offence or offences and identify a multitude of factors or circumstances – ranging from lack of educational attainment to mental health concerns - which may have contributed to such behaviour. The extent to which a section is associated with the likelihood of further offending is rated on a 0 – 4 scale.

0 Not associated at all
1 Some association
2 Associated
3 Strongly associated
4 Very strongly associated

5.12 While there are a number of domains within the assessment, those relating to emotional and mental health and vulnerability, most clearly demonstrate the prevalence of need amongst the YOT cohort. An analysis of assessments completed by Tameside YOT during the 1st April 2014 to 31st March 2015 shows the following results:

Table 3: Young People Assessed by Tameside YOT using ASSET- 1st April 2014 to 31st March 2015

Asset Section	Asset Score / Vulnerability Indicator	Total Number of Assets	Total Number of young people	% of young people
Emotional & Mental Health	2	201	53	31%
	3	55	27	16%
	4	10	7	4%
Vulnerability	No	98	38	22%
	Yes	516	133	78%

(Source: Tameside Youth Offending Team, 2015)

The table demonstrates, in 51% of all cases, the assessments evidenced an association between emotional and mental health, equating to 87 young people in total, suggesting that half of the YOT caseload would benefit from intervention and support in this area.

Domestic Abuse

5.13 Domestic Abuse often remains hidden. Abuse is not disclosed for a variety of reasons, shame and stigma, fear of not being believed, confidence in both services and often victims themselves in dealing effectively with abuse and the relationships where it occurs. As such the data reported should be viewed as an under representation of the true prevalence of domestic abuse. Data for 2011/12 shows that Tameside is ranked fourth highest out of ten Greater Manchester Authorities in terms of rate of domestic abuse per 1,000 population. Within Tameside the rate has fluctuated year on year rising from 5.9 crimes per 1,000 population in 2009/10 to 6.9 on 2010/11 and decreasing again to 6.3 in 2011/12. Almost 80% of domestic abuse crimes in Tameside are linked to violence compared to an average of 76% across Greater Manchester as a whole (Tameside Domestic Abuse Strategy 2013-16). There is a long lasting impact on children and young people's emotional well-being due to being exposed to the trauma of witnessing domestic abuse.

5.14 Some of the effects on children and young people as a result of witnessing domestic abuse are as follows:

- Anxiety or depression
- Difficulty in sleeping or nightmares
- Experience of physical pain
- Temper tantrums
- Low self-esteem
- Use of drugs or alcohol
- Eating disorders

Some children may also experience many mixed emotions such as being angry, powerless, frightened, lonely, insecure and confused and they are often unable to articulate these feelings.

Tameside and Glossop Children and Young Peoples Mental Health

Prevalence

5.15 The following application of prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with the criteria that the disorder causing distress to the child or having a considerable impact on the child's day to day life.

Preschool

5.16 The National Child and Maternal Health Intelligence Network reports relatively little data on the prevalence rates for mental health disorders in preschool age children. However from a literature review of four studies looking at 1,021 children aged to 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorders was 19.6% (Egger, H et al 2006) Applying this prevalence rate to the population of Tameside and Glossop gives a figure 2,350 aged 2 to 5 years.

School age

5.17 The report ‘Mental Health of Children and Young People in Great Britain, 2004 (Green et al (2004) provides a prevalence estimate for mental health disorders in children aged 5 to 16 years. Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or experiencing mental health problems than girls (7.8%). Children aged 11 to 16 are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the following tables highlight the estimated prevalence of mental health disorders by age group and sex in Tameside and Glossop. *Note: in the following tables the numbers do not add up as the numbers in each age group are different*.

Table 4: Estimated Number of Children with mental health disorders by age group and sex

	Estimated number of children aged 5-10 years with mental health disorders (2012)	Estimated number of children aged 11-16 years with mental health disorders (2012)	Estimated number of children aged 5-16 years with mental health disorders (2012)	Estimated number of boys aged 5 -10 years with mental health disorders (2012)	Estimated number of boys aged 11 -16 years with mental health disorders (2012)	Estimated number of girls aged 5 - 10 years with mental health disorders (2012)	Estimated number of girls aged 11 -16 years with mental health disorders (2012)
Tameside & Glossop	1,275	1,925	3,190	860	1,070	415	850

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Green, H et al (2004))

Mental Health Disorders

5.18 Prevalence rates of mental health have been broken down by the following disorders:

- Conduct (a range of antisocial types of behaviour);
- Emotional (person's ability to be happy, control their emotions e.g. anxiety);
- Hyperkinetic (enduring pattern of severe, developmentally inappropriate inattention, hyperactivity and impulsivity)

The following tables show the estimated number of children with these disorders In Tameside and Glossop.

Table 5: Estimated Number of Children with conduct disorders by age group and sex

	Estimated number of children aged 5-10 years with conduct disorders (2012)	Estimated number of children aged 11-16 years with conduct disorders (2012)	Estimated number of children aged 5-16 years with conduct disorders (2012)	Estimated number of boys aged 5 -10 years with conduct disorders (2012)	Estimated number of boys aged 11 -16 years with conduct disorders (2012)	Estimated number of girls aged 5 -10 years with conduct disorders (2012)	Estimated number of girls aged 11 -16 years with conduct disorders (2012)
Tameside & Glossop	810	1,105	1,915	580	690	230	420

Table 6: Estimated Number of Children with emotional disorders by age group and sex

	Estimated number of children aged 5-10 years with emotional disorders (2012)	Estimated number of children aged 11-16 years with emotional disorders (2012)	Estimated number of children aged 5-16 years with emotional disorders (2012)	Estimated number of boys aged 5 -10 years with emotional disorders (2012)	Estimated number of boys aged 11 -16 years with emotional disorders (2012)	Estimated number of girls aged 5 -10 years with emotional disorders (2012)	Estimated number of girls aged 11 -16 years with emotional disorders (2012)
Tameside & Glossop	400	840	1,240	185	340	205	505

Table 7: Estimated Number of Children with Hyperkinetic disorders by age group and sex

	Estimated number of children aged 5-10 years with Hyperkinetic disorders (2012)	Estimated number of children aged 11-16 years with Hyperkinetic disorders (2012)	Estimated number of children aged 5-16 years with Hyperkinetic disorders (2012)	Estimated number of boys aged 5 -10 years with Hyperkinetic disorders (2012)	Estimated number of boys aged 5 -16 years with Hyperkinetic disorders (2012)	Estimated number of girls aged 5 -10 years with Hyperkinetic disorders (2012)	Estimated number of girls aged 11 -16 years with Hyperkinetic disorders (2012)
Tameside & Glossop	265	235	500	230	435	35	35

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Green, H et al (2004))

Autism-Spectrum conditions

5.19 A survey by Baron-Cohen et al (2009) of Autism-Spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimated of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ration known to unknown is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases. The following table shows the estimated prevalence of children in Tameside and Glossop with Autism-Spectrum disorders.

Table 8: Estimated Number of Children with Autism-Spectrum conditions

	Estimated Autism in Children aged 9 - 10 years (2012)	Estimated Other ASDs in Children aged 9 - 10 years (2012)	Estimated Total of all ASDs in Children aged 9 - 10 years (2012)	Estimated Autism-Spectrum conditions disorders in children 9 -10 years (2012)
Tameside & Glossop	110	215	320	245

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Baron-Cohen, S. et al (2009))

Children and Young People with Learning Disabilities

5.20 People with learning disabilities are more likely to experience mental health problems (Emerson, E. et al 2008). Despite this, prevalence rates of learning disabilities prove to be difficult. Emerson et al (2004) calculates prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 0.97%; 10 to 14 years 2.26%; 15 to 19 years 2.67%. The following table applies these rates to Tameside and Glossop.

Table 9: Estimated total number of children with learning disabilities

	Estimated Children aged 5 - 9 years with a learning disability (2012)	Estimated Children aged 10 - 14 years with a learning disability (2012)	Estimated Children aged 15 - 19 years with a learning disability (2012)	Estimated Children aged 5 - 19 years with a learning disability (2012)
Tameside & Glossop	150	305	400	855

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Emerson, E. et al (2004))

These rates reflect that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with Learning disability, with higher rates for those with severe learning disabilities. The following table shows how many children with learning disabilities who also experience mental health problems expected estimation for Tameside and Glossop.

Table 10: Estimated total number of children with learning disabilities with mental health problems

	Estimated Children aged 5 - 9 years with a learning disability with mental health Problems (2012)	Estimated Children aged 10 - 14 years with a learning disability with mental health Problems (2012)	Estimated Children aged 15 - 19 years with a learning disability with mental health Problems (2012)	Estimated Children aged 5 - 19 years with a learning disability with mental health Problems (2012)
Tameside & Glossop	60	125	160	345

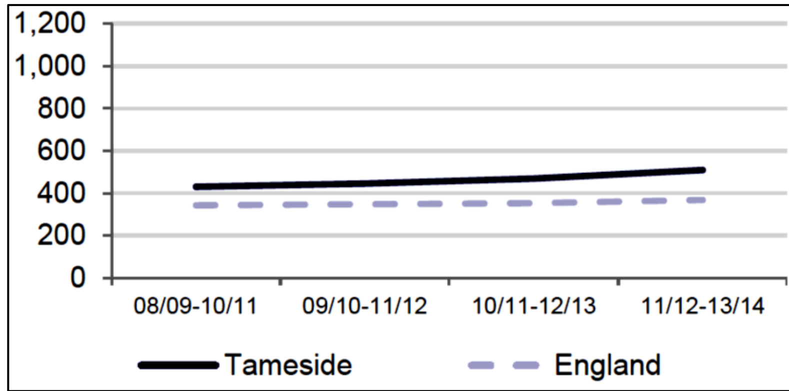
(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Foundation for People with Learning Disabilities (2002))

Self-Harm

5.21 Literature reviews evidence the levels of self-harm are higher among young women than young men. However, self-harm SUS data for Tameside 2011 to 2013 shows that from the age of 20, 53% of those who self-harm are male. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K. 2012). Nationally self-poisoning was the most common method (Hawton, K. 2012).

5.22 In comparison with the 2008/09 - 2010/11 periods, the rate of young people aged 10 to 24 years who were admitted to hospital as a result of self-harm was higher in the 2011/12 - 2013/14 period. The admission rate in the 2011/12-2013/14 period was higher than the England average.

Figure 1: Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

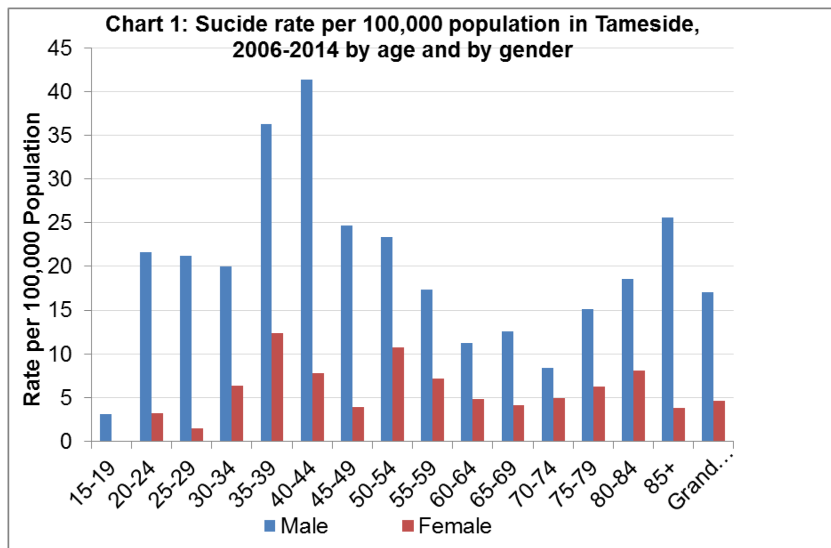


(Data source: Hospital Episode Statistics, Health and Social Care Information Centre)

Three years of pooled data on hospital admissions for self-harm in Tameside show that under the age of 20, 79% of those admitted for self-harm were female.

Suicide

5.23 In England, men are at three times more likely to die by suicide than women (DoH, 2012). Suicide is the leading cause of death in British men under 50 years of age. In Tameside, the peek age range for male suicide is 35 to 54 years and the peek age group is 40 to 44 years. There is also a relatively high level of suicide in younger males aged 20 to 34. For suicide in females there are two peak age groups of 35 to 39 and 50 to 54 (H&SCIC, 2015). *See chart 1 below*



(Source: PCMD data, 2015 courtesy of Ruth du Plessis, Specialty Registrar TMBC Public Health)

For males there is a clear gradient across the deprivation quintiles with those in the most deprived quintile having a significantly higher rate of suicide than those in the least deprived quintile.

Estimated Service Demand

5.24 Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tier 1, 2, 3 and 4 have been provided by Kurtz (1996). A description of the CAMHS Tiered model of care is provided in Section 4.

5.25 The following Table shows the estimates for the poplulation aged 17 and under in Tameside and Glossop who may experience mental health problems.

Table 11: Estimated number of children and young people who may experience mental health problems requiring intervention and CAMHS services

	Estimated Tier 1 needs (2012)	Estimated Tier 2 needs (2012)	Estimated Tier 3 needs (2012)	Estimated Tier 4 needs (2012)
Tameside & Glossop	7,730	3,610	995	40

(Source: General Practice (GP) registered patient count aggregated up to CCG level; Office for National Statistics mid-year population for 2012. Kurtz, Z. (1996))

The above Table shows that an estimated 12,375 children and young people potentially need an intervention applying the CAMHS Tiered Model of Care.

Tameside and Glossop CAMHS Activity Data

5.26 Tameside and Glossop in the period between 1st April 2014 and 31st March 2015 received 1,889 referrals; of which 1,369 (63%) were accepted, 751 (35%) were rejected and a further 42 (2%) classified as pending a decision. The table below provides a breakdown on the referrals and the presenting problems. It evidences the current high level of demand on our service and that this is higher than the estimated number of children and young people who may experience mental health problems requiring a CAMHS services.

Table 12: Tameside and Glossop CAMHS Referrals 1st April 2014 to 31st March 2015

Accepted Referrals - Presenting Problem ICD / Description	Total
Anxiety disorder, unspecified	80
Atypical autism	< 5
Childhood disorder of social functioning, unspecified	< 5
Childhood emotional disorder, unspecified	62
Conduct disorder, unspecified	< 5
Depressive episode, unspecified	81
Developmental disorder of scholastic skills, unspecified	< 5
Developmental disorder of speech and language, unspecified	< 5
Eating disorder, unspecified	18
Feeding disorder of infancy and childhood	< 5
Hyperkinetic conduct disorder	< 5
Hyperkinetic disorder, unspecified	26
Mental & behaviour disorder multiple/psychoact drug:	< 5

unspecified mental & behaviour disorder	
Mixed disorder of conduct and emotions, unspecified	40
Mixed specific developmental disorders	< 5
Moderate mental retard sig impairm of behav req attent /treat	< 5
Nonorganic encopresis	< 5
Obsessive-compulsive disorder, unspecified	7
Occurrence at unspecified place	103
Other childhood emotional disorders	< 5
Pervasive developmental disorder, unspecified	119
Phobic anxiety disorder of childhood	< 5
Predominantly obsessional thoughts or ruminations	< 5
Problem related to social environment, unspecified	< 5
Problems relating alleged child sex abuse	< 5
Tic disorder, unspecified	8
Unspecified behaviour emotion disorder	< 5
Unspecified disorder of psychological development	14
Unspecified organic or symptomatic mental disorder	< 5
Not specified (blank)	775
Accepted Total	**1,369**
Pending Total	**42**
Rejected	**751**
Total of all Referrals received	**2,162**

(Source: Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015)

5.27 The table below (table 13) provides a breakdown of the referral source. It shows that the majority (35%) of the referrals to Tameside and Glossop CAMHS are from GPs, which would be expected in relation to the access pathway at this time.

Table13: Tameside and Glossop CAMHS Referral Source – 1st April 2014 to 31st March 2015

Referral Source	Total
Accident and Emergency	3.49%
Consultant	8.67%
Education Establishment	15.14%
Emergency Services	0.05%
GP	34.76%
Internal (from across the NHS Trust)	19.66%
Judicial Establishment	0.14%
Local Authority	5.96%
Non-medical individual	1.58%
Nursing	3.82%
Other	0.28%

Other Medical Practice	0%
Health Worker	2%
Grand Total	100%

(Source: Tameside and Glossop CAMHS, Pennine Care NHS Foundation Trust, 2015)

As of the 30th of June 2015 the average waiting list for unseen clients in weeks was 16.3, or 113 days (Pennine Care NHS Foundation Trust, 2015). This is within the national target to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral.

Benchmarking CAMHS Activity data

5.28 In reviewing Tameside and Glossop CAMHS activity we are able to draw comparisons with four other Greater Manchester CCGs (Bury, Oldham, Stockport and Heywood Middleton and Rochdale), which all commission CAMH services from Pennine Care NHS Foundation Trust.

5.29 Regionally within this cluster of localities, Tameside and Glossop CAMHS holds the highest proportion of assessments that lead to treatment (retention rates), with 91% of all assessments leading to children and young people coming back for a second appointment and commencing treatment. This is higher than the national expectation. The mean average for the five localities is 74% and the lowest is proportion being 39%. In addition Tameside and Glossop CAMHS has the has the highest proportion of contacts recorded.

Table 14: Number of contacts recorded by CAMHS services across five Pennine Care locality services, 2014/15

Locality	Contacts
Tameside & Glossop	17,932
HMR	14,144
Stockport	13,009
Oldham	11,450
Bury	7,739

(Source: Pennine Care NHS Foundation Trust, 2015

5.30 In summary, benchmarking our activity with the regional cluster of Bury, Oldham, Stockport and Heywood Middleton and Rochdale (HMR) CCGs we able to extrapolate:

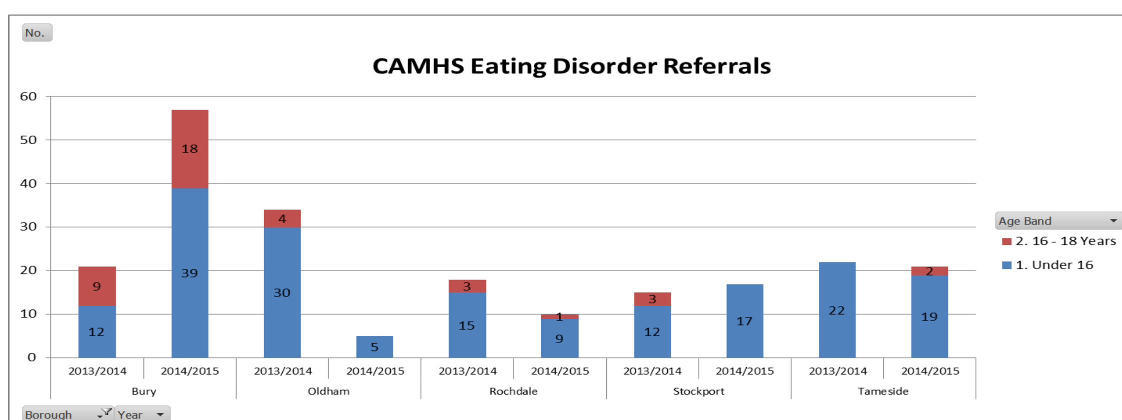
- Our locality holds the second highest (after Bury) for number of referrals to a CAMHS services.
- Our locality CAMHS service holds the highest percentage of referrals that are rejected – not authorised for assessment.
- Our locality CAMHS service holds the shortest average waiting time in performance for routine referrals.

- Our locality CAMHS service holds the highest proportion of assessments that lead to treatment (retention rates), with 91% of all assessments leading to treatment (second appointment).
- Our locality CAMHS service has the highest proportion of contacts recorded - *see table 14.*

In Patient activity for Eating Disorders

5.31 The table below highlights that within the regional cluster Tameside and Glossop has the second highest referrals rate for Pennine Care inpatient eating disorders. In 2014/15, Pennine Care Hope and Horizon units received 21 referrals, for 18's years of age and under, from the Tameside and Glossop locality.18 (85.7%) of these were accepted (authorised). The number of bed days, based on OBD reports for the Hope and Horizon Unit, shows that Tameside and Glossop required 1,907 days in 2014/15. This is increase on the 1,800 bed days required in 2013/14. Currently in 2015/16 to date (September 2015) Tameside and Glossop has the highest number of beds days (n=1,015) from across the five localities.

Table 15: Number of Eating Disorder referrals for Pennine Care NHS Foundation Trust services by age and borough for the periods 2013/14 and 2014/15



(Source: Pennine Care NHS Foundation Trust, 2015)

Transition 16-18 Activity Data

5.32 The following Table provides a summary of the activity of 16-18 years olds that are excluded in the CAMHS activity and that sit within Pennine Care Adult Adults Mental Health (AMH) Services.

Table 16: Under 18 year of Age activity undertaken with Adult Mental Health services, for the period 01/04/2015 - 31/08/2015

Description	Number of Under 18s	All AMH Activity	<18 as % of all AMH Activity
Referrals accepted - All Access (inc RAID)	129	3548	3.6%
Referral Tameside Health Minds (IAPT)	478	3366	14.2%
Total	607	6914	8.78%

Attended Activity (appointments /contacts)	3947	36874	10.7%
Open Caseloads* (T&G Registered Patients)	700	4326	16.2%

* Open Caseload taken as snap shot on 31/08/2015

(Source: Pennine Care NHS Foundation Trust, 2015)

Tameside and Glossop Key Findings

5.33 Listed below is a summary of the key findings related to the Tameside and Glossop area:

- Almost a quarter of our population is under 19 years of age
- 18.6% of school children are from a minority ethnic group.
- Tameside secondary schools exclusions (fixed period and permanent) rate in 2012/13 was higher than the England average and the highest in the North West*
- The health and wellbeing of children in Tameside and Glossop is generally worse than the England average.
- The level of child poverty is worse than the England average with 22.7% of children aged under 16 living in poverty.
- The number of Tameside and Glossop children in a looked after care setting is higher than the England average.
- 51% of all Tameside YOT cases during 2014-15 (financial year), the assessments evidenced the need for emotional and mental health intervention, of which 39% could need a clinical intervention.
- The admission rate for self-harm among 10 to 24 years in the last three years is higher than the England average; 79% of those admitted for self-harm were female.
- An estimated 12,375 children and young people could need an intervention applying the CAMHS Tiered Model of Care, of which 1,035 would require specialist input
- 41,785 5-19 years olds would benefit from awareness and prevention programmes in over 100 schools across Tameside and Glossop
- Referrals to our CAMHS service are higher than estimated expected demand, with 62% of all referrals in 2014-15 accepted.
- The average waiting list for unseen clients is 113 days from referral to assessment as of 30.06.2015
- Tameside and Glossop has a higher than expect demand for inpatient eating disorder services
- Within our Adult Mental Health provision just under 9% of accepted referrals are for under 18's, whilst under 18's makes up 16.2% of the open case load (as 31.08.2015)

(Additional Source: Public Health England, Child Health Profile June 2015, * Department for Education)

Section 6: Harness the Power of Information

6.1 In this section the plans to develop and monitor the performance of the Transformation Plan across the life of the five year strategy is summarised. Through this work we seek to support and sustain a culture of continuous evidence-based service improvement, promote transparency and accountability across the whole system and ensure collaborative decision making.

Introduction

6.2 Robust service planning is based on good information and requires access to data that demonstrates outputs and outcomes. Locally there are significant gaps in information and data that we seek to address. This gap is reflected nationally not just here in Tameside and Glossop. The document 'Future in Mind' highlights that in order to drive improvements in the delivery of care, and standard of performance to ensure we have a better understanding of how to get the best outcomes for children, young people and their families and value from our investment we need to harness the power of information (Future in Mind 2015).

6.3 We consider the following areas that we need to address to achieve transformation and deliver our local vision and that set out in the Future in Minds:

- Transparency, Accountability and Governance
- The Voice of the Child
- Data Sets and Key Performance Indicators (KPIs)
- Clear Outcomes and the use of Routine Outcome Measures
- CAMHS Commissioner Modelling Tool

Through the triangulation in applying and combining multiple observers, methods (both quantitative and qualitative) we aim to overcome the gaps in our information and weakness that come from single method approaches.

Transparency, Accountability and Governance

6.4 As outlined in Section 2, Tameside and Glossop CCG have formed a Children and Young Peoples Emotional Well Being and Mental Health Programme Board. The Programme Board is accountable for the delivery of the Transformation Plan and continued development of working relationships between health and social care commissioners and provider organisations. The Programme Board is a partnership that takes whole system ownership of the priorities, challenge performance and manage risk to deliver a whole system approach and accountability on behalf of the population of Tameside and Glossop. Each member organisation has a responsibility to report back through its own governance structures and collectively to the Health and Wellbeing

Boards (Tameside and Derbyshire). See Appendix 1 for the Terms of reference.

6.5 The Programme Board was initially set up with a fixed term remit, until the 31st of March 2016, to develop and produce this plan. However the Programme Board came into operation before the publication of the Future In Mind document. Since then an agreement by the board is to continue until 2020 to:

- Ensure constant stakeholder engagement throughout the plan's life span
- Ensure stakeholders are committed and enabled to take the work forward
- Ensure all stakeholders having the ability to challenge, input and embrace new models of thinking and service delivery
- Ensure continued robust structures for programme governance
- Ensure multi agency and collective monitoring and evaluation of the Transformation Plan

6.6 The assurance process requires the Transformation Plan to be signed off by the Health and Wellbeing Board. All Local Transformation Plans are then assured by NHS England, led by the regional Director of Commissioning and Operations (DCO's). It is the intension beyond 2015-2016 to integrate assurance within the mainstream planning framework that requires the CCG to work closely with our Health and Wellbeing Boards, NHS England and other key agencies including the third sector and education to refresh the plan and monitor improvements, making an annual declaration.

6.7 The Transformation Plan ensures transparency about service provision and the levels of investment, our base line information and stretched target - outlined under KPIs. The Transformation Plan and subsequent annual action plans and annual declarations will be published on the CCG and our partners' websites and making sure it is accessible to all. We are committed to improving all aspects of transparency in connection with the plan. As part of this commitment in order to ensure our investment has the most impact, on improving experiences and delivering the outcomes for children, young people and those who care for them, we have embarked upon unpicking the mental health block contract that potentially limits our understanding and future system modelling. This is a substantial piece of work and undertaking, which NHS Mental Health Providers across the country are working to resolve.

6.8 Tameside and Glossop CCG invests £22.4million through a block contract with Pennine Care NHS Foundation Trust to provide Mental Health services for the population of Tameside and Glossop. The Trust has been unable to provide a detailed breakdown of the costs and therefore only divisional level information is available, i.e. the operational budget for services across Tameside,

Stockport, Bury, Oldham and Rochdale, plus additional cross boundary elements. This provides a fundamental challenge to our intention to achieve transparency within this Plan.

The Voice of the Child

6.9 At the heart of our vision is to ensure the voice of children and young people is heard and acted upon, shaping the design and delivery of services and ultimately this Transformation Plan. Children and young people are experts in their own lives and when they are equipped and supported to influence commissioning, delivery and monitoring of the services they and their peers use, those services improve and in turn they develop and build skills and confidence. In 2016, we will build on our young people's voice and influence, working to establishing a service user fora for children and young people who are receiving or have been in receipt of interventions. The service user fora will have a direct voice into our programme board to ensure decisions around design and delivery are shaped by those best placed to know what works and that our impact and effectiveness is also scrutinised by service users. In this way, we will continually learn and improve what we do as a result of the genuine involvement of our service users' experiences.

Data Sets and Key Performance Indicators (KPIs)

6.10 We support the introduction of the new Mental Health Services Data Set (MHSDS). This new data set requires our CAMHS commissioned service to measure referral to treatment pathway activity and outcomes for the assessment and treatment of children and young people. Providers are mandated to begin collecting the relevant data no later than 1 January 2016 as such our commissioned service is putting in place plans for the collection of the MHSDS. In addition to the national data set, for our NHS CAMHS commissioned service, we seeking to ensure a local data is implemented by April 2016 that can be applied to a system wide approach and the collaborating services. The application of minimum data set, will support the evaluation of the effectiveness of our services and the Transformation Plan as whole.

Key performance indictor's for CAMHS 2015-16

6.11 The following targets have been established and supported through the application of a CQUIN in 2015-16. The targets seek the improvement on access and reduction on the waiting times:

- Total number of referrals received
- Total number and percentage if referrals accepted
- Fewer rejected (inappropriate) referrals (% decrease on baseline);
- First contact (consultation, triage or assessment) within 12 weeks of referral;
- 98% of accept referrals treatment is commenced in 18 weeks of referral.

Clear Outcomes and the use of Routine Outcome Measures

6.12 Services need to be outcomes focused as such a core set of outcomes are being defined that will be embedded in contractual Service Specifications going forward for 1st April 2016. It is our intention to develop a robust set of metrics covering access, waiting times and outcomes (covering patient experience and treatment concordant and effectiveness) that enables benchmarking of local services at regional (Greater Manchester) and national level.

6.13 The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively. We will ensure that all providers commissioned across Tameside and Glossop are NICE concordant, adhering to the latest evidence based practices.

6.14 In addition we will ensure as local commissioners and providers we are meeting NHS England Access and Waiting time Standards in Mental Health including the recently published Eating Disorders guidance and Early Intervention in Psychosis.

6.15 As we embark on a five year journey our new approach in collectively monitoring evaluating the effectiveness of plan will be refined over this period, year on year. As such we will strive to seek data quality, compliance and completeness improvement year on year. This desire will be reflected by commissioners placing into contracts the clear requirements for data and information. As part of this work, Tameside and Glossop is accessing support to develop a linked local area data set to monitor the implementation of Transformation Plan over the next 5 years.

6.16 Building on their existing funded work, the CAMHS Evidenced Based Practice Unit (EBPU) with input from Child Outcome Research Consortium (CORC), part of the Anna Fraud Centre, are working with us offering support to:

- Selecting the best outcome measures and indicators across education, health and social care to use with your particular populations and ensuring local consensus and ownership
- Determining best options for linking data across agencies and organisations to ensure comprehensive monitoring of the progress of your Local Transformation Plan and service user outcomes
- Feedback of cross agency and organisational trends in outcomes and performance to commissioners, providers and users of services, facilitating the review and refinement of your plan over time

6.17 Work has already begun on establishing and enabling the application of routine outcome measures across the system. Working with CORC and our partners we have agreed the use of the following outcome measures:

- Child Outcome Rating Scales (CORS) for 6 to 12 year olds and Outcome Rating Scales (ORS) for 13 plus years
- Child Session Rating Scales (CSRS) for 6 to 12 year olds and Session Rating Scales (SRS) for 13 plus years
- Goal Based Outcomes (GBOS)

ORS and CORS

6.18 The Outcome Rating Scales is a session by session measure designed to assess areas of life function known to change as result of intervention. ORS assess four domains of young person functioning that are widely considered to be valid indicators of successful outcomes (Lambert et al. 1996).

- Personal or symptom distress (measuring individual Wellbeing)
- Interpersonal Wellbeing (measuring how well the young person is getting along in relationships)
- Social role (measuring satisfaction with work/school and relationships outside of the home
- Overall wellbeing

SRS and CSRS

6.19 The application of these routine outcome measures enables the 'service user' to rate their experience of the session within an intervention. The ORS and SRS give children, young people and those who care for them a voice in treatment as it allows immediate feedback on what is working and what is not. The application of these routine outcome measures improves retention and outcome, whilst decreasing deterioration, length of stay and costs (Law, D. et al, 2014).

GBOS

6.20 Goals based outcomes are a way to evaluate progress towards a goal. They simply measure how far a young person feels they have moved towards reaching a goal they set at the binging of intervention. The setting of the goals should be collaborative and reflect the wishes of the young person (Law, D. et al, 2014). They help determine the aim of the intervention from the start.

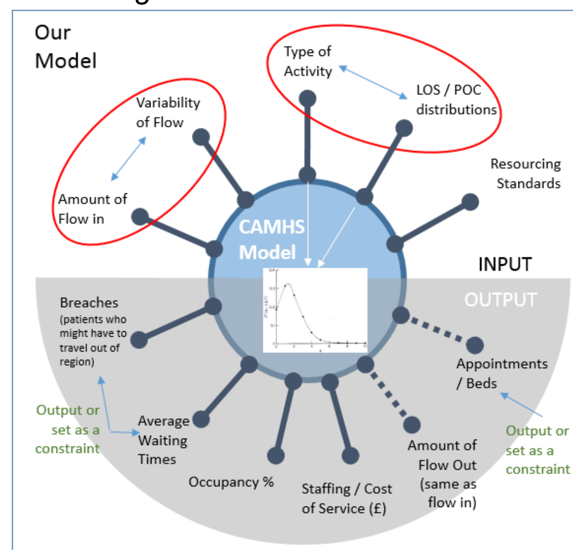
CAMHS Commissioner Modelling Tool

6.21 In October 2014 NHS England commissioned Central Southern Commissioning Support Unit in partnership with HCD Economics and Oxford Health Foundation Trust to develop a modelling tool to support the delivery of improved mental health services for children and young people. Tameside and Glossop CCG with its partners are piloting the use and application of the CAMHS Commissioner Modelling Tool (Version 1.0 Beta Release)

6.22 The tool is designed to be a practical planning tool for Commissioners of CAMHS services. The tool has multiple aims, but in brief summary it:

- Helps the commissioner meet the needs of its population by providing data on historic activity, and augmenting this with local prevalence information.
- Helps to record future commissioning intentions
- Creates an auditable record of intentions and scenarios for making changes to where that activity might take place. For example considering scenarios like more crises outreach to substitute for Inpatient Care.
- It helps with estimating cost of services and allows you to compare scenarios.
- Allows the Commissioner to model and optimise their future service.
- Supports commissioners to help plan and invest in services that will improve the transition between children's mental health services and other services for young adults including adult mental health services.

Figure 1: Schematic showing the information the tool makes explicit.



(Source: CAMHS Commissioner Modelling Tool Business Guide, Central Southern Commissioning Support Unit, HCD Economics and Oxford Health Foundation Trust, July 2015)

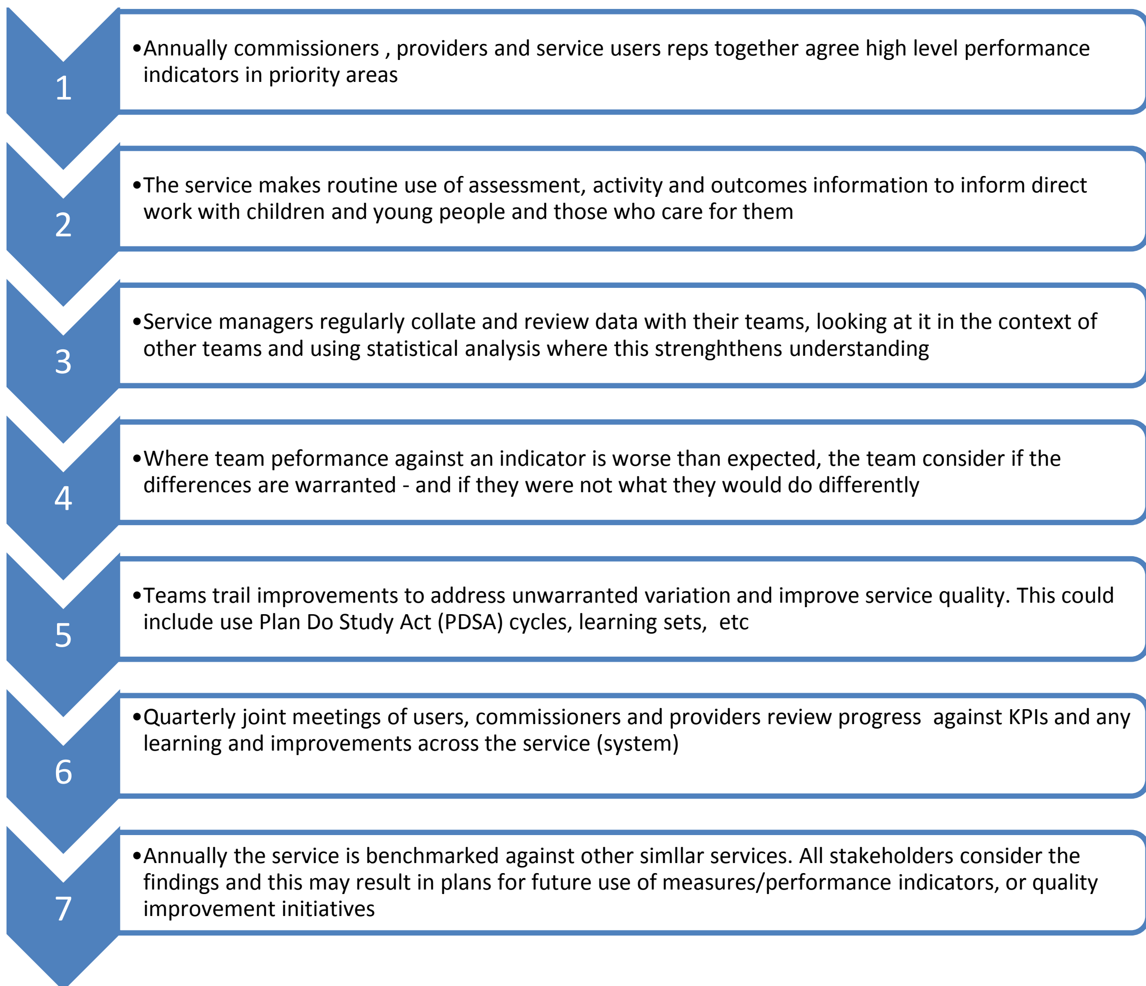
7 Steps to MINDFUL Performance Management

6.23 In combining multiple observers we ensure transparency and the ability draw on the strengths of each of our partners – stakeholders - so that we are best placed to deliver our vision and ambition. Working with CORC ensure the ability to benchmark our findings regionally and nationally and thus avoid seeing interpreting our findings in isolation. Services and teams will hold an emphasis on continual learning supported by the application of routine outcome measures. Embedding service users within our performance management approach ensures that we continually hold their views and experiences centrally.

6.24 Acting on this approach and recognising that this is a five year programme of change, which applies a phased approach in transforming system wide delivery, it is vital that learning collaborations are embedded from the start. As such within our performance management approach we seek to ensure making better use of information by applying and adapting the CORC 7 Steps to MINDFUL use of PROMS for performance management. This framework

provides a useful model to ensure transparency, joint ownership and accountability. Going forward the following performance framework will be embedded at the heart our governance and contractual service specifications.

Figure 2: 7 Steps to MINDFUL Performance Management



(Source: Adapted from CORC, 2015 & steps to MINDFUL use of PROMs for performance management)

Section 7: Our Plan with the Future in Mind

7.1 This final section of the transformation plan outlines and summaries our priorities in taking forward and delivering our vision and ambition. In addition it outlines the proposal for the new Emotional Wellbeing and CAMHS funding.

7.2 We have already started to take forward our vision and aim for children, young people and those who care for them in Tameside and Glossop. Our initial phase, in this first period 2015 to 2016, sees our focus and attention on access and partnerships and developing learning collaborations (developing robust information and monitoring and performance systems). We have embarked upon linking services so that care pathways can be joined up, simplified and to seek the removal of artificial barriers and duplication. We are developing creative and initiative ways to ensure that the voice of the child is held at the heart of our transformation.

Community Eating Disorders Service

7.3 Tameside and Glossop CCG is working with 5 others CCGs (Trafford, Stockport, Oldham, Bury and Heywood, Middleton and Rochdale) and Pennine Care NHS Foundation in a partnership to develop and deliver a community based eating disorder service that meets the requirements established by NHS England (July 2015), 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder'. *See Appendix 3 for full details on PCFT Eating Disorders Business case*

7.4 In summary the proposal is to provide a comprehensive locally based service to young people, who are resident in the identified Boroughs and who have an eating disorder. The pathway will be delivered through the development of a dedicated Community Eating Disorder Service (CEDS) staffed by a range of multi-disciplinary professionals. The national guidance states that there should be a dedicated team per 500,000 of the general population. Across the localities covered there is a population of 1.3 million and this would require the development of a minimum of two teams. It has been agreed in partnership with other CCG commissioners and the provider that two teams will be developed as follows:

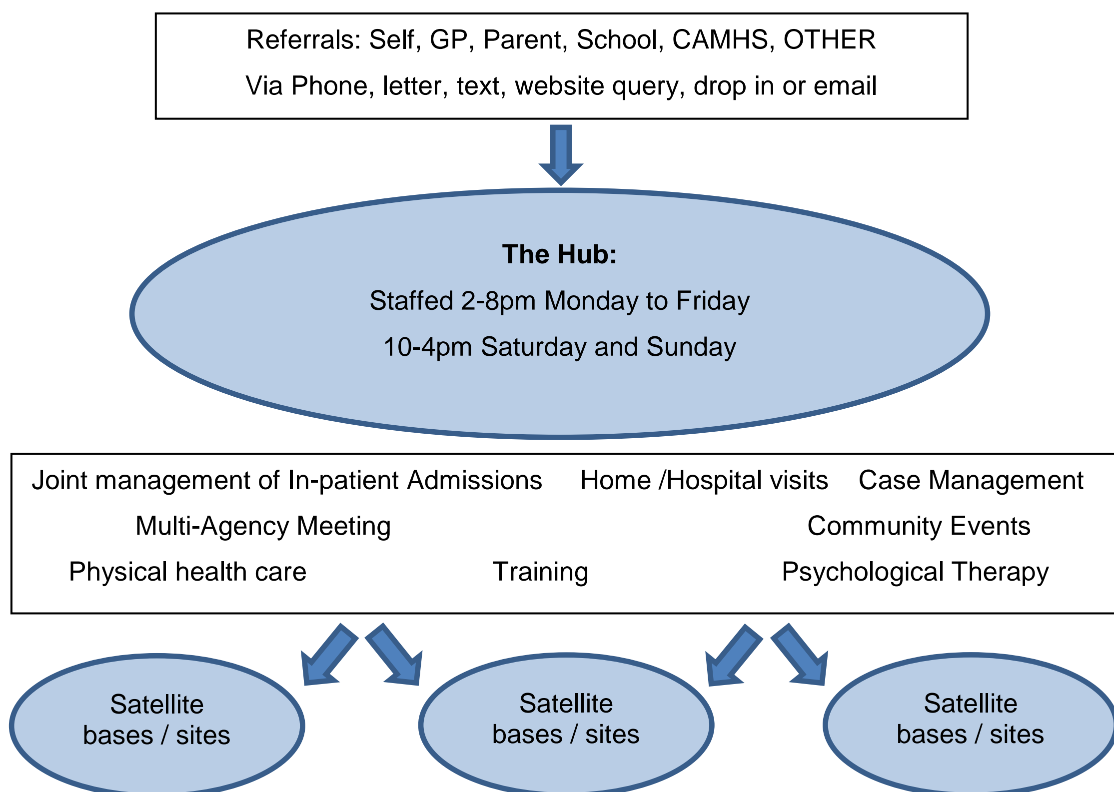
- South Hub –Tameside and Glossop, Trafford, and Stockport
- North Hub – Bury, Heywood, Middleton and Rochdale (HMR), Oldham.

The teams will mirror each other in terms of skill mix and pathway but the development of two separate teams allows for the evolution of local identity over time as the team becomes embedded.

7.5 The service will be structured on a hub and spoke model due to the large geographical area covered and the relatively small size of the teams. The following has been agreed in principle. The South Hub will be based in Stockport with satellite bases in Trafford and Tameside and Glossop. The North Hub will be based in Oldham with satellite bases in HMR and Bury.

7.6 We envisage The Hub as a vibrant, child oriented, community facility, located centrally. The Hub will be staffed 7 days a week and will be the main base offering drop ins, groups, assessments and treatments. Our ambition is for it to be a thriving community resource including a library of self-help resources, a café and a centre for training events, groups and meetings/talks. Staff at the hub will be able to offer same day responses to screen referrals and will be able to travel to carry out emergency visits where needed. Routine and specialist services will be available including family based approaches. There will also be a number of smaller satellite bases/sites that can offer assessments and treatments, located conveniently in separate geographical locations

Figure 3: Visual representation of the Hub Model



7.7 The expected outcomes for this service are:
- A more equitable and standardised level of provision for children, young people and their families
- More timely access to evidence based community treatment
- Fewer transfers to adult services
- Earlier step down and discharge from inpatient settings
- Reduced use of both medical and mental health inpatient.
- Reduction in crisis presentations and re referrals to specialist services
- Increased awareness and skill within the community including families/carers and peers
- Extend the Early Help offer to include lower level eating disorders
- Release capacity within generic CAMHS to enable shorter access times into the service

Our Priorities 2015-2017

Period	Key Priority	Thematic Domain
June 2015 to March 2016	**Getting Help** – we will ensure children, young people and those who care for them can access help when and where they need it through a single point of access that covers the whole system and not just specialist CAMHS; providing a clear understandable service offer (what support should be received). We aim to: - • Review access pathways for specialist CAMHS, benchmarked with other similar partnership area service(s). • Undertake referral mapping and audit to identify low and high referral sources; Identify key sources of redirected referrals and focus of redirection (which services are families signposted to); Re-referral rates. • Identify the hard to reach young people and families by locality and collect baseline information on access to specialist CAMHS and benchmark findings • Develop and produce access pathways and a clear, '*understandable'* CAMHS 'local offer' for meeting emotional wellbeing and mental health needs, which includes self-referral • Develop and plan, in partnership, interventions (training needs analysis and programme, supervision, link practitioners) to encourage self-referral and improve referral quality and appropriateness (address low and high referral sources/routes). • Ensure that the most experienced professionals with expert knowledge of children and young people's mental health are accessible from the start' across the system; particularly placing them where children and young people are most vulnerable (LAC, Youth Offending), so that there are no gaps through which they can fall • Work with NHE England and the Department for Education to pilot and test the named lead approach and the training programme with schools. • We will ensure that all GPs have a named CAMHS Consultant to improve communication and access between primary care and CAMHS • Implement Single Point of Access (SPA) within the integrated Public Service Reform Hub to improve access for children, young people and those who care for them • Place the third sector within the management of the NHS CAMHS service to enable a joined up offer between statutory and voluntary services; offer mediation within referral appeals • Implement local waiting time targets that seek the improvement in access specialist CAMHS services support and treatment • Agree our parenting programme offer, ensuring that we have consistent access to high quality evidence based parenting programmes, delivered to model fidelity	A, C, D, E, F
September	**Community Eating Disorders Pathway** – we will work with our identified CCG partners and Pennine	A, B, C, D, E

2015 to March 2017	Care NHS Foundation Trust to develop and deliver a community based eating disorder service that meets the requirements established by NHS England (July 2015), 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder'. We aim to: - • Ensure the service model is developed in partnership with key stakeholders, placing the voice of the child and those who care for them at the heart; utilising national guidance, local clinical expertise, performance data and service user feedback • Review the range of services available for young people with eating disorders, including inpatient treatment, support from the In reach/Outreach team (IROR) and community CAMHS intervention ensuring that the new service provision builds on and takes into account existing provision and expertise • Explore the true need in providing support to young people across a full pathway form emerging, lower levels to moderate and severe, ensuring support is readily available for all levels of need • Scope and ensure that Paediatric and Dietician services are seamless delivered within an integrated Eating Disorders Pathway • Ensure the reduction of inequalities in access and outcomes; service design and communications should be appropriate and accessible to diverse communities. Scope building services in more visible, more central and more accessible sites may assist in addressing socio-economic or cultural barriers to access. • Review and consider the findings from the Surveillance Review December 2013 of the 2004 NICE Eating Disorders Guidance with emerging evidence that day patient care is equally effective as in-patient care but associated with lower cost • Ensure CYP accessing the service are offered a generic mental health assessment to identify/exclude any co-morbid needs, a specialised eating disorder assessment, a baseline physical health screening and an individualised care plan. • Ensure the service can offer a range of therapeutic interventions, which are evidence based and underpinned by a multidisciplinary team (MDT) ethos and approach. The MDT will work in close collaboration with the virtual team members that they regularly interface with such as Acute Trust Paediatric and Medical services, and with Primary Care, to ensure young people's co-existing physical health needs are met.	
October 2015 to October 2016	**Transition to Adulthood** – we will continue to explore all avenues to smooth the transition from children's to adult services by taking a developmental, personalised approach rather than being dictated by chronological birthdates. We aim to:- • Establish an all age Eating Disorder Service, enabling young people to stay on within the same service	A, B, C, D, E

	until they are ready to be discharged. • Establish an all age ADHD service to support CAMHS graduates and families as well as adults. • Review mental health provision for young people aged 16 and 17 and engage young people in the design of options for consideration • Strengthen the integrated pathways between CAMHS and AMHS, using the learning from the transformation plan to better support the service transition in particular for vulnerable groups including CSE, Looked after young people and young people who self-harm. • Explore evidence base and options for vulnerable young people to continue within the CAMH service until they are ready to leave. • Develop a CQUIN that builds upon and improves transition arrangements between CAMHS and Adult Mental Health.	
September 2015 to December 2016	**Parental Mental Health** – we will continue our focus on Parent Infant Mental Health and expand this to include parents of children of all ages. We aim to:- • Undertake a whole system audit of practice based on the NICE Guidance on Ante and Postnatal Mental Health and check our findings against gathered experiences of care in the perinatal period from parents. • Refresh our Integrated Parent Infant Mental Health Pathway in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health. Review training programme and amend as required. • Establish a pathway for families with high needs, such as those within the child protection system and parents with learning needs, from early pregnancy to school. To support this we will extend the capacity of our Early Attachment Service to deliver intensive evidence based parenting programmes such as Mellow Parenting to prospective mothers and their partners and to extend provision for dads. • When published, work with partners across GM to agree a sector solution to the expectations of the NHS England Perinatal Mental Health Standards to ensure women have access to specialist perinatal services when they are required, including access to Mother and Baby Units/community based alternatives as an option for all expectant mothers or those in the first year after birth. • Build on last year's Parental Mental Health CQUIN, CCG Carers review, evidence base on outcomes for children where parents have mental health needs and agree whole system requirements to promote good outcomes for children.	A, B, C, D, E, F
October 2015 to May	**Neurodevelopmental Umbrella Pathway** – we will work with all partners across the health and economy and children's social care and education to deliver an umbrella pathway for children and young people	A, B, C, D, E

2016	where there are queries or concerns about difficulties in the following areas: Attention, concentration, impulsivity and hyperactivity (ADHD and ASD). In addition we will strive to widen the pathway within a phased approach to also cover: Learning, thinking behaviours; Tics and other motor mannerisms; and other difficulties such as sensory processing. We aim to:- • Work with CYP and those who care for them to improve assessment, diagnosis, management, on-going support and outcome plans for all children and young people, whether a specific diagnosis is reached or not • Establish multi agency partnership and steering group to review, develop and implement a pilot Neurodevelopmental Umbrella Pathway, continuing to work in partnership with the ADHD Foundation • Deliver the GM and Lancashire Strategic Clinical Network ADHD standards • Ensure timely access to NICE concordant care through the delivery of Neurodevelopmental Umbrella Pathway - drawing on, but not limited to, Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults; and Autism: The management and support of children and young people on the autism spectrum • Ensure clear ownership and accountability for the pathway • Review and monitor the effectiveness and impact on resources and ensure provision is sustainable	
August 2015 to June 2016	**Develop the Workforce** – we develop training programmes that lead to an appropriately skilled workforce across the whole system that seek to ensure a 'no wrong door' approach and promotes early invention and timely access. We aim to:- • Implement workforce audits that leads to the development of training pathway and programme that cuts across the whole workforce; including volunteers, support staff and receptionists • Establish multi agency partnership and steering group to review, develop and implement a training programme that can be accessed by all agencies and organisations across Tameside and Glossop that are working with children, young people and those who care for them. This will include training and development on adult mental health to enable children's services staff to support parents into adult mental health provision if required • Promote access to e-learning and tuition lead courses to all CYP workforces, including volunteers, across Tameside and Glossop; minimising the barriers to access • Develop and implement Self-Harm and Suicide Strategy, guidance for all practitioners across setting supported by training and supervision (action learning model) • Maintain and roll out CYP IAPT from our NHS CAMHS service to all partners, including the third sector and education. • Develop and implement training programme for parents and carers	B,C D, F

September 2015 to April 2016	**Coping** – we will ensure access to a range of information and develop the infrastructure that enable those children, young people and those who care for them the choice over their care that enables self-directed care and management. We aim to:- • Develop and support infrastructure that enables self-directed care and management (e-platforms and apps), one off contact (online or face to face) and peer mentoring • Develop choice and control for children, young people and those who care for them through: promotion of the local offer; Personal Health Budgets (PHB); establish and maintain Service User Fora • Ensure promotion of mental health and emotional wellbeing through tackling stigma campaigns, workshops and local events (e.g. World Mental Health Day)	A, B, C
September 2015 to June 2016	**Getting Risk Support** – we will continue to develop preventative and proactive as well as intervention services for children and young people who are vulnerable such as those who are looked after, in the criminal justice system, those with a mental Health crisis and those requiring in-patient care. We aim to:- • Review interface between CAMHS community based and CAMHS inpatient services (including secure) • Review interface between CAMHS (PCFT) and Paediatrics (THFT). • Establish interface meetings to ensure effective pathways and joint working between CAMHS and Tameside Hospital emergency department through to the Paediatric ward. • Build effective risk management and early intervention for children and young people at risk of a crisis • Refresh our Crisis Care Concordat to ensure that children and young people are appropriately reflected (see appendix 4 Tameside Template action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat). • Review crisis care for children and young people within our evaluation of RAID services at Tameside General Hospital in line with NHS England Psychiatric Liaison Standards. • Review CAMHS In-reach Outreach Service in conjunction with the development of the home treatment aspect of the Community Eating Disorder service and develop urgent/crisis care home treatment model, ensuring cross organisational support and integrated delivery. • Scope opportunities in conjunction with the LA to develop Edge of Care services in localities to prevent family breakdown and reduce the use of unplanned care episodes • Work with colleagues in GM to develop a local approach to commissioning CAMHS Inpatient care and alternatives to in-patient care in line with GM Devolution. • Ensure, with the Local Safeguarding Children's Boards (LSCBs), that findings from Serious Case Reviews (SCRs) in relation to emotional well and mental health are implemented • Review CAMHS pathway for Child Sex Exploitation (CSE) and develop action plan based on findings	A, B, C, D, E

September 2015 to March 2017	**Joint Commissioning** – in line with our Care Together plans we will integrate the commissioning of emotional and mental health services and ensure a Mindful approach to commissioning that ensures services meet the emotional wellbeing and mental health needs of children, young people and those who care for them. We aim to:- • Maintain our commitment to systematically ensuring the voice of the child is heard and acted upon within commissioning arrangements • Build on our engagement with children and young people by developing and maintaining Service User Fora to provide a direct voice into our Programme Board and future commissioning intentions; ensuring decisions around design and delivery are shaped by those best placed to know what works and help monitor effectiveness • Place the Voice of Child statements as KPI's and audit within all service specifications commissioned to deliver emotional wellbeing and mental health service for CYP and those who care for them • Ensure all service specifications (including physical health) highlight emotional wellbeing and mental health requirements of the provider. • Expand the remit and terms of the current Children, Young People's emotional Wellbeing and Mental Health Transformation Programme Board until 2020. • Pilot CAMHS Modelling Tool to support the of improved mental health services for children and young people beyond 2016/17 • Ensure outcome based commissioning is developed and that Routine Outcomes Measure (ROMS) are stipulated within service specifications • Review and consider implementation of online web based IT system to capture and collate data from CAMHS and partners agencies, ensuring business intelligence support form CORC. • Establish New service specification for Community CAMHS 2016/17 based on Local Transformation Plan principles and Thrive Model for CAMHS; placing the voice of child 'I' statements at the heart service specifications • Through the CCG Nursing and Quality Directorate undertake audit and quality visit to PCFT CAMHS and ensuring NICE concordant delivery • Develop and Maintain Pennine Care CAMHS Commissioning and Provider interface, with those CCGs who commission Pennine Care NHS Foundation Trust as their CAMHS provider (Tameside and Glossop, Oldham, Trafford, Stockport, Bury and Haywood, Middleton and Rochdale) • Work with all partners within our work to create an Integrated Care Organisation that supports a single point of access to all children and young people's provision (including Mental Health). This will ensure smooth pathways into a range of support with a significant reduction in 'asks for help' being rejected and/or referred on. We will ensure direct access to help for children, young people and those who care	A, B, C, D, E, F

	for them.	

Thematic Domain Key:

A. The voice of the child - reforming care delivery based on the needs of young people, children and those who care for them;
B. Developing resilience, prevention, early intervention and promoting good mental health and wellbeing;
C. Improving access to appropriate services that are as close to home as possible and at the right time that are implementing evidence based pathways;
D. Promoting working across agencies leading to a clear joined up approach for the benefit of children and young people in Tameside and Glossop;
E. Improved accountability, transparency and ownership of an integrated whole system; and
F. Development of training programmes that lead to an appropriately skilled workforce across the whole system.

Finance Plan

7.8 The following Finance Plan shows the new funds allocated to Tameside and Glossop and our commissioning intentions as to its potential use, subject to assurance process for final agreement.

Figure 1: Tameside and Glossop Commissioning Intentions 2015-17 utilising NHSE CAMHS Transformation investment

Tameside &Glossop CAMHS New Funding	**2015/16**		**2016/17**	**2017/18**	**2018/19**	**2019/20**
New CAMHS Income						
Community ED (initial allocation on submission of plan - October 2015	145,589					
Following assurance (Nov/Dec time)	364,423					
All	510,012		510,012	510,012	510,012	510,012

Potential Expenditure	**Forecast Outturn 2015-16**	Notes	***2016-17 Plan***
Core Programmes:			
Community Eating Disorders	145,589	1	*147,045*
Parent Infant Mental Health	10,000	*2*	*40,000*
Access and Transitions	8,000	*3*	*32,000*
Early Help	0	*4*	*43,772*
Neurodevelopment Umbrella Clinics	9,000	*5*	*36,360*
LAC Psychology	14,910	*6*	*60,237*
YOS Forensic & Transition	0	*7*	*51,575*
Schools Liaison and Consultation	12,766	*8*	*43,772*
Workforce Development (Training Post)	10,835	9	*43,772*
CYP/Service User Fora	10,000	10	3,678
LTP Benefits Realisation (Monitoring and Evaluation)	16,000		7,800
Non Recurrent Service Development:			
Neurodevelopment Umbrella Service Development and Coordination	34,000		0
Neurodevelopment Umbrella Clinical Development	45,000		0
School Health and CAMHS Service Development	45,000	11	0
LAC Emotional Well Being and Mental Health Service Development	45,000		0
Challenging Behaviour Service Development	46,000		
Non Recurrent Programmes:			0
Voice of the Child Findings & Development	20,000		0
Public Health Campaign Awareness/resources	15,000	12	
Youth Mental Health First Aid Course (2 trainer the trainers)	5,476		0
Training Materials Non Pay Costs	17,436		*0*
Total	**510,012**		**510,012**
Remaining	**0**		**0**

All Schemes subject to review and evaluation for continuation to 2020.

Notes

1 Planning & Delivery of an Integrated Service
2 Expansion of Early Attachment Service (EAS) and perinatal Care
3 *3rd Sector Funding to improve access and transition for children and young people and to coordinate and embed 3rd sector offer within our statutory CAMHS service*
4 Early Help funded through non-recurrent funding and ends 31.03.2015
5 New Umbrella Neurodevelopment Pathway with additional Community Paed Clinics
6 New dedicated LAC service with Psychology
7 NHSE divisionary funding end 31.03.2015 establish New dedicated YOS service with MH practitioner based in YOT
8 New CAMHS School Consultation and Liaison Service
9 New MH Training Officer post
10 Support Cist for CYP service user Fora
11 New service developments cost
12 Non Recurrent programmes - Public Health Campaigns and Training Programmes

7.9 The plan is built on sustainability and supports a phased approach in delivering our vision and ambition. As such this first phase of commissioning intentions outlines the potential expenditure to 31st March 2017, building on the existing Emotional Wellbeing and CAMHS 2015-16 Investment outlined in 4.64. The commissioning intensions make explicit our plans in prompting equality and addressing health inequalities. As such the commission intentions hold a focus around those children and young people deemed vulnerable to mental health

issues, such as LAC, School Exclusions/truancy, those associated with criminal Justice (YOS) and having a parent who has had mental health problems.

7.10 Following assurances at a local, regional and national level we will adhere to the performance management framework outlined in section 5 that will review and decide upon subsequent use of monies pass this date. As such the commissioning intentions outlined here as all subject to review and evaluation going forward to 2020.

APPENDICIES

APPENDIX: 1

Terms of Reference

Tameside Metropolitan Borough · DERBYSHIRE County Council Improving life for local people · NHS Tameside and Glossop

Children and Young People Emotional Wellbeing and Mental Health Services Programme Board

Terms of Reference

The CYP Emotional Well Being and Mental Health Programme Board is partnership to lead the shared mission, vision and values (the "who, what and why") to improve access and support within an integrated approach to providing an emotional wellbeing and mental health system.

The aim of the programme Board is to ensure children, young people and families have:

- Clearly signposted routes to support including specialist CAMHS
- An 'open door' into a system of joined up support
- Clear understanding of the service(s) offer (what support they should receive).
- Timely access to this support

It will deliver a clear offer to meet the emotional wellbeing and mental health needs of children and adolescents through partnership service delivery. This will require the development of pathways across an array of services and the active involvement of children, young people, parents and cares.

It is a programme board to continue to develop working relationships between health and social care commissioners and provider organisations.

The Partnership through the programme board will take whole system ownership of the priorities, challenge performance and manage risk to deliver whole system approach and accountability on behalf of the population of Tameside and Glossop.

The programme board has a fixed terms remit to deliver its aim and objectives.

Core members:

- Clinical Commissioning Group (CCG) Officer(s) and Clinical Lead (GP)
- Tameside Metropolitan Borough Council (TMBC)
- Derbyshire County Council (DCC) – High Peaks & North Dales Locality Manager
- Pennine Care NHS Foundation Trust (CAMHS Provider Service)
- Stockport NHS Foundation Trust (ChS Community & School Nursing Provider Service)
- Tameside Hospital NHS Foundation Trust
- 42nd Street
- CVAT
- User representative
- Stakeholders representative from Education
- Stakeholders representative from Children's Social Care

Chair:

The meeting will be chaired by the CCGs Commissioning Business Manager for Children, Young People & Families.

Governance:

Each member organisation has a responsibility to report back through its own governance structures:

- Clinical Commissioning Group via the Planning, Implementation and Quality committee
- TMBC via Executive member for health and neighbourhoods the Health & Wellbeing Board and SMT/ET
- DCC via the Assistant Directors of Commissioning and Operations and through the High Peaks & North Dales Locality Manager
- Pennine Care NHS Foundation Trust via • The CAMHS Transformation plan and relevant actions will be implemented and monitored via the Tameside and Glossop CAMHS Senior Management, CAMHS Directorate Clinical Business Unit and Divisional Business Unit structures

Role of the Programme Board to:

1. Set the strategic direction for an emotional wellbeing and mental health whole system, across the health and social care economy, with partners working together to meet the service and financial challenges which exist. To agree a joint mission, vision and values by October 2015.

2. Improve children, young peoples and their families experience and outcomes, and ensure they are supported or treated by the most appropriate setting in line with their needs. To ensure that users and carers are engaged in the mission, vision and values agenda.

3. Improve quality and performance across all providers. To work collectively to meet national and local KPIs. To acknowledge each other's contribution in the reform of pathways and service models, whilst recognising individual organisational challenges and performance regimes.

4. Ensure that the economy meets national requirements and objectives relating children and young people Mental Health

5. Deliver new pathways/models of care for children and young people's emotional wellbeing and mental health needs by October 2015.

6. Co-ordinate and be responsible for the implementation of an emotional wellbeing and mental health whole system approach from April 2016 onwards.

7. Develop resilience and escalation processes and planning to manage surges in the demand for services across health and social care partners.

8. Continue and review the systematic approach to monitoring the demand and unmet demand across health and social care.

9. Ensure that there are robust plans in place to actively engage with patients, carers, staff and the wider public in the planning and implementation of a whole system approach to meeting the emotional wellbeing and mental health needs of children and young people.

10. Ensure that all partners have the capacity and capability to deliver improved service pathways and work in an integrated way, supporting appropriate training and development across the whole system.

The Programme Board will have a sub structure of formal task and finish groups, with their own Terms of Reference, which report into the Board on a regular basis, as a minimum, every other month. These will include:

- Third sector evaluation and development
- Core CAMHS performance and quality indicators
- Outcome measures (system wide initiative)
- Education offer
- Social care Offer
- Health offer (inc CAMHS, Primary and Secondary/Community Care)
- Service user Involvement

Quorum:

There will be a chair and 3 group members making a minimum of three representative organisations (from NHS Tameside and Glossop CCG, Tameside Metropolitan Council, Derbyshire County Council and Pennine Care NHS Foundation Trust) in attendance at the meeting. There should be a minimum one representative from the CCG and two representatives from other organisations.

Other members will be co-opted to attend on an ad hoc basis as required.

Attendance at Meetings:

Members are asked to identify named deputies, who are appropriately briefed and are able to attend meetings on their behalf if required. All members must understand and accept that this is a decision making forum of the most senior level.

Frequency of Meetings:

Meetings will be held monthly in the first with a view to move to 6 weekly

Fix Term remit:

The Board exist to deliver a draft vision and plan by October 2015. The aim of which is to inform service specifications reviews going forward from November 2015 and

commissioning intentions for 2016/16. As such it is envisaged the Programme Board will review its continuation after March 2016.

Date Approved:

Review Date:

These Terms of Reference will be reviewed in 3 months, 6 months then every 12 months thereafter

APPENDIX: 2

a) Report on the Findings from Focus Groups on Emotional Wellbeing and Mental Health Services in Tameside and Glossop August 2015

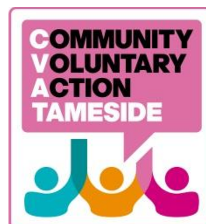
b) Tell Us Survey- Tameside and Glossop July 2015

Young People's Emotional Wellbeing and Mental Health Services

Report on the Findings from Focus Groups on Emotional Wellbeing and Mental Health Services in Tameside

August 2015

Report produced by



On behalf of

NHS
Tameside and Glossop
Clinical Commissioning Group

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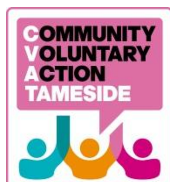

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Community and Voluntary Action Tameside (CVAT)
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1. Introduction

The Children and Young People Emotional Well Being and Mental Health Programme Board is a partnership to lead the shared mission, vision and values to improve access and support within an integrated approach to providing an emotional wellbeing and mental health system.

The aim of the programme Board is to ensure children, young people and families have:

- Clearly signposted routes to support including specialist CAMHS
- An 'open door' into a system of joined up support
- Clear understanding of the service(s) offer (what support they should receive).
- Timely access to this support

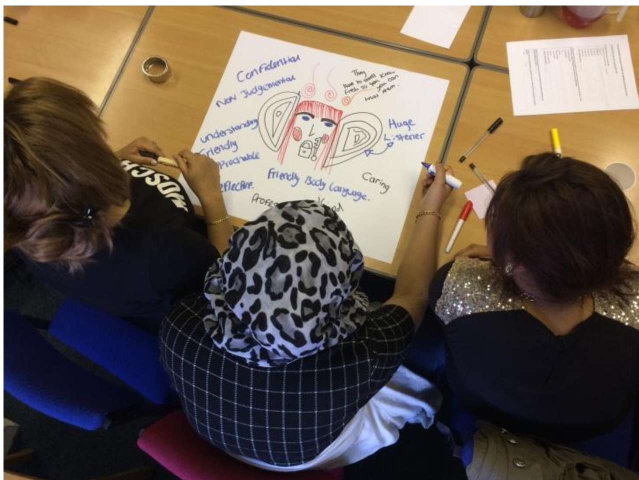
The programme Board has a number of roles, they key roles to this work are:

11. Improve children, young peoples and their families experience and outcomes, and ensure they are supported or treated by the most appropriate setting in line with their needs. To ensure that users and carers are engaged in the mission, vision and values agenda.
12. Ensure that there are robust plans in place to actively engage with patients, carers, staff and the wider public in the planning and implementation of a whole system approach to meeting the emotional wellbeing and mental health needs of children and young people.

In order to ensure that young people are given the opportunity to feed into the development of Child and Adolescent Mental Health Services in Tameside, it was recommended that a focused consultation with young people aged 11-25 takes place in relation to the support and services that they might access at various stages of their mental health/ill-health and wellbeing. The consultation was framed around the Thrive model in order to inform how services might be configured and commissioned in the future. This report provides the main findings from focus groups undertaken by Community and Voluntary Action Tameside (CVAT) in order to inform the work of The Children and Young People Emotional Well Being and Mental Health Programme Board.

2. Methodology

Seven focus groups were undertaken throughout August 2015 engaging 69 young people aged 11-25 across Tameside. We utilised existing groups to provide focus groups on our behalf, we focussed on protected characteristic groups not covered by other agencies including; BME, Women, and Disability. The groups we engaged are, Off the Record, Our Kids Eyes, Hyde Community Action, Water Adventure Centre (women's group), young people who access Active Medlock, Active Copley and Active Denton sessions.



The focus group session was developed to be an interactive engaging session which used the consultation questionnaire developed by 42nd Street as a framework.

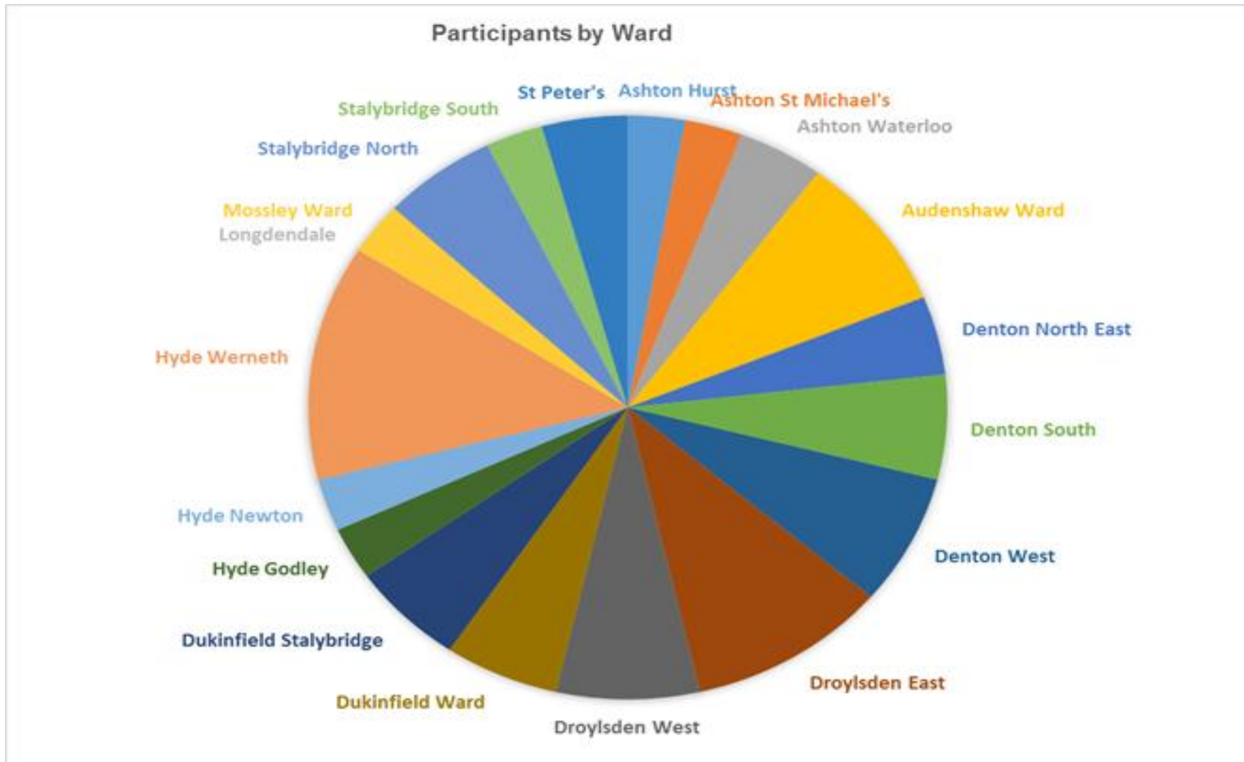
The session was developed to be a visually engaging and active session, to support the active engagement of children and young people of all abilities.

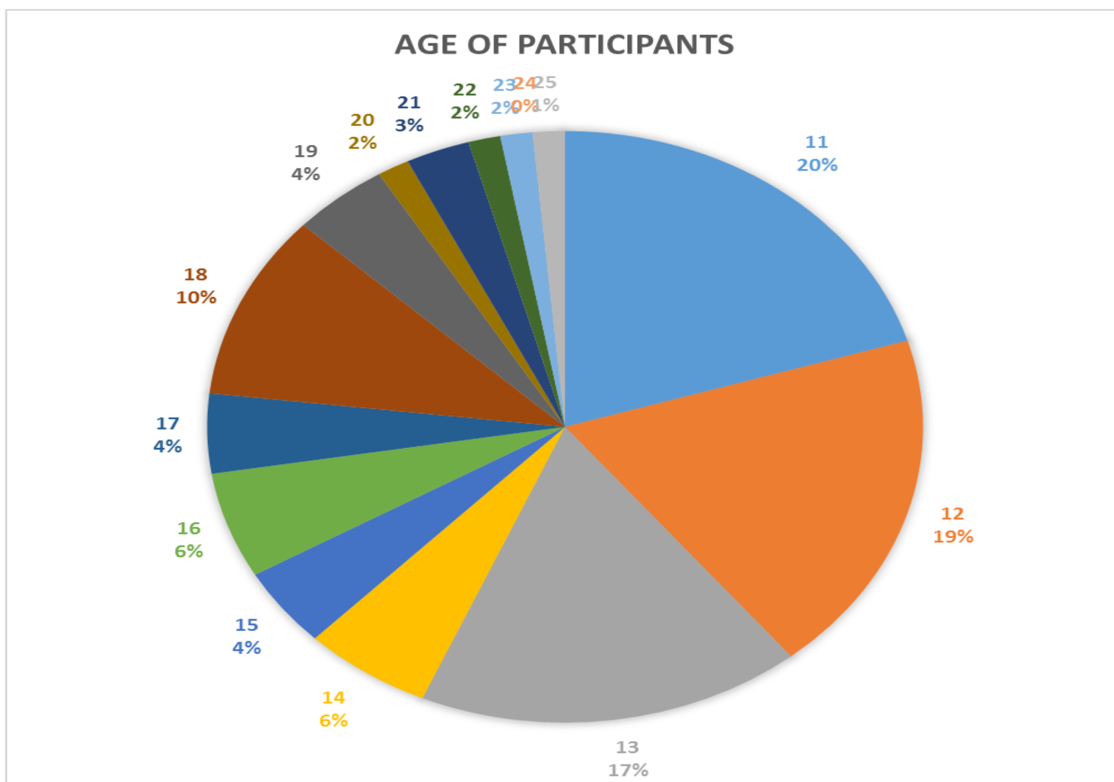
Dedicated breakout space was offered so that young people could share their experiences 1-2-1 if

they were unable to do this in the group.

2.1 Who Participated?

The demographics of those who took part by their age and the ward in which they live are represented in the charts below.

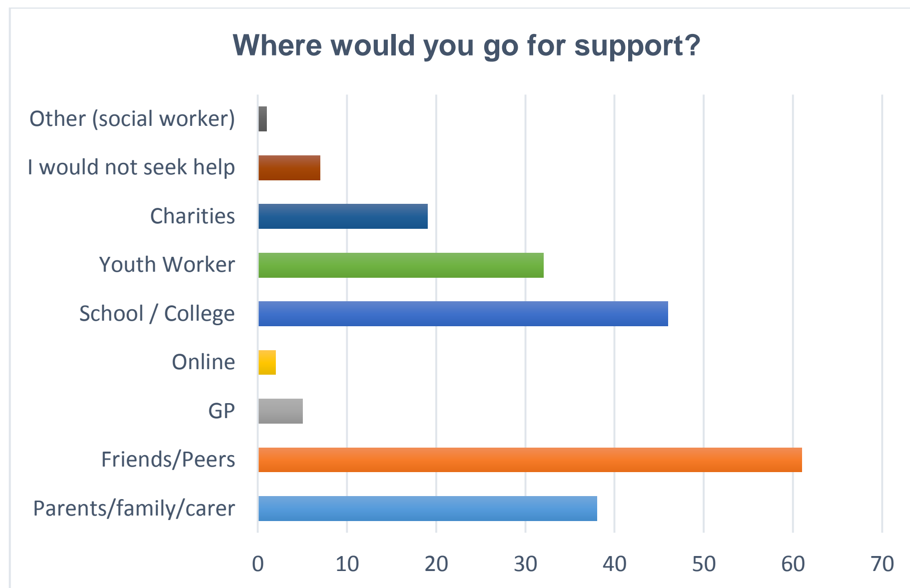




3. Outcomes of the Focus Groups

Each of the focus groups were asked a series of questions in line with the wider questionnaire framework, below are the questions and the themes that emerged that reflect the discussions and some direct quotes from participants.

3.1 Where would you go for help if you had been feeling a bit worried, anxious or low for more than a week?



Key themes that emerged from discussions include:

Friends were are very important group in young people finding support initially. There are a number of reasons for this including:

- Friends are trusted confidants
- Friends may have been through a similar experience themselves
- Friends understand who I am and 'get me'
- My friends know everything about me so I wouldn't have to start from the beginning with them

School or College came out as an important place where young people would access support, through discussions it emerged that the most common things to impact on young people's emotional health and wellbeing are school or college issues including bullying, not achieving well, young people dealing with the consequences of struggling to manage their behaviour within the school / college rules of what is acceptable. The participants felt that they could get access to support at school or college.

Parents, Families and Carers came out as an important group, especially with younger participants (11-16) and those with additional needs and disabilities. These groups felt that they would speak to their parents and families as they would be best placed to support them. It is worth noting that older participants 16+, BME participants and participants who are Looked After by the Local Authority where all much less likely to go to this group for support.

Around half of the respondents said that they would seek support from their youth worker, this is reflective of the discussion that took place around young people seeking out support initially from a trusted adult that they have an established positive relationship.

3.2 What support is available at your school/college when people are feeling a bit worried, anxious or low?

Key themes from discussions included:

There is some support at school, but not specialist support, participants in the main felt that they could get some help and advice, particularly when they were worried or anxious about something, but that there was not really any useful help if they were feeling low / down or emotional.

The main people they would get help from are the pastoral staff/ mentors, and many of the participants talked about getting help in school with managing anger.

> ***"You can get good support if your problem is about school, but if it's about something else like if you've got stuff going on at home you might not get the help you need."*** **Female 13**

3.3 Have you ever accessed your school's nurse for help with your emotional or mental health?

None of the participants across the seven focus groups had accessed support from their school nurse around their emotional or mental health, a number of young people were aware of their school nurse, but viewed the service from the school nurse as a physical health thing, for example getting weighed and measured.

3.4 If you have accessed the school's nurse, how would you rate the help that you received?

None of the participants have accesses the school nurse for this type of support, so where unable to rate the help.

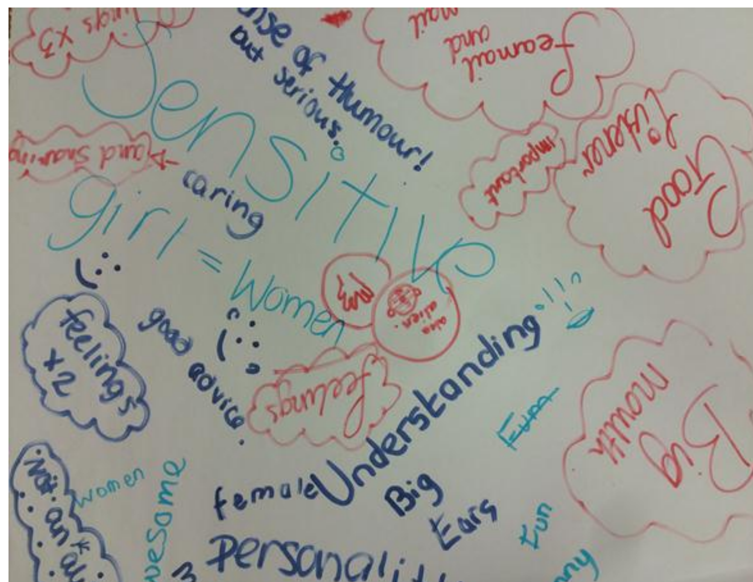
3.5 What qualities would you look for in a person that could help you with your emotional health and wellbeing?

To support discussion on this question, participants were asked to draw the perfect person that could help them in groups and then present back to the other groups:

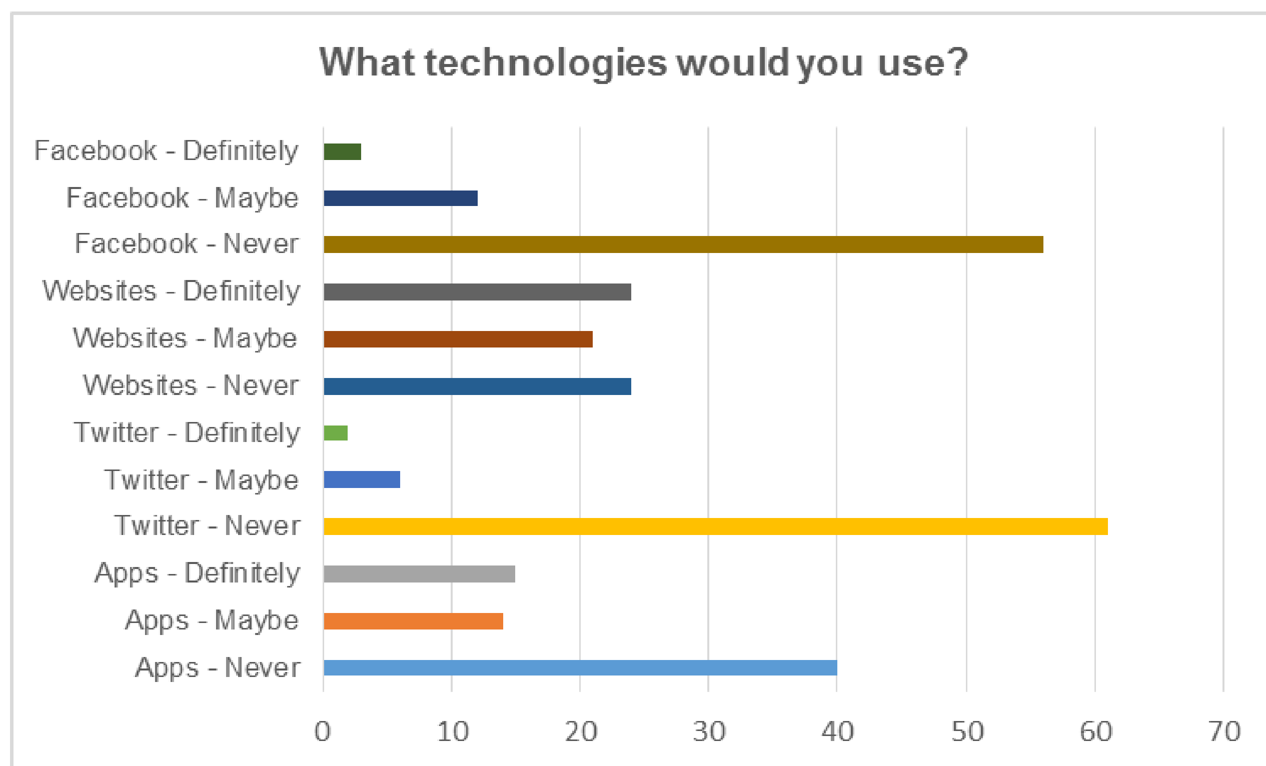
The following key themes came through discussion:

- Someone who is understanding
- A good listener
- Non-judgemental
- Can see/understand how you feel
- Someone who is knowledgeable who can give good advice
- Someone who can give balanced advice
- Friendly / approachable
- Professional – not looking at their phone and slouched during appointments
- Must have lots of empathy
- Be kind
- Make you feel safe
- Show they are friendly and listening by their body language
- Must be able to relate to young people
- Must be trust worthy
- Must be patient
- Be able to give the right advice
- Someone who is prepared for you to take small steps
- Someone who treats you as an individual
- Someone who knows how to talk to you sensitively (ie not saying "so are you feeling suicidal then")
- Someone who doesn't think that if you are self-harming you are just seeking attention.
- Aged 21-40, because younger people understand better
- Girls would work better with a female worker and boys would work better with a male worker
- Someone who is experienced and knows what to say

> *"I had a worker who made loads of assumptions about me because my situation was similar to someone else she was working with, just because the situation was similar didn't mean that I would deal with stuff in the same way, I just wanted to be treated as an individual."* **Female 17**



3.6 Would you use any of the following to help you with your emotional and mental health and wellbeing?



Overall the discussions around using technology to get support for emotional and mental health were lively and the participants had very strong views around this. There was a real mistrust of social media, apps and websites. A mistrust that the information wouldn't be correct and up to date, that the privacy / confidentiality would not be sufficient and that you wouldn't know who was responsible for the information / advice / support.

There was concern about using Facebook or twitter due to privacy issues, although the group said they would use links on Facebook that were signposting to support services, but that they wouldn't want to share information about how they were feeling on Facebook or twitter.

The group were split on using apps, half of the group said they wouldn't use apps as they generally don't trust online help or advice, also that they don't think that help that could be delivered through an app would be as effective. There was a strong feeling in the group that help needs to be delivered by a real person. There was a view and agreement that an NHS app would have credibility and would more likely be used, but the content would need to be specific, not generic, the group felt that generic info was too vague and rarely useful. The accessibility of apps at any time of day and night was generally regarded as useful. Accessing info on websites was generally problematic for the groups as they had issues about trusting the information or advice, not knowing if it was edited by a professional or if they were talking to someone on a website that that person was a professional. There was a sense that an NHS website would be more trusted than other websites.

> *"I've had a bad experience talking to a counsellor on a website, I wouldn't ever do it again or advise anyone else to."* **Female 21**

3.7 In what ways do you think technology could better support young people with their emotional and mental health and wellbeing?

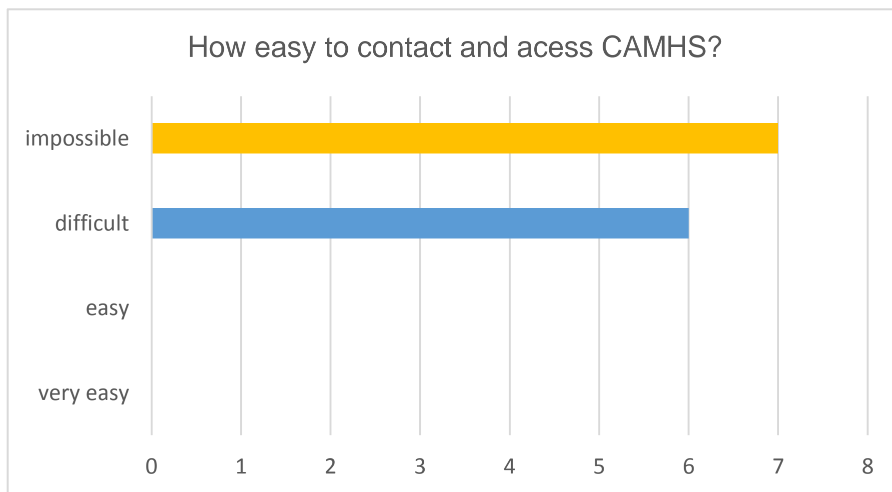
The key themes from discussion were:

- ✓ Better up to date information online about where to get help.
- ✓ More tips about what to do if you're worried or feeling low - not just vague and general info but some really practical tips for different situations.
- ✓ Better up to date information online about where to get help – correct info about support services, better advertisement.
- ✓ More specific self-help not just generic info about what to do if you're feeling worried, stressed, anxious or low or depressed.

3.8 Questions relating to those who have experience of statutory Child and Adolescent Mental Health Services (CAMHS.)

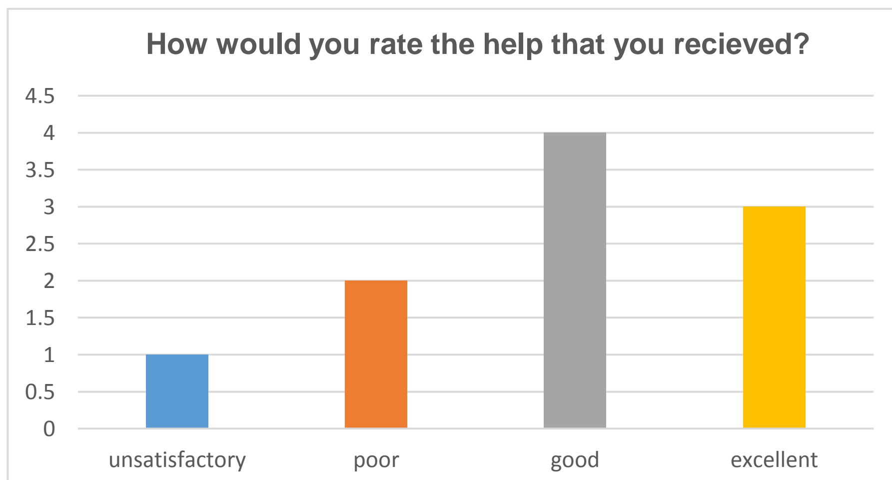
Across the seven focus groups 13 participants had direct experience of CAMHS.

3.9 How easy was it in your experience to contact and access CAMHS?



Three of the seven participants who said it was impossible to contact and access CAMHS had been referred to CAMHS but had been refused a service.

3.10 If you attended CAHMS how would you rate the help that you received?



3.11 What do you think worked best for you at CAHMS

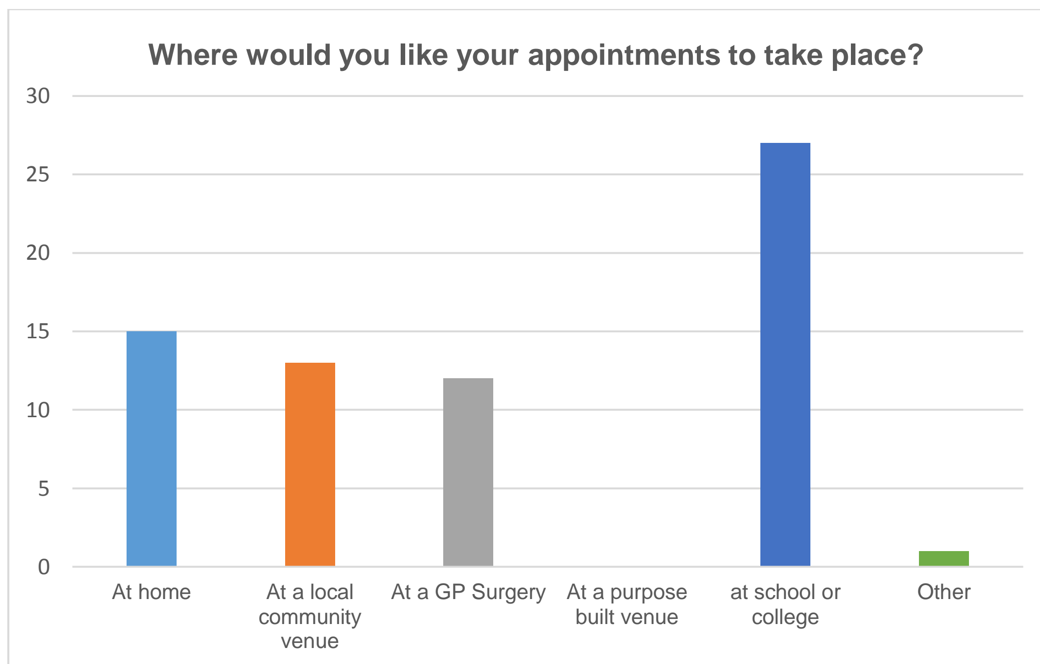
It was difficult for participants to articulate what had worked best for them, generally there was a feeling that talking to someone really helped.

3.12 What do you think could be improved at CAHMS

There was a number of issues discussed including:

- Doctors are quick to label you but don't explain what it means
- You feel like you're constantly fighting a battle trying to get the help you need
- The person doesn't get to know you they just ask what the problem is straight off
- Instead of giving anti -depressants – they should do more therapy or CBT work.
- I only went once but it didn't help me so I didn't go back

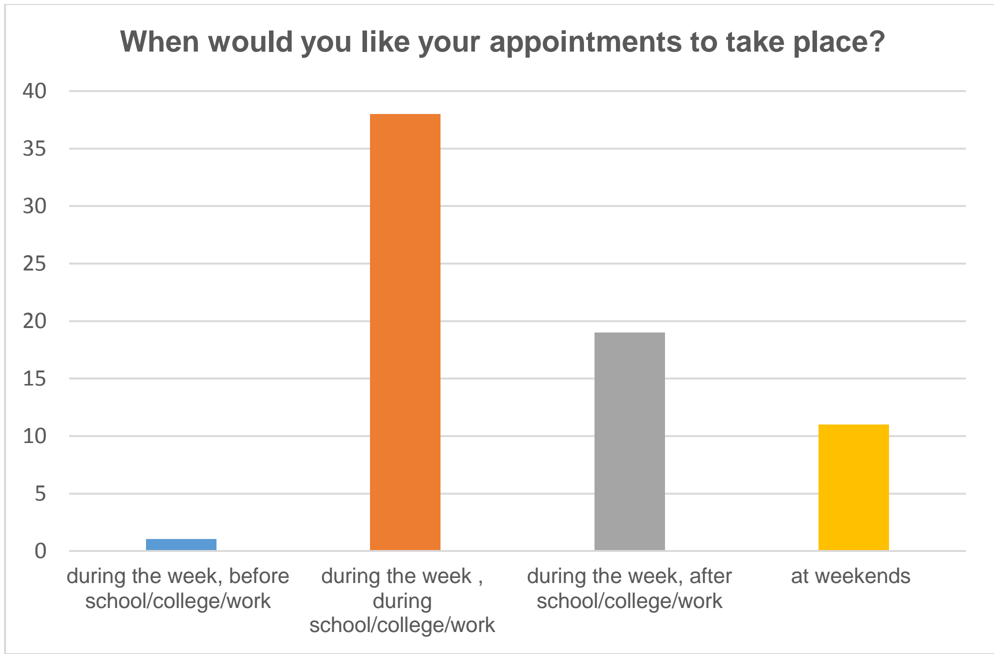
3.13 If you were going to see a professional about your emotional wellbeing or mental health, where would you like your appointment to take place?



The groups were relatively split about where they would prefer appointments to take place, the most popular was at school or college, although a number of young people would like to be seen more at home, at their GP surgery or at their local youth club. The key things that were important about where appointments would take place were:

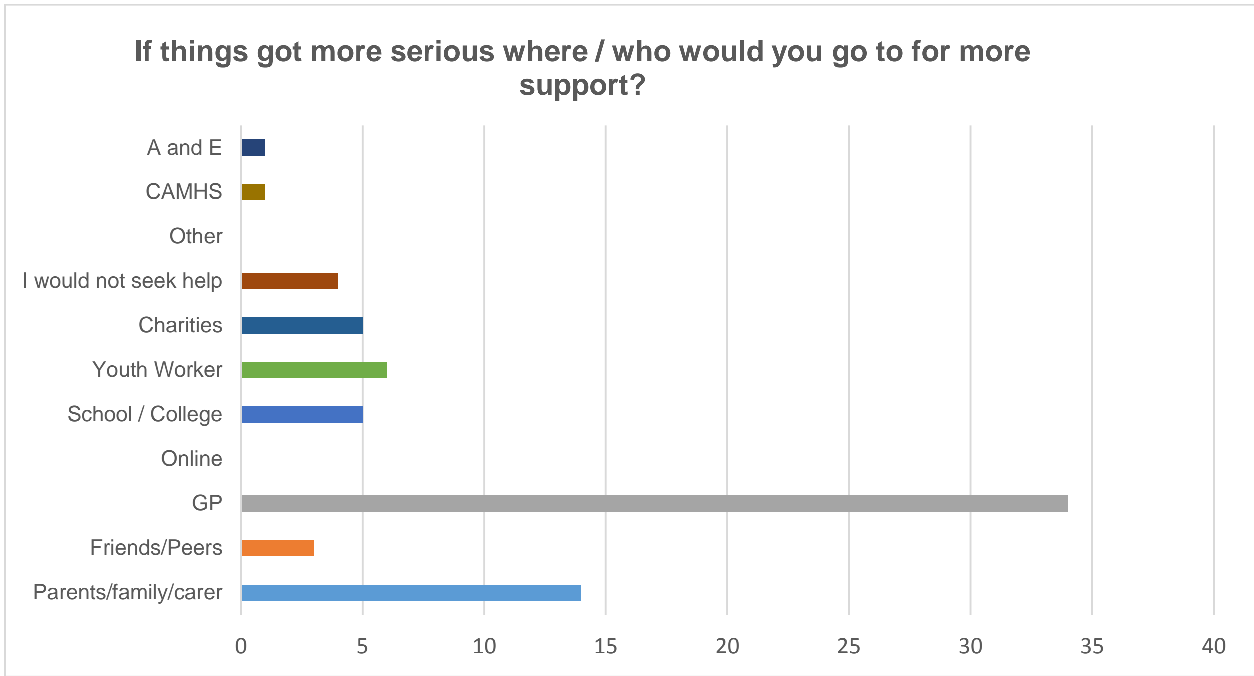
- ✓ Somewhere private
- ✓ Somewhere safe
- ✓ Somewhere where you could be getting help for anything not just how you were feeling
- ✓ Somewhere convenient where you feel comfortable

3.14 If you were going to see a professional about your emotional wellbeing or mental health when would you like your appointment to take place?



The most popular times for appointments were during school or after school, this fits with where participants would like their appointments. A number of participants felt that if there appointments were during the day, that this would help them get through their day.

3.15 If your mental health became more serious where/who would you go to for more help?



The most popular choice of where participants would go for help if their emotional and mental health became more serious is their GP.

A number of young people said that they would still want support from their families, friends, school, and college or from their youth worker, young people accepted that if they needed more specialist help they would make an appointment to see their GP. A number of young people who have accessed CAHMS said that they didn't think that they would be able to go back to CAHMS without going to their GP first.

A high number of young people said that they would only go to A and E for something physical like a broken leg, not for help with how they were feeling. There was a small number of young people who have had experiences of attending A and E in crisis, they said that they would do anything they could to avoid attending at A and E again:

> *"I was taken to A and E by a Police officer because I said that I wanted to kill myself. I had to wait for 10 hours, I was asked questions very insensitively and then didn't get any support before being told to go home. Everyone was looking at me like I had done something wrong because there was a policeman with me the whole time, but I hadn't done anything wrong, going to A and E just made me feel worse."* **Female 17**

> *"I took an overdose, was taken to A and E and then was admitted, I was put on a surgical assessment ward when I was 19 the women in the next bed had medication next to her bed, she had dementia and was screaming all night it was horrific."* **Female 24**

3.16 What would you like to see to help young people in Tameside and Glossop with their emotional wellbeing and mental health?

Participants were asked to give one priority of what they would like to see to help young people the key themes were:

Better information about what help is available:

- Better information about where to go for help
- Better specialist support in school/college that is better advertised – because when I have felt like this I didn't know where to go for help
- More services available in schools and colleges - Make sure they are promoted properly and you don't have to wait until you have a big problem for someone to offer you help, you should know how to get help before anyone notices something is wrong.

More support available and quicker access:

- More varied support available – not one size fits all
- Less waiting time for help including counselling
- More support workers
- More young peoples' support groups with people who are going through similar things.
- Quicker access to specialist support and help
- More services available in schools and colleges - Make sure they are promoted properly and you don't have to wait until you have a big problem for someone to offer you help, you should know how to get help before anyone notices something is wrong.
- A dedicated mental health nurse at all GP centres / walk in centres
- More help to access support that is needed
- More help available for people who need it, there are not enough people who can help, so you have to wait a long time before you can get help
- More people to talk to who understand what you are going through
- More services for younger children, I needed help when I was very young, at primary

school but didn't get any help until I was much older
- If you could ring up a doctor and he would come to your house
- To have more options where you can get help so that you wouldn't have to wait so long
- Your support worker should be easy to contact - not impossible!

Better awareness for young people about emotional health, mental health and wellbeing:

- More learning at school and college about coping with your feelings and what is normal and what is not normal
- More peer education in schools about mental health
- People should go into schools and tell everyone about mental health
- There should be more peer support projects
- Mental health should be included in sexual health talks

Not being passed around:

- Having one professional to help you rather than being passed around and referred to lots of different people.
- Not having to tell different people the same thing over and over again
- One worker to be key around my journey so I don't have to keep repeating myself, and getting different opinions all the time about what will help
- To not have to tell your story to every professional you meet, it gets harder each time
- For people to be more aware of your emotional state before just referring you on
- Be aware that some services eg social services make emotional and mental health worse
- Give my social worker more time to talk to me because they don't always have time to come and see me and my foster carers don't understand how to help me enough.
- To be able to get help without my family being told

4. Recommendations

From all the data gathered in the focus groups here are the following recommendations for improving children and young peoples' emotional, mental health and wellbeing services.

- ✓ Develop a programme of mental health awareness raising in schools and colleges for children and young people
- ✓ Develop more peer support groups
- ✓ Develop training for parents and carers to help them to understand the issues, support their children and know where to go for more help.
- ✓ Develop a variety of support services that can be delivered flexibly – not one size fits all
- ✓ Ensure more specialist support is available in schools and colleges
- ✓ Invest in better information about where to get help and better specific self-help advice
- ✓ Ensure that if CAMHS aren't going to be offering a service for them to clearly explain why
- ✓ To improve the experience of children and young people who present at A and E who are in crisis
- ✓ Improve waiting times for services by increasing the capacity of all support services to meet the demand
- ✓ Develop better pathways for young people who need to be passed onto to other services, including handover meetings and a consistent key worker throughout.

Tell Us Survey- Tameside and Glossop

Tell us Report – 1 September 2015

Produced by

Background

Tameside and Glossop CCG commissioned 42nd Street to conduct an online survey of young people aged 11-18 years living and being educated in Tameside and Glossop. An online questionnaire was designed in consultation with the Emotional Wellbeing and CAMHS Programme Board set up to oversee the Department of Health national pilot project.

The survey was promoted across Tameside and Glossop by partners associated with the Programme Board from the end of July 2015 until early September 2015.

Young people were invited to complete the survey on their own. All answers were treated as confidential.

The Questionnaire was split into seven sections:

SECTION ONE was designed to capture basic demographics of postcode and age

SECTION TWO was designed to capture attitudes and behaviours in relation to low level stress and low mood and included a specific focus on support within school/college settings and specific questions around school health nurses.

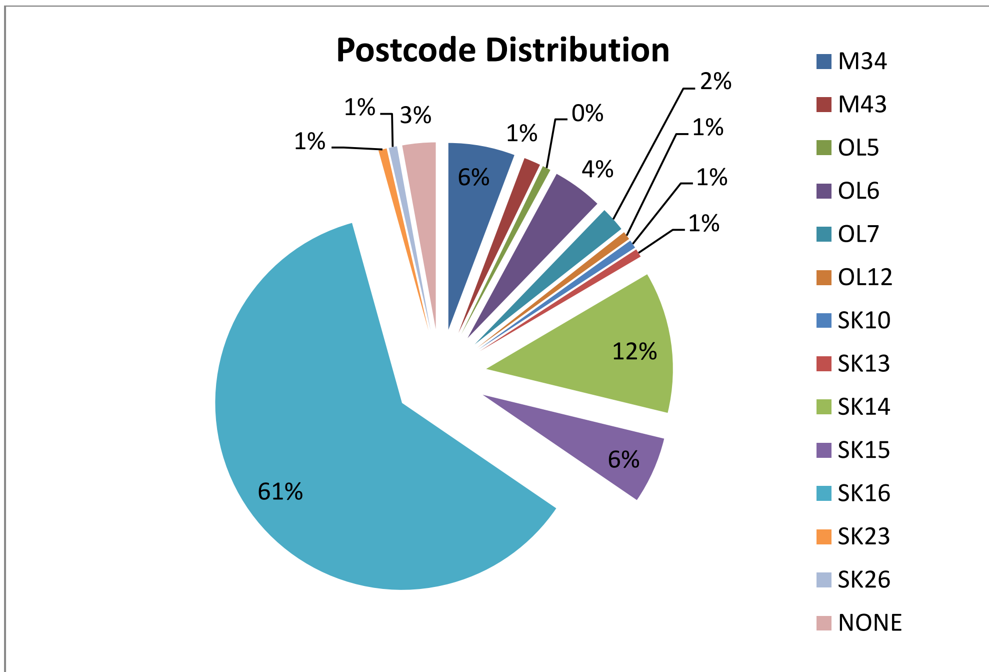
SECTION THREE focused on the type of qualities young people would expect from professionals who might support them with their emotional health and wellbeing

SECTION FOUR explored how new technology and social media might support young people with their emotional health and wellbeing

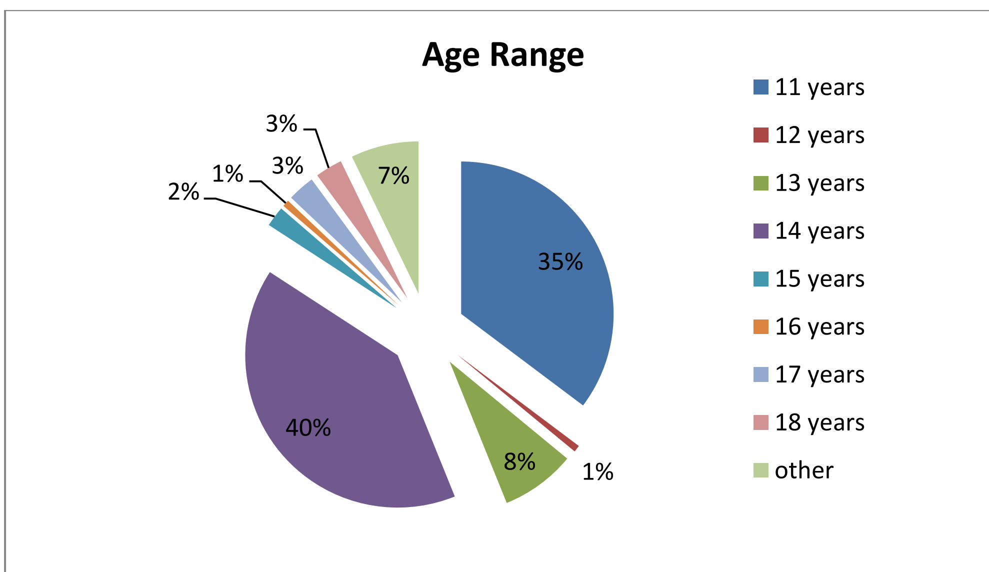
SECTION FIVE was only completed by young people who had experienced statutory Child and Adolescent Mental Health Services (CAMHS) in Tameside and Glossop and focused on accessibility and service quality

SECTION SIX focused on where and when young people might like to access appointments SECTION SEVEN was designed to capture attitudes and behaviours in relation to more serious, escalating mental health issues and ideas for future provision

Demographics



A total of 139 questionnaires were completed; 41 young people completed the CAMHS section. There is clearly a large proportion of respondents from the SK16 area. This is likely to be due to the fact that a specific school completed more surveys than any other setting. This could skew the data as the young people from that school may have had a particular experience of services that may not be typical of services and service- users across Tameside and Glossop.



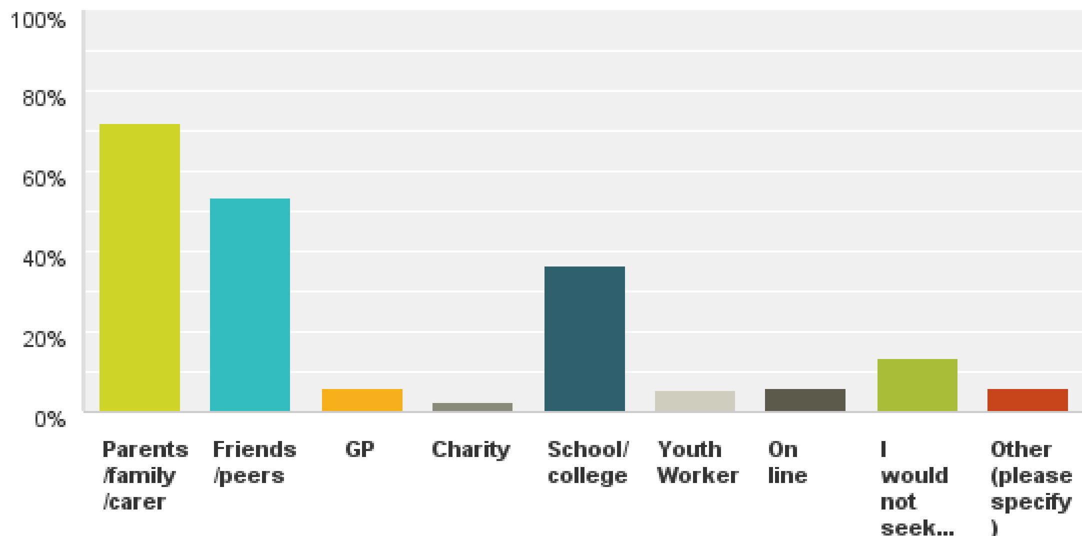
Again the age range is skewed, perhaps due to particualr year groups completing the survey in a particular school. It is also worthy of note that the Partnership Board took a decision only to consult with young people aged 11-18 years old. It may be advisable to talk to some older young people that are able to reflect on services received to enhance the findings withn this report and there is

also a potential for consulting with younger children and parents in order to build up a wider understanding of need and experience

Accessing Support

Participants were asked to indicate where they would be most likely to go for support if they were feeling worried anxious or low for more than a week. There were 8 prompts and a space for other/free text, unprompted responses. Respondents could choose any number of responses that were relevant to them. The language used was deliberately non-technical and based on the language used in the Thrive Model being adopted across Tameside and Glossop.

Early help



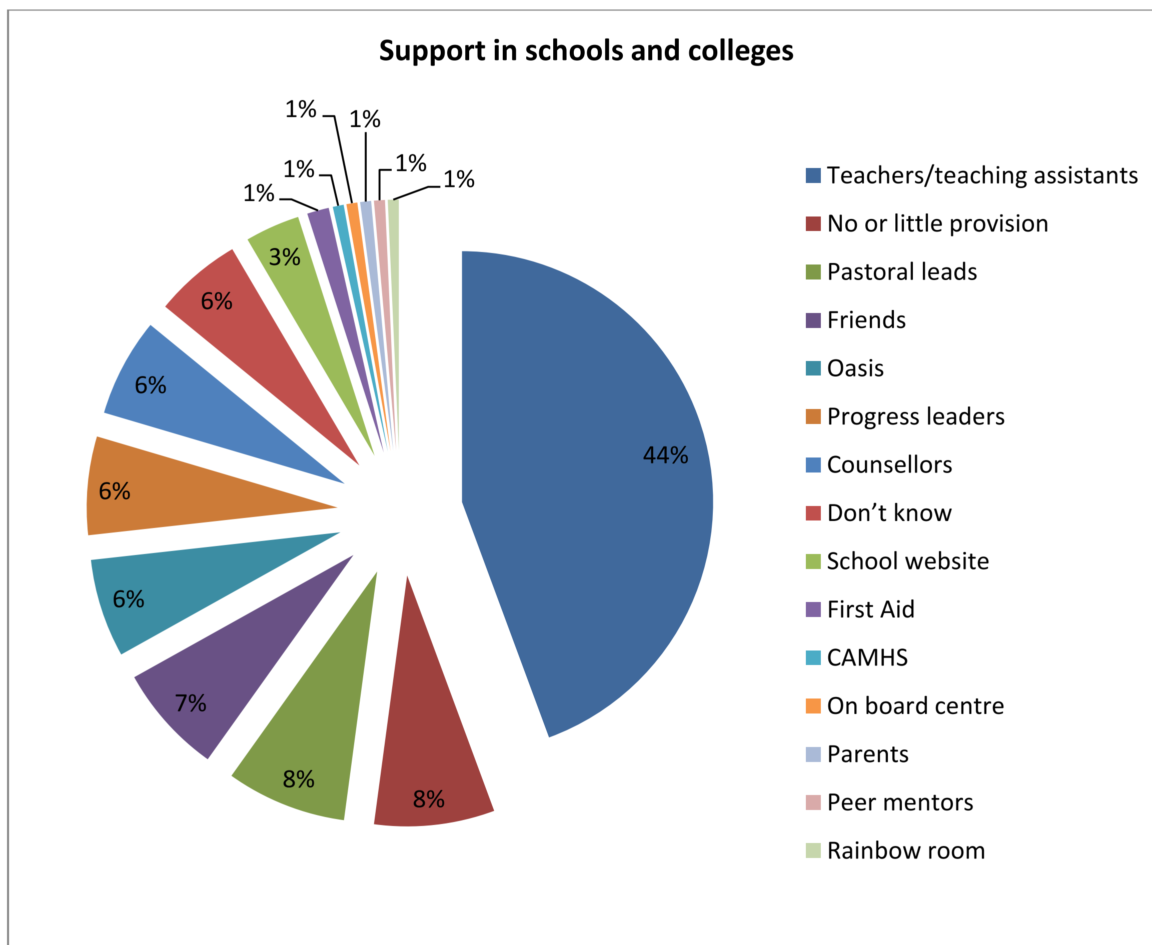
It is clear that young people's parents, families and carers are very important to them when they need low level support followed closely by friends and peers. These responses make a clear case for ensuring that family and friends are equipped and trained to deal with these calls for support from young people; offering the wrong kind of advice at this stage could lead to escalation of issues. Conversely, if the right information is available to these networks then young people are more likely to receive trusted, informed support when they need it and from people that they trust.

Other sources of support identified were Grandparents (1 response), boyfriend (1), doctor (1), "Everyone I trust" (1) and Childline (3)

Help in schools and colleges

Schools and colleges also represent significant importance for young people in terms of early help, the following section breaks down respondent's attitudes and experience to provision within school and college settings.

Young people were asked an open, free text question: "**What support is available at your school/college when people are feeling a bit worried, anxious or low?"**



Core teaching and teaching assistant staff represent 44% of the responses from young people, going up to 52% if pastoral staff are included. Comments suggested that many young people feel teaching staff are approachable and available. For example comments included:

"We can talk to our teachers any time in private"

"Teachers will help you feel happy"

"If any child feels upset, worried or scared our Yr. 6 teacher would take us out of class and try to figure out what is affecting us

However, 14% of responses indicated that young people did not know what help was available or felt there was little or no support

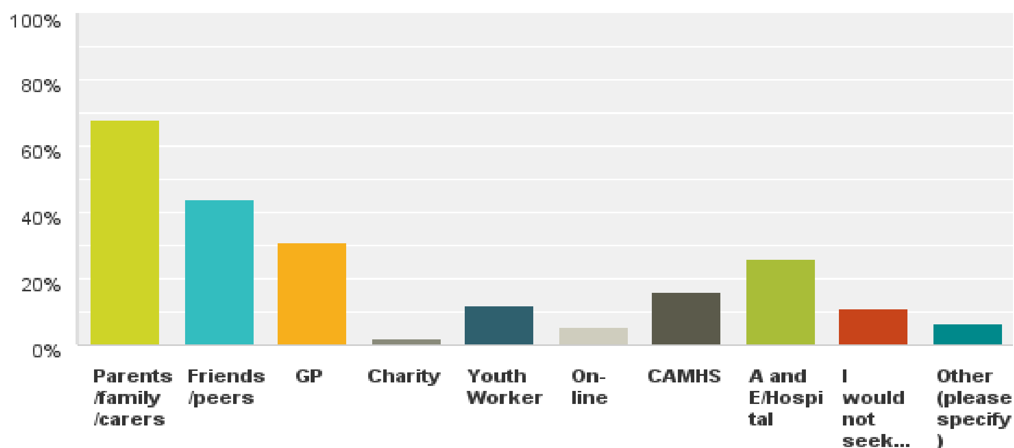
Other services i.e. Oasis, Progress Leaders and counsellors all represented 6% of responses, the schools website was mentioned by 3% of respondents. CAMHS featuring in only 1% of responses alongside parents, peer mentors and bespoke school provision.

The survey focused two specific questions around school nurse provision: "Have you ever accessed the school nurse for help with your emotional or mental health?" and "If so how would you rate the help that you received?"

Only 14% indicated that they had accessed a school nurse for support in this way and of them 21% rated the service as unsatisfactory, 7%-poor, 54%-good and 18%-excellent. This is an interesting spread with 72% rating the service well but 21% indicating dissatisfaction.

More Help

Later in the survey young people were asked where they would go to for more help if their mental health became more serious. Again the participants were asked to choose from a set of prompts with space for other/free text, unprompted responses. Respondents could choose any number of responses that were relevant to them.



Parents, family and carers remain consistently high in the responses dropping by just 4%, friends and family also remain high but the drop is a more significant at 9%. These trends suggest that

family and friends remain a critical part of the young people's support network as issues escalate. Perhaps the drop in responses in relation to friends and peers reflects increased stigma or isolation as issues escalate or perhaps that young people recognise that they need more experienced perhaps professional support at this stage.

This second explanation is supported by the fact that GPs become a much stronger feature of the support at this stage, with an increase of 25% and CAMHS is also indicated by 16% of the respondents as a somewhere to go for more support as issues become more serious

The number that would not seek help at all does drop by 3% as the issues escalate, but it is still worthy of note considering the increased need for help.

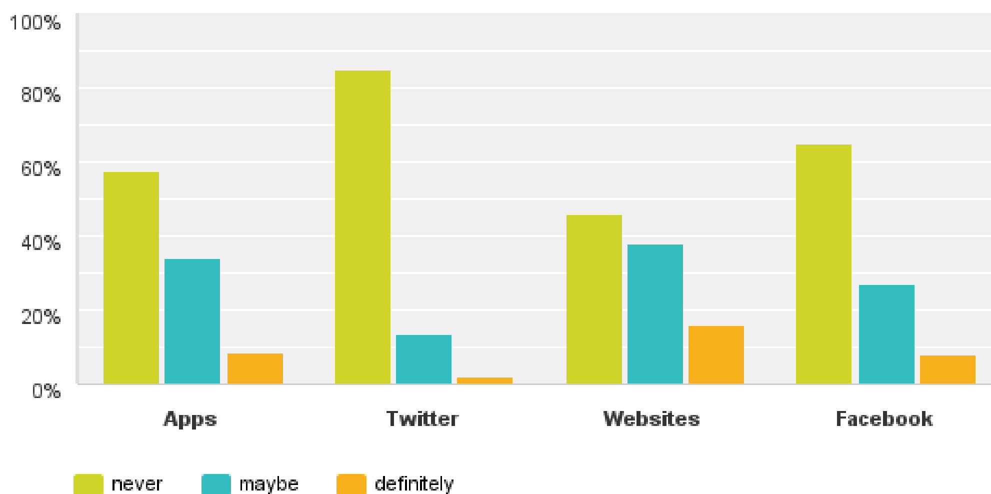
Professional Qualities

Young people were asked the open question "What qualities would you look for in a person that could help you with your emotional wellbeing and mental health?"

The words used most were **KIND** and **UNDERSTANDING** (20% each) with **GOOD LISTENER** (19%), Supportive (18%) and Trustworthy (16%) also being popular choices.

Technology and Social Media

Respondents were asked:

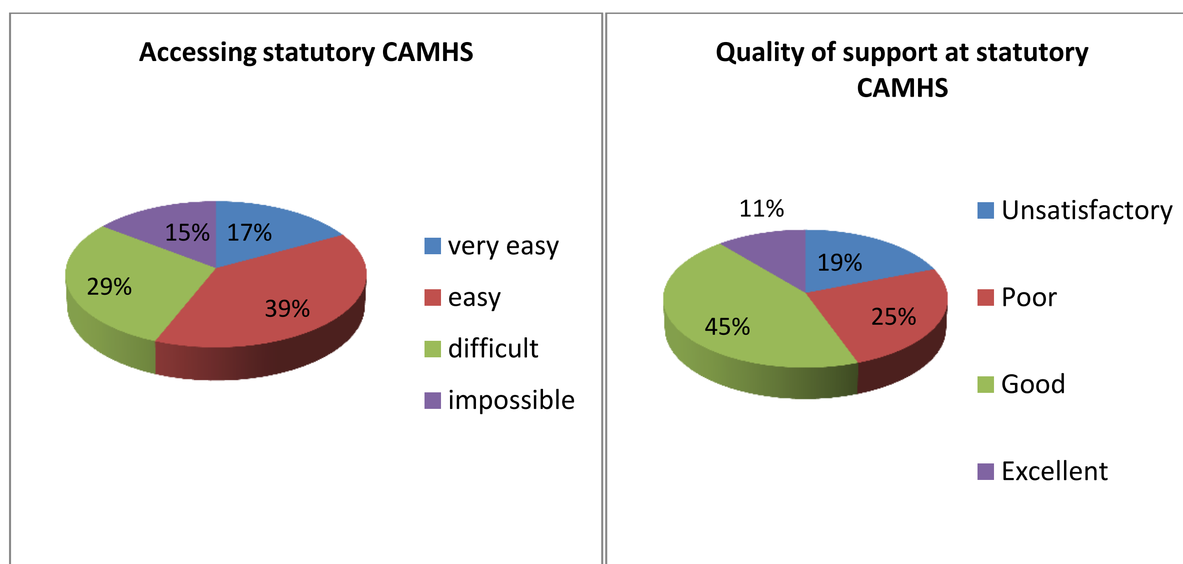


The responses indicate that young people generally do not feel the options presented would be helpful; with websites being the only medium where the combined “maybe” and “definitely” scored more highly than “never”. This is worthy of more exploration but may reflect the risks associated with accessing social media for young people and the fact that what they want is to access face to face, professional support

Statutory Child and Adolescent Mental Health (CAMHS)

This section of the survey was only completed respondents that had experienced statutory CAMHS. Of the 139 that responded to the survey in total, 41 young people completed this section

Young people were first asked to rate accessibility to CAMHS and then the quality of the service that they had received. The results are as follows:



The first chart indicates a relatively even split between very easy/easy and difficult/impossible responses in terms of accessibility. Comments associated with accessibility included:

Very easy/easy:

“It was done for me”

“Because it was sorted out by my social worker”

“They come into hospital and talk to you”

Difficult/ impossible:

“Not taken seriously by the people”

“3 referrals from health professions and nothing”

"Too many boxes to tick"

"Nobody rang me I had to do all the chasing around"

"My old school said they would get in contact with them for me but they didn't"

"I didn't know what to do and they did not have a clue what I was saying"

It is interesting that the consistent theme here is that where young people are supported well in their referral they find access easy, but where they perceive they have been let down or not supported the accessibility feels much more difficult. There is perhaps something to explore here in terms of self- referral processes and integrated processes and services

Once accessed, responses recorded in the second table suggest that most young people felt the service was "good", however there were still 44% of respondents that felt the service was poor or unsatisfactory.

When asked "What do you think worked best for you at CAMHS?" 11 of 24 respondents indicated "nothing" (4) or don't know (7)

Other responses included:

"Weekly meeting with someone who understood and listened explained that's its ok sometimes to feel low"

"Allowed me expression which helped me understands my past. Activity based as well so it was not boring"

"My support coordinator"

"We get achievement"

"The talking"

"Professional workers"

When asked what could be improved at CAMHS responses included:

"Less group sessions and more one to one"

"More training in understanding ASD"

"Stop cutting this service, children need it"

"Access post 18 as part of being a care leaver"

"Listening to parents"

"At times it was more about my mom than me"

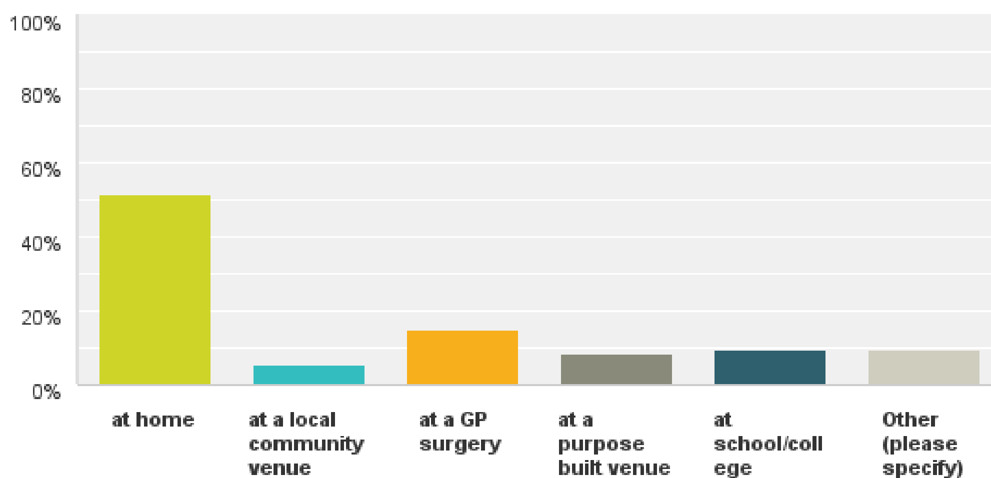
"Out of hours service"

"Calming people who understand"

"Less waiting time"

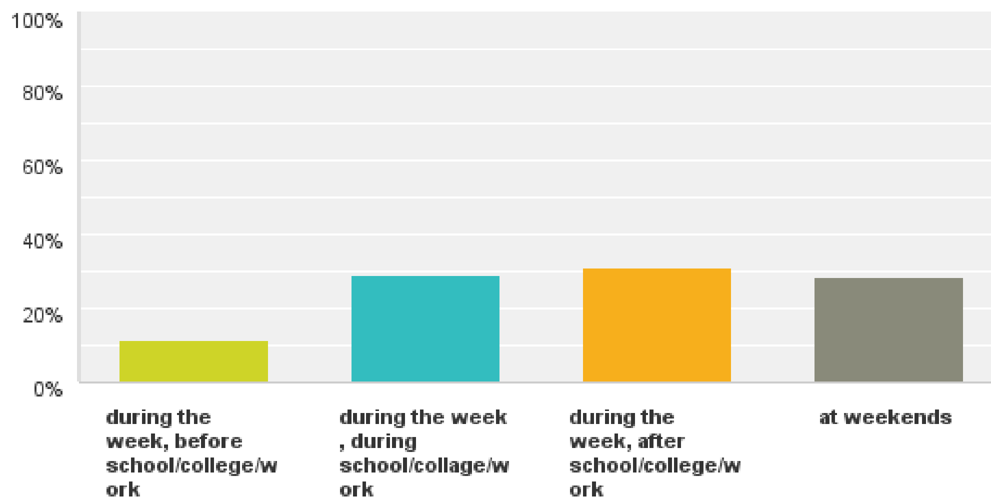
Where and When

Young people were asked "If you were going to see a professional about your emotional health and wellbeing or mental health, where would you like your appointment to take place?"and they were given 5 options to choose from and an option for other/free text



This is an unusual response but does link with earlier responses around seeking support from family, parents and carers. Perhaps this response also reflects the difficulties that young people experience in terms of travel around Tameside and Glossop and a perceived lack of community venues. The responses could also be an indication of how young people do not want to be seen to be accessing mental health services but want a private, confidential appointment in familiar surroundings. This result is worthy of further exploration with young people. "Other" responses included, hospital, a forest or park, "somewhere private, but no family" and "not bothered".

Young people were also asked, "If you were going to see a professional about your emotional health and wellbeing or mental health, when would you like your appointment place?" Again respondents were given a series of prompts but no opportunity for free text. The results are shown below:



The responses show a fairly even spread of preferences, with 31% opting for during the week after school/college/work, 29% opting for during the week during school/college/work and 28% opting for weekends. Notably young people do not want appointments to take place during the week before school/college/work as only 11% indicated this option.

Improvements for the future

Finally, young people were asked what they would you like to see to help young people in Tameside and Glossop with their emotional wellbeing and mental health and given the opportunity for free text for their responses.

The Responses were as follows

“A place just to pop into for advice”

“More investment and training in specific needs of children, to be taken seriously”

“More support for siblings and mums”

“Someone to talk to other than a referral to TAMESIDE hospital”

"More CAMHS workers, not so many boxes to tick and hoops to jump through, support for as long as it was needed with the same person"

"More services- less stigma"

"Better services"

"More advertising more awareness and leaflets through the post because this is serious"

NEXT STEPS

This report and the findings within it should be discussed with key professionals, funders and young people to co-create a set of recommendations for the improvement of child and adolescent emotional wellbeing and mental health services across Tameside and Trafford.

These recommendations can be used to inform:

- Future In Mind forward planning including transformation plans
- Commissioning priorities
- Devolution planning
- Transition Planning
- Early Help Service Planning

ensuring that the needs and voice of young people inform and influence these decisions

APPENDIX: 3

Eating Disorders Business Case Peninnine Care NHS Foundation Trust

Pennine Care NHS
NHS Foundation Trust

Business Case

Proposal for the development of a Community Eating Disorder Service for Young People in Pennine Care

Pennine Care NHS Foundation Trust

Version 1.0

01st October 2015

Sara Barnes

CAMHS Directorate Manager

Document Author	Sara Barnes-CAMHS Directorate Manager
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Document Title	Business Case-Proposal for the development of a Community Eating Disorder Service for Young People in Pennine Care
Version Number	1.0

1. Abstract

"***Young Peoples Mental health services need to be outcomes-focused, simple and easy to access, based on best evidence and built around the needs of children, young people and their families, rather than defined in terms of their organisational boundaries."***

(Future in Mind report March 2015)

This business case describes the shared vision of the Pennine Care footprint CAMHS community to build an innovative Community based Eating Disorder service and proposes a framework for service delivery that is entirely congruent with the Future in Mind ambition.

As part of the Service Development Strategy (SDS) Pennine Care has been leading an inclusive multi-agency work stream to scope the baseline need for Eating Disorders, map the services available, identify usage of these services and agree key design principles for future service developments.

The SDS sets out how Pennine Care NHS Foundation Trust intends to develop its services, improve the quality of care and make efficiencies over the next five years. The SDS outlines a commitment to developing community based care and community pathways in order to reduce demand on hospital based services.

The Trust is committed to "delivering whole person care in places that work" and has determined the following population segments upon which to base the pathways for the transformation programme.

CAMHS is working under the children and young people segment. Development of an all age eating disorder pathway is a key Trust priority and will be incorporated into the wider CAMHS transformation agenda.

Within a national context the Government has committed to make children and young people's mental health and emotional wellbeing a priority In early 2015 the Children and Young People's Mental Health and Wellbeing Taskforce released the document Future in Mind. This was followed up by the Access and Waiting times guidance for Eating Disorders which sets out standards and requirements for providing community-based eating disorder services for children and young people (CEDS-CYP). This guide describes the referral process that is required to ensure swift access to an appropriate service, the staffing and skill-mix and the commissioning arrangements needed, and how a range of services need to work together as part of a wider child and adolescent mental health (CAMH) strategy. Allocation of funding has now been made to individual CCGs in order to support the development of new service models.
Pennine Care would like to propose a service delivery model that will be consistent with the guidance and are seeking support from the CCG commissioners to enable this through new investment. The commissioners and Pennine Care have agreed an ambition to extend this service up to 25 years by 2017 but at present this is outside the scope of the paper.

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3. Context

3.1 Eating disorders (ED) are a range of complex conditions which typically present in mid adolescence and have adverse effects physically, psychologically and socially on a young person. Eating disorders have the highest mortality rate of all Psychiatric conditions.

3.2 Eating disorders are characterized by a preoccupation with food, weight, body shape and harmful eating patterns. The three most common ED are Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED).

3.3 Eating disorder not otherwise specified (EDNOS) is a diagnosis given when the general symptoms of ED are present but don't fit the exact criteria for one of the three main diagnostic criteria. This is the most common form of ED seen in clinical practice.

3.4 Young people with ED often have other mental health needs, experience guilt and low self-esteem and perceive their ED to not be a problem. These factors impact significantly on presentation to services at an early enough stage and can further impact on engagement and access to treatment. Timeliness of access to treatment is a strong indicator of the outcome and duration of the ED.

3.5 Currently services for ED are provided in a fragmented way particularly for young people who can access primary care, (Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMHS) and third sector organisations both in and out of their resident locality. This in conjunction with the complexity of presentation means that accurate and reliable data is challenging to source both locally and nationally. However it is estimated that 1.6 million people in the United Kingdom are affected by an eating disorder.

3.6 Treatment for AN often includes inpatient, residential, or day programmes. However, studies of the effectiveness of such treatment programs for AN are limited. The available data suggest that hospital treatment for adolescent AN is not more effective on average than outpatient treatment.

3.7 Approximately 20 % of young people with ED's will require Inpatient/residential or Day care

3.8 The evidence also suggests that young people seen in a generic community based CAMH service have a higher rate of inpatient admission than young people seen in a specialist dedicated ED service.

3.9 ED's have a high cost to individuals and their families/carers in terms of emotional impact, disruption to education and employment and in their usage of physical and mental health services through their life span.

4. Current Provision

4.1 Within Pennine Care there are a range of services available for young people with ED which include inpatient treatment, support from the in reach/Outreach team (IROR) and community CAMHS intervention.

4.2 Inpatient intervention
Pennine Care provides services in two inpatient units. The Hope unit is an acute unit which provides short term crisis intervention to young people aged 13 – 18 years whose mental health needs cannot be managed safely in the community. Typically the length of stay in this unit is 6 – 8 weeks with the aim of formulating mental health need, identifying appropriate support and intervention pathways, stabilising a young person's mental state and managing risk.
The Horizon unit is a unit for young people aged 13- 18 with more complex and enduring mental health needs. Typically the length of stay in this unit is 9 months plus in order to provide treatment and rehabilitation to young people and their families. Young people presenting with eating disorders would usually access the Horizon unit from either a medical inpatient setting or the community, a pathway which is supported by an outreach consultation and liaison model. On occasions young people can present in crisis and are admitted through the acute pathway to the Hope unit due to comorbid risk factors but it becomes evident that an ED is a significant feature. These young people are then directed to appropriate pathways which may include transfer to the Horizon unit.

Over the last two years the Horizon unit has seen an increased presentation of ED's and in order to provide effective and high quality care has developed additional skills and expertise in managing ED's in an inpatient setting. Over the last 9 months the unit has piloted the use of a day place to support young people stepping down from inpatient care.

A small number of young people require out of area inpatient or residential placements as a result of having an ED and this are agreed on an case by case basis.

4.3 IROR intervention.
The IROR team provide telephone and face to face support to young people, families and other healthcare professionals out of hours to avert or shorten an inpatient admission. This can be delivered across a number of settings including the young person's home or an acute medical ward. A key role of the IROR team is to provide

support, advice and consultation to medical wards managing young people with ED's. This is supported by clear documentation around care planning and risk management.

4.4 Community based intervention
For the under 16 age group there are clear care pathways within community services with dedicated staff who have acquired additional skills and experience in ED treatment. Interface with paediatric services is an integral part of the care pathways including medical outpatient and inpatient care. A range of individual, group and family based psychological therapies can be accessed although this is subject to local variation depending on team configuration and resources available.

4.5 Other eating disorder pathways
For the under 16 age group there are a number of third sector and charity providers which can be accessed directly by young people and their families or be signposted by a professional. These provide advice, information and support to young people, their families and the wider children's workforce however do not provide direct clinical intervention.

In some localities education services have developed expertise in supporting students with ED's in Pupil Referral Units and provide an outreach support pathway for mainstream schools and colleges.

4.6 16 – 18 year olds.
For this age group there is significantly more variation of service provision and there are not clear and consistent pathways across localities. Commissioning arrangements differ in each Borough with both contractual and spot purchase arrangements in place with a range of third sector and independent providers. As such demand is not yet robustly mapped. Some of the generic community CAMH teams do reach up to 18 and accept ED referrals for this age group and these young people would follow the generic CAMHS pathway.

A particular gap exists for this age group in accessing eating disorder specific physical health support.

5. Constraints of the current provision

5.1 Identification of true need is a challenge as services only provide support to young people with moderate to severe ED's. Young people with lower levels of need often don't access services or if they do find that the right support is not readily available. In addition families/carers may want to access support even if their child does not and this is hard to manage in generic CAMHS teams – young people have to have

been referred and accepted by the service in order for them or their families to receive support.

5.2 Paediatric services provide care up to 16 years but there is an identified gap for 16 – 18 year olds in terms of medical input. Within adult medical provision there is a less consistent approach and limited ED expertise.

5.3 Dietician time is not integrated into the pathway in generic CAMH services. There is however dedicated and embedded dietician time in the inpatient care pathway.

5.4 Capacity within the IROR team and generic Community CAMH services means that intensive home treatment and or day provision is not achievable within existing resources. As such there is no intensive community alternative to inpatient admission for the most severely unwell young people.

5.5 Equally capacity within generic CAMHS teams is not sufficient to deliver training, consultation and support to the wider children's workforce in order to promote early intervention and support the prevention agenda.

5.6 Young people with moderate to severe ED's are small in number but require intensive, long term input from a range of professionals with specific ED skills and knowledge. There are pragmatic challenges to developing mini teams in localities and maintaining the skills and providing on-going training and supervision. In addition such small teams are fragile if staff are absent or leave.

5.7 The administrative and governance processes required for referral pathways into specialist services can sometimes inadvertently act as a barrier to access.

6. Developing the Model

6.1 The model has been developed in partnership with key stakeholders utilising national guidance, local clinical expertise, performance data, user feedback and the wealth of service development experience available within Pennine Care and in particular within the CAMHS Clinical Business Unit.

There remains a need to widen the consultation particularly with young people and their families/carers however a shared vision has been achieved with some overarching design principles as described below:

- **Enhance Engagement**
  Services need to be offered in ways young people find acceptable, accessible and useful. Support and help should be delivered in a non-stigmatising, child focused, friendly and welcoming environment that is built around the needs of young people

and their families/carers and provides the least intensive intervention needed to achieve a health benefit.

- **Reduce inequality**
  The reduction of inequalities in access and outcomes is central. Service design and communications should be appropriate and accessible to diverse communities. Building services in more visible, more central and more accessible sites may assist in addressing socio-economic or cultural barriers to access.

- **Improve accessibility**
  Mental health support needs to be more visible and easily accessible for children and young people. Every area should have a Single Point of Access (SPOE), open child and work friendly hours, referrals accepted from anyone via any means and a wider focus of activity to include supporting families/carers, promoting resilience, raising awareness of ED and assisting primary care in early identification.

- **Strengthen Resilience, Prevention and Early Intervention**
  Early intervention results in better prognosis for recovery and can reduce risk of relapse from an eating disorder. In order to intervene early, it is essential that children, young people and their families feel able to ask for help easily. Widening the focus to offer support, guidance and information as well as expert specialist services is likely to mean that people feel able to request support at a much earlier stage.

- **Provide Effective, Evidence based Help**
  Eating disorders are serious mental health conditions and it is essential that Community Services are able to meet the needs of very unwell children and young people. These children have previously often been treated in hospital. However the surveillance review of the 2004 NICE Guidance noted that evidence is emerging that day patient care is equally effective as in-patient care but associated with lower cost.

- **Improve continuity of Care**
  Without continuity of care, people with eating disorders relapse readily leading to repeat admissions. Further, there is evidence that there are effective treatments for those less ill, but these are often inaccessible due to there being a focus on those most severely unwell. Therefore the children and young people likely to benefit most from treatment do not get offered it. Services should endeavour to offer continuity of care, from early identification, through intense evidence based treatments, Day Services and Home Treatments and support for hospital admissions, and via a recovery focus that will maintain support for children, young people and families for as long as they need it or until they require transition to adult services.

6.2 The entire Health and Social Care economy is undergoing the most significant transformation and reform in its history and as a consequence there are a number of allied programmes of work that need to be referenced in any service development programme.

a) ***Locality specific Public Service Reform Hub*** – Within all localities there is a strategic vision to radically reform public services. The Public Service Reform Hub is a pooled resource from across a range of services, bringing together skills, expertise and knowledge that will:
   - Identify and respond to risk of harm
   - Prevent escalation to complex dependency
   - Support people to live well and be self-reliant

b) ***Greater Manchester (GM) Devolution*** – the Devolution Agreement brings new opportunities to work collaboratively and develop exemplar practice at scale. CAMHS has been identified as a priority work stream with focus on specific pathways including ED.

c) ***Pennine Care Commissioning Footprint*** – the six CCGs who commission CAMHS provision from Pennine Care NHS Foundation Trust work closely together with Pennine Care to co-commission quality CAMH services. They are currently working together to jointly commission Specialist Community Eating Disorder services in line with NHSE Standards.

d) ***CQUINs:*** There are a range of CQUINs in place across inpatient and community CAMH services. The primary CQUIN for community services is around improved access and partnership working with the aim of delivering improved waiting times targets for CAMHS and strengthening partnership working across the whole emotional wellbeing and mental health pathway;

e) ***Safeguarding Child Boards/Children's Trust Boards*** – Within localities these boards have established their priorities for 2015-18.

f) ***NHS England Mental Health Access and Waiting Time Standards*** – children and young people's needs are being taken into account within our local plans to meet the new/emerging standards for Liaison Psychiatry and Early Intervention in Psychosis

g) ***CYP IAPT programme –*** Pennine Care has been part of the CYP IAPT programme since November 2011 and were phase 1 of this programme. There are four key principles to CYP IAPT that we embed into all service development and delivery and these are:

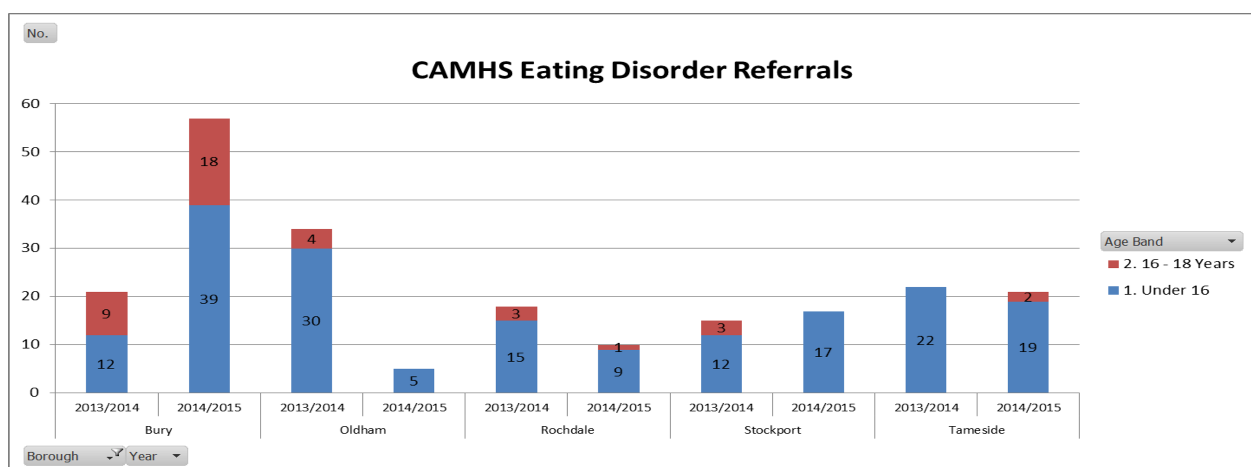
- Service user participation
- Evidence based practice
- Routine Outcome Measures (ROM)
- Improved Access to services

h) ***Parity of Esteem –*** both providers and CCG's are committed to continuing to aim for more equal distribution of resources between physical and mental health disorders and ensuring the association between the two are supported in all commissioning

i) ***Special Educational Needs (SEND)Reforms*** – this places duties on local authorities and other services in relation to both disabled children and young people and those with Special Educational Needs. Under this process children and young people identified as meeting the thresholds will have an Education Health and Care Plan (EHC Plan).

Local need has been reviewed for two years based on available data. For young people aged under 16 years this data can be seen as reliable however for the age group 16 – 18 years this data is likely to underestimate the need.

Table 1. Number of Eating Disorder referrals for Pennine Care services by age and borough for the periods 2013/14 and 2014/15



***The table above does not include the number of referrals that Trafford CAMHS received during the period 2013/14 and 2014/15 this is due to their recording systems differing – however in 2013 Trafford received 16 referrals with an average age of 15 years and in 2014 they received 19 referrals with an average age of 14.9

Table 2. Total Eating Disorder referrals for under 18s to Pennine Care services for the North Hub (Bury , HMR and Oldham) with presenting problem code for the periods 2013/14 and 2014/15

YEAR	2013/14	2014/15
Total referrals	**57**	**53**
Presenting problems	F509 (EDNOS) **56**	F509 (EDNOS) **53**
	F505 (Vomiting associated with Psychological Disturbance) **1**	

Table 3. Total Eating Disorder referrals for under 18s to Pennine Care services for the South Hub (Trafford, Stockport and Tameside and Glossop) with presenting problem code for the periods 2013/14 and 2014/15

YEAR	2013/14	2014/15
Total referrals	**49**	**55**
Presenting problems	F500 (Anorexia Nervosa): 1	F509 (ED unspecified) **55**
	F502 (Bulimia Nervosa): 1	
	F508 (Other Eating Disorder): 1	
	F509 (EDNOS): 46	

Table 4. Total number of Eating Disorder referrals to the Inreach /Outreach team referrals for under 18s for the periods 2013/14 and 2014/15

Year	2013/14	2014/15
Total Referrals	13	10

Inpatient Services

Table 5. Number of young people with eating disorders discharged from the Horizon Unit during the period 2013/15

Admission Date to Unit	Diagnosis	Discharge Date	Total Bed Days	Discharged To	Year
09/07/2014	ED	24/10/2014	107	Home address	2014/2015
31/07/2014	ED	17/12/2014	139	Home address	2014/2015
17/01/2013	AN	22/01/2015	735	Care in Mind	Admitted in 2013/2014 Discharged in 2014/2015
30/06/2014	ED	19/02/2015	234	Home address	2014/2015

Table 6: Number of young people with eating disorders who are currently inpatients on the Horizon Unit

Presenting Condition	Admission Date	Discharge Date	Occupied Bed Days to Date	Year
Eating Disorder	18/12/2014	Remains on Unit	110	2014/2015
Eating Disorder	10/11/2014	Remains on Unit	142	2014/2015
Eating Disorder	06/10/2014	Remains on Unit	177	2014/2015
Eating Disorder	17/02/2015	Remains on Unit	43	2014/2015
Eating Disorder	18/03/2014	Remains on Unit	379 Split – 14 days 13/14 365 days 14/15	Admitted 2013/14 Remains in 2014/2015
Eating Disorder	26/01/2015	Remains on Unit	65	2014/2015

6.3 National Prevalence

As previously stated ED's are known to give one of the highest morbidity rates and tend to result in high cost patient admissions when identified in late primary care.

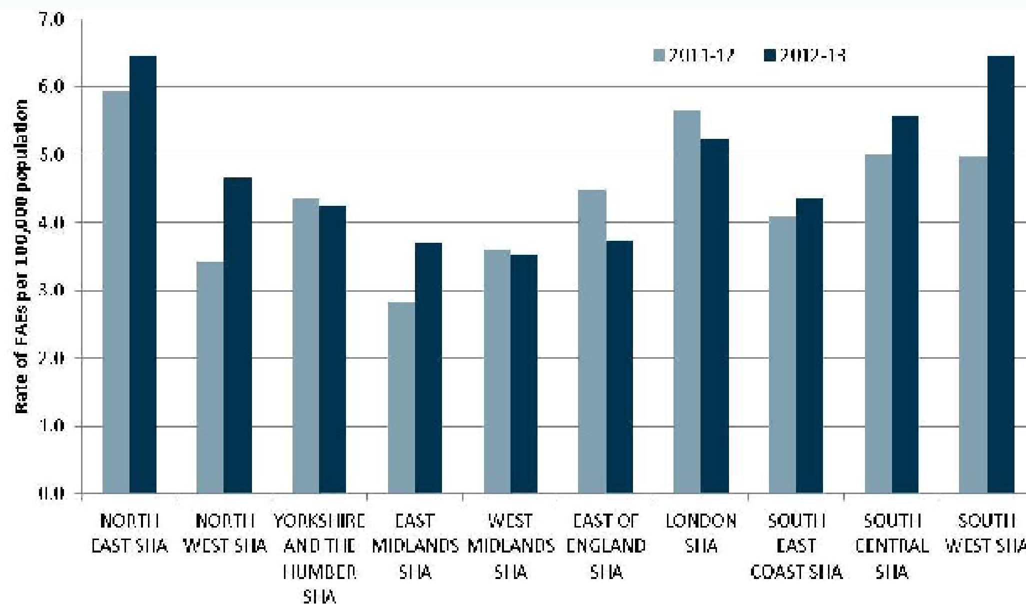
Figures from the the Health and Social Care Information Centre (HSCIC) show a national rise of 8 per cent in the number of admissions to hospital for an eating disorder.
In the 12 months to October 2013 hospitals dealt with 2,560 eating disorder admissions, 8 per cent more than in the previous 12 months (2,370 admissions).
In 2012-13 The North West Strategic Health Authority had the fourth highest rate of hospital admissions for an eating disorder (over 4.5 per 100,000 of the population).

Figure 1.

hscic Health & Social Care Information Centre

Eating Disorders: Hospital Admissions up by 8 per cent in a year

Graph to show hospital admissions for an eating disorder in 2011-12 and 2012-13 in SHAs in England



Research involving GP data in the UK indicates an increase in the age-standardised annual incidence of all diagnosed eating disorders (for ages 10-49) from 32.3 to 37.2 per 100,000 between 2000 and 2009. This equates to around 750,000 people with an eating disorder in the UK.

7. Overview of the Proposed Community Based Eating Disorder Pathway

7.1 The proposal is to provide a comprehensive locally based service to young people up to their 18th birthday, who are resident in the identified Boroughs and who have an eating disorder. The pathway will be delivered through the development of a dedicated Community Eating Disorder Service (CEDS) staffed by a range of multi-disciplinary professionals via a recruitment process. The national guidance states that there should be a dedicated team per 500,000 of the general population. Across the localities covered by Pennine Care there is a population of 1.3 million and this would require the development of a minimum of two teams., It has been agreed in partnership with commissioners that two teams will be developed as follows:

North Hub – Bury, Heywood, Middleton and Rochdale (HMR), Oldham.
South Hub – Trafford, Stockport and Tameside and Glossop.

The teams will mirror each other in terms of skill mix and pathway but the development of two separate teams allows for the evolution of local identity over time as the team becomes embedded.

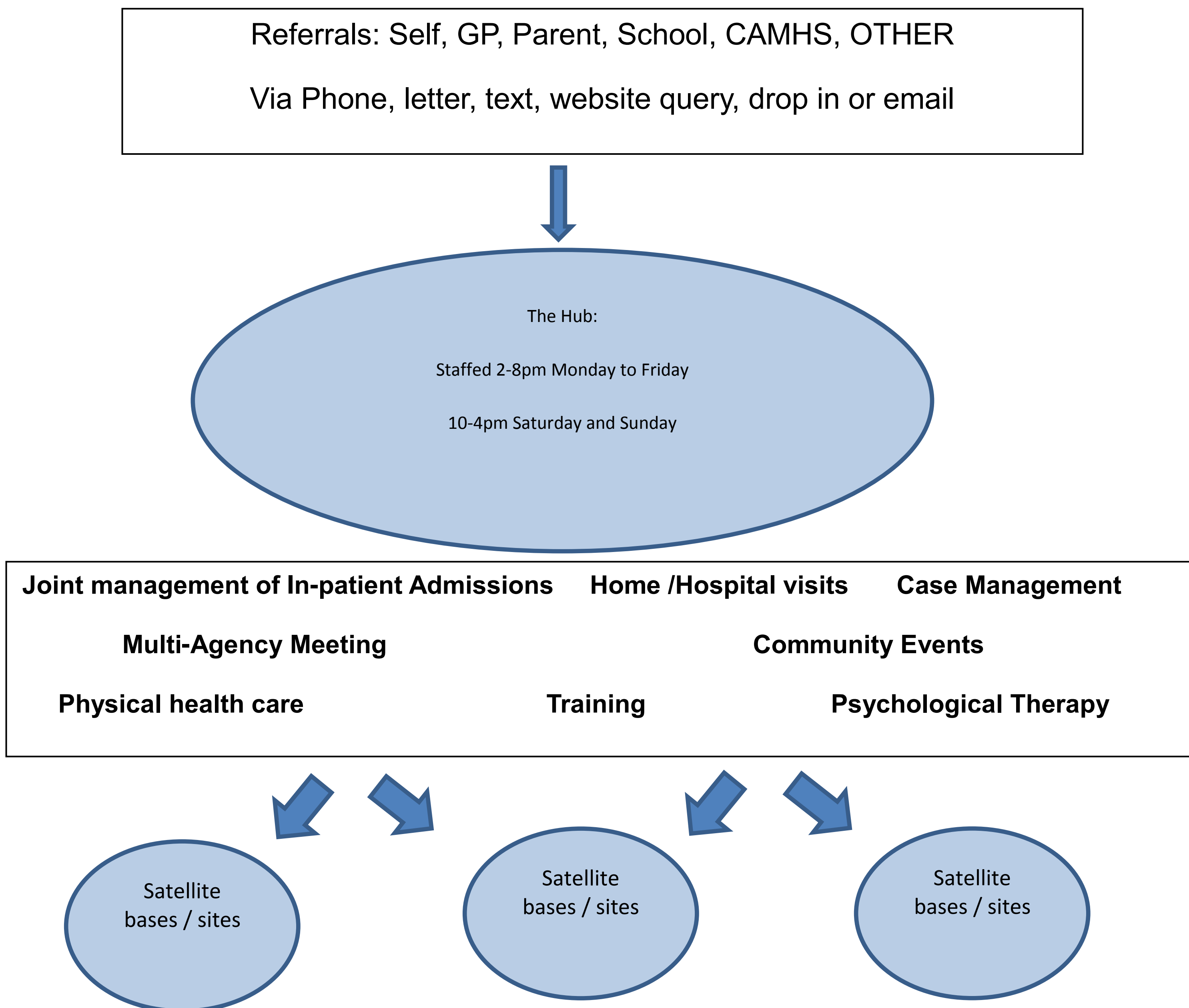
7.2 The service will be structured on a hub and spoke model due to the large geographical area covered and the relatively small size of the teams. The following has been agreed in principle:

The North Hub will be based in Oldham with satellite bases in HMR and Bury.
The South Hub will be based in Stockport with satellite bases in Trafford and Tameside and Glossop.

7.3 We envisage The Hub as a vibrant, child oriented, community facility, located centrally. Based on a stepped care approach (Figure 2) the Hub will be staffed 7 days a week and will be the main base offering drop in, groups, assessments and treatments. Our ambition is for it to be a thriving community resource including a library of self-help resources, a café and a centre for training events, groups and meetings/talks. Staff at the hub will be able to offer same day responses to screen referrals and will be able to travel to carry out emergency visits where needed. Routine and specialist services will be available including family based approaches. There will also be a number of smaller satellite bases/sites that can offer assessments and treatments, located conveniently in separate geographical locations.

Figure 2.

Figure 3. Visual representation of the Hub Model



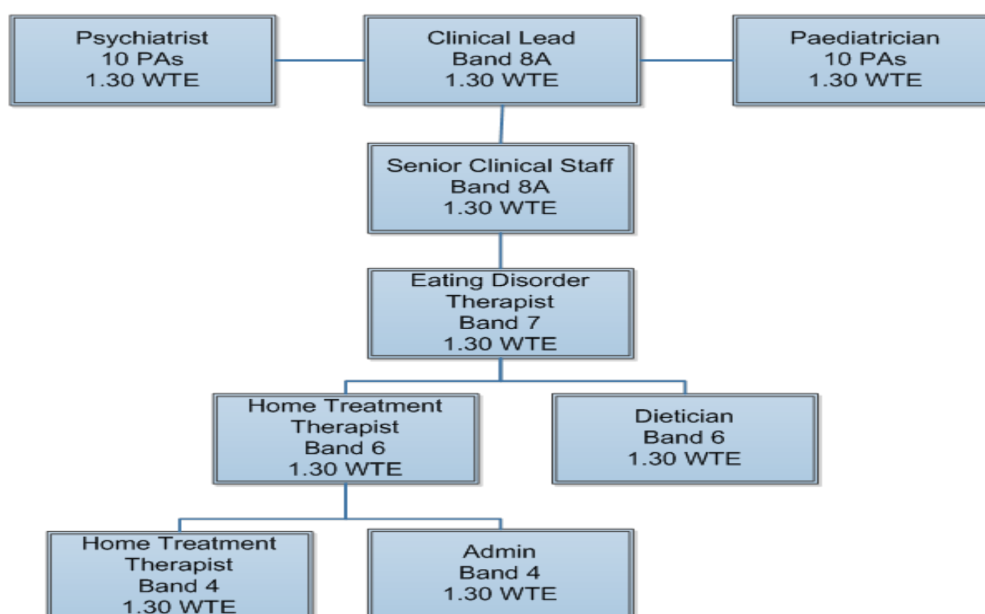
7.4 The guidance clearly outlines the skill mix and establishment for a CEDS and describes the types of interventions which should be accessible. In the financial section (section 8) of this business case we have provided three costing's. These will each support a different staffing structure with specific activity targets and scope for each. Any service specification will need to clearly define activity levels deliverable within the financial envelope. A brief outline of each costing and allied staffing structure is as follows:

Costing option 1.

The ideal staffing structure recommended in the guidance. This is currently significantly outside of the available financial envelope and has been included for benchmarking. The Costing option 1 below is the total expenditure for one hub team only.

Costings - Eating Disorder Pathway					
Description	Notes	WTE	AFC	Enh	Full Year Cost (Per 650k Popn)
Clinical Lead	Band 8a (MID)	1.30	54,423		£70,750
Psychiatrist	10 PAs at 120k	1.30	120,000		£156,000
Paeditrician	10 PAs at 140k	1.30	140,000		£182,000
Senior Clinical Staff	Band 8a (MID)	1.30	54,423		£70,750
Eating Disorder Therapist	Band 7 (MID)	1.30	43,842	7,892	£64,886
Home Treatment Therapist	Band 6 (MID)	1.30	36,567		£47,537
Home Treatment Therapist	Band 4 (MID)	1.30	25,078	4,514	£37,116
Dietitian	Band 6 (MID)	1.30	36,567		£47,537
Admin	Band 4 (MID)	1.30	25,078		£32,602
Total Pay		11.70			£709,176
Travel/Other Non-Pay	At 5% of staff costs				£35,459
Mobile Device	Running costs				£8,190
Total Non Pay					£43,649
Total Pay/Non-Pay					£752,825
Trust Overheads	At 10%				£75,282
Surplus	At 1%				£8,281
Total Cost					£836,388

Staffing Structure



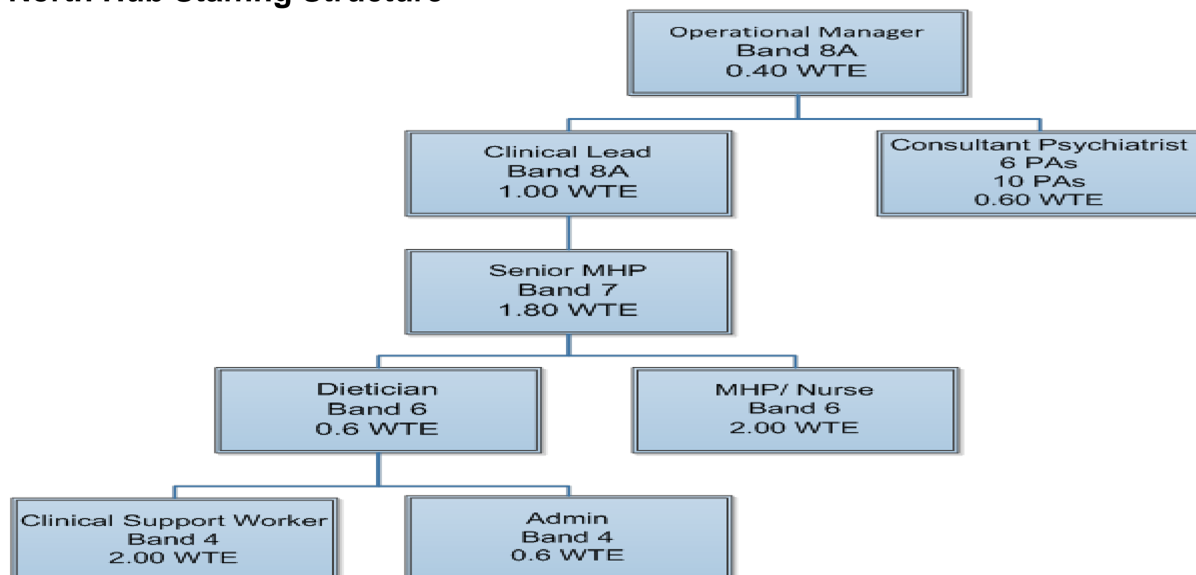
Costing Option 2

An aspirational staffing structure that is outside the available financial envelope but would more effectively provide the intensive support and early intervention described in the guidance. Day provision would be available in a community setting within this staffing structure but may be limited. This staffing model provides the overarching skill mix but may not be sufficiently resourced to be fully compliant with the guidance.

North Hub Staffing Structure

North HUB Costings - Eating Disorder Pathway					
Description	**Notes**	**WTE**	**AFC**	**Enh**	**Full Year Cost**
Operational Manager	Band 8a (MID)	0.40	54,423		£21,769
Clinical Lead	Band 8a (MID)	1.00	54,423		£54,423
Consultant Psychiatrist	6 PAs. 10 PAs at 120k	0.60	120,000		£72,000
Senior MHP	Band 7 (MID)	1.80	43,842	7,892	£86,807
Dietitian	Band 6 (MID)	0.60	36,567		£21,940
MHP/Nurse	Band 6 (MID)	2.00	36,567		£73,134
Clinical Support Worker	Band 4 (MID)	2.00	25,078	4,514	£54,670
Admin	Band 4 (MID)	0.60	25,078		£15,047
Total Pay		**9.00**			**£399,790**
Travel/Other Non-Pay	At 5% of staff costs				£19,989
Mobile Device	Running Costs				£6,300
Total Non Pay					**£26,289**
Total Costs					**£426,079**
Trust Overheads	At 10%				**£42,608**
Surplus	At 1%				**£4,687**
Grand Total					**£473,374**

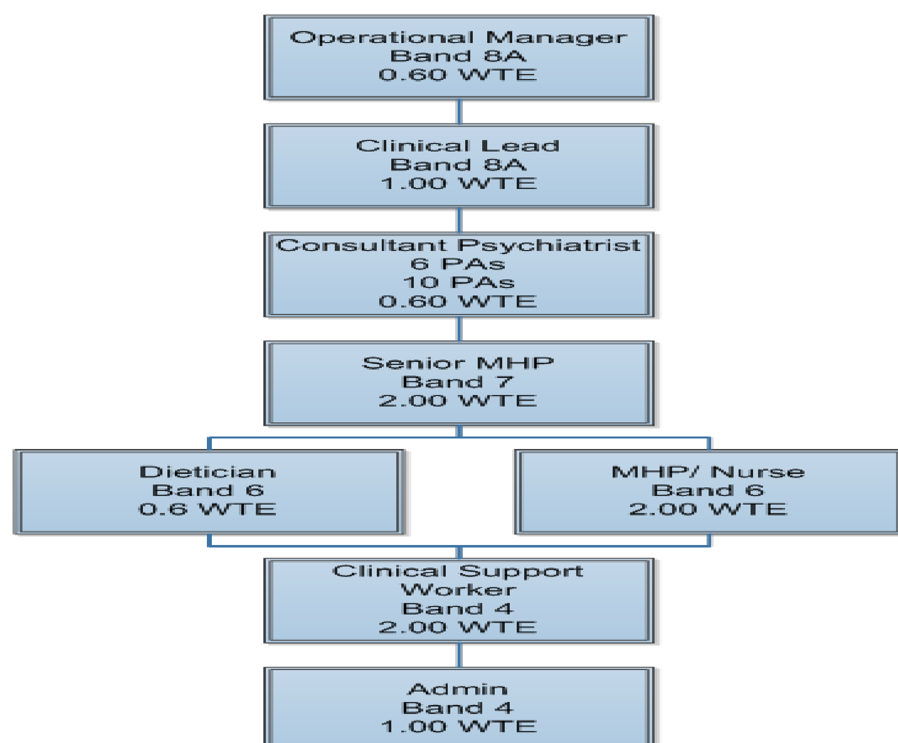
North Hub Staffing Structure



South Hub Staffing Structure

South HUB Costings - Eating Disorder Pathway					
Description	**Notes**	**WTE**	**AFC**	**Enh**	**Full Year Cost**
Operational Manager	Band 8a (MID)	0.60	54,423		£32,654
Clinical Lead	Band 8a (MID)	1.00	54,423		£54,423
Consultant Psychiatrist	6 PAs. 10 PAs at 120k	0.60	120,000		£72,000
Senior MHP	Band 7 (MID)	2.00	43,842	7,892	£95,575
Dietitian	Band 6 (MID)	0.60	36,567		£21,940
MHP/Nurse	Band 6 (MID)	2.00	36,567		£73,134
Clinical Support Worker	Band 4 (MID)	2.00	25,078	4,514	£54,670
Admin	Band 4 (MID)	1.00	25,078		£25,078
Total Pay		**9.80**			**£429,474**
Travel/Other Non-Pay	At 5% of staff costs				£21,474
Mobile Device	Running Costs				£7,000
Total Non Pay					**£28,474**
Total Costs					**£457,948**
Trust Overheads	At 10%				**£45,795**
Surplus	At 1%				**£5,037**
Grand Total					**£508,780**

South Hub Staffing Structure



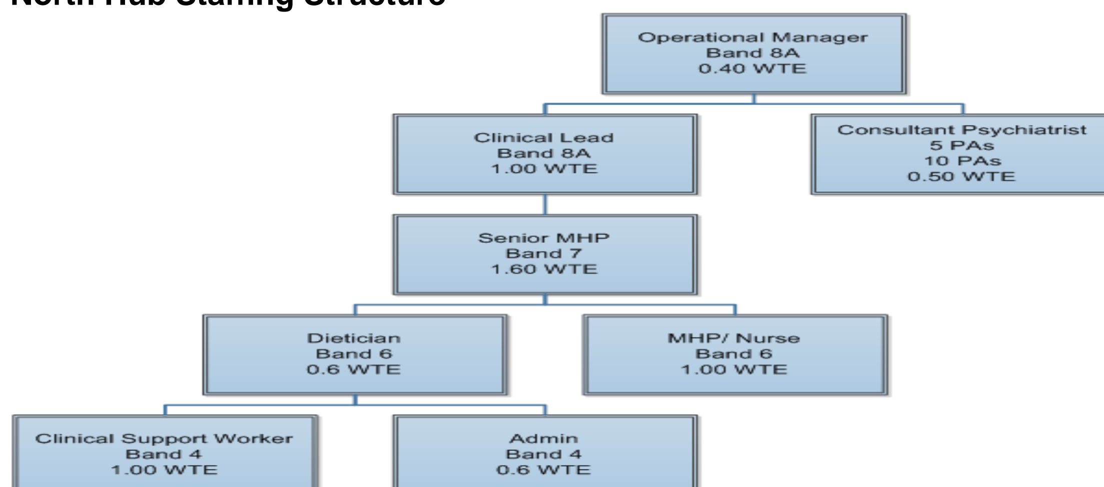
Costing Option 3.

A staffing structure within the financial envelope available. This would provide a foundation upon which to build additional functions to ensure compliance with the guidance. Day provision would continue to be offered on a case by case basis through the Horizon inpatient unit with the CEDS facilitating step down to intensive home and community support. For year 1 early intervention tasks may be limited dependent upon the demands on the team at any one time. Generic CAMH services will be required to support service delivery where there is co-morbidity and utilise the CEDS staff for consultation and supervision around the eating disorder aspects of the young person's presentation. It is envisaged this will be achieved by robust job planning and inclusion of generic CAMHS practitioners as part of the extended virtual team. Any benefits realised make take longer to be achieved within this service model as other work streams need to be concluded in order to deploy resources effectively across the whole emotional wellbeing and mental health pathway.

North Hub Staffing Structure

North HUB Costings - Eating Disorder Pathway					
Description	**Notes**	**WTE**	**AFC**	**Enh**	**Full Year Cost**
Operational Manager	Band 8a (MID)	0.40	54,423		£21,769
Clinical Lead	Band 8a (MID)	1.00	54,423		£54,423
Consultant Psychiatrist	5 PAs. 10 PAs at 120k	0.50	120,000		£60,000
Senior MHP	Band 7 (MID)	1.60	43,842	7,892	£78,038
Dietitian	Band 6 (MID)	0.60	36,567		£21,940
MHP/Nurse	Band 6 (MID)	1.00	36,567		£36,567
Clinical Support Worker	Band 4 (MID)	1.00	25,078	4,514	£29,592
Admin	Band 4 (MID)	0.60	25,078		£15,047
Total Pay		**6.70**			**£317,376**
Travel/Other Non-Pay	At 5% of staff costs				£15,869
Mobile Device	Running Costs				£4,900
Total Non Pay					**£20,769**
Total Costs					**£338,145**
Trust Overheads	At 10%				**£33,815**
Surplus	At 1%				**£3,720**
Grand Total					**£375,679**

North Hub Staffing Structure

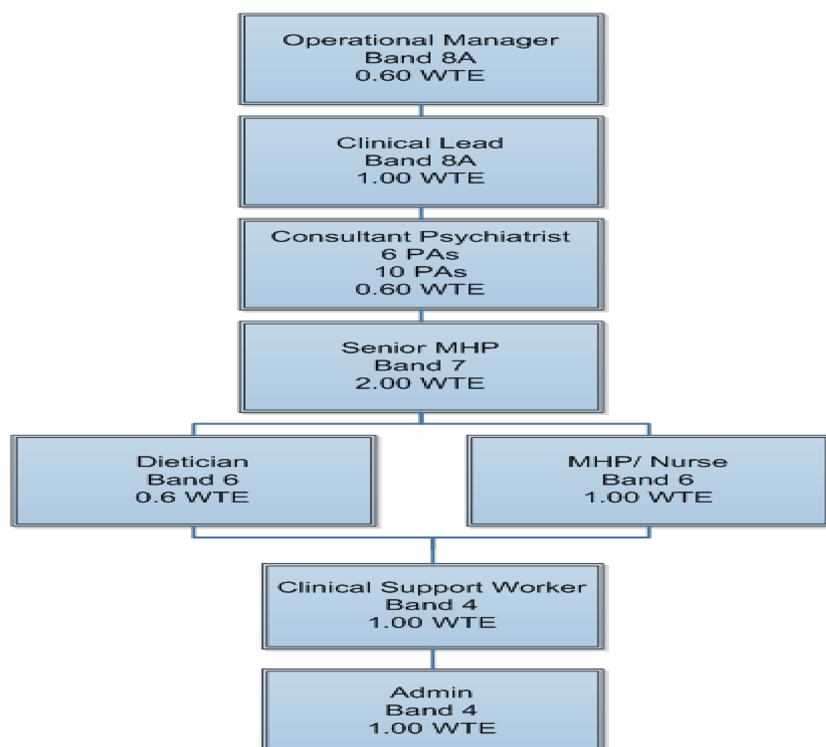


South Hub Staffing Structure

South HUB Costings - Eating Disorder Pathway

Description	Notes	WTE	AFC	Enh	Full Year Cost
Operational Manager	Band 8a (MID)	0.60	54,423		£32,654
Clinical Lead	Band 8a (MID)	1.00	54,423		£54,423
Consultant Psychiatrist	6 PAs. 10 PAs at 120k	0.60	120,000		£72,000
Senior MHP	Band 7 (MID)	2.00	43,842	7,892	£95,575
Dietitian	Band 6 (MID)	0.60	36,567		£21,940
MHP/Nurse	Band 6 (MID)	1.00	36,567		£36,567
Clinical Support Worker	Band 4 (MID)	1.00	25,078	4,514	£29,592
Admin	Band 4 (MID)	1.00	25,078		£25,078
Total Pay		**7.80**			**£367,829**
Travel/Other Non-Pay	At 5% of staff costs				£18,391
Mobile Device	Running Costs				£5,600
Total Non Pay					**£23,991**
Total Costs					**£391,820**
Trust Overheads	At 10%				**£39,182**
Surplus	At 1%				**£4,310**
Grand Total					**£435,312**

South Hub Staffing Structure



7.5 Access to the CEDS should be the same whichever costing model is agreed in order to prevent multiple access points however a service specification will need to be in place to describe the amount of activity post referral and signposting and transition pathways that are in place. This is being developed in conjunction with lead commissioners for North and South Pennine.

7.6 The service is expected to receive 65 referrals per annum through a single access point from anyone and via a range of mediums. Referrals will be screened within 24 hours over 7 days and urgent case seen the same day. Routine referrals will wait no longer than 4 weeks.

As well as targeted consultation advice and support will be available through a range of mediums including electronically.

Young people accessing the service will be offered a generic mental health assessment to identify/exclude any co-morbid needs, a specialised eating disorder assessment, a baseline physical health screening and an individualised care plan in which they and their families are key partners. The service can offer a range of therapeutic interventions, which are evidence based and underpinned by a multidisciplinary team (MDT) ethos and approach. The MDT will work in close

collaboration with the virtual team members that they regularly interface with such as Acute Trust Paediatric and Medical services, and with Primary Care, to ensure young people's co-existing physical health needs are met.

7.7 Some young people will present with additional complexity including high levels of psychiatric risk, acute medical risk and significant co-morbidity or social adversity. In order to manage this safely and effectively the team will need to have strong and routine interfaces with other professionals to ensure that they can draw upon the appropriate additional resource identified whether that is Tier 4 CAMHS, Social Care or urgent medical intervention. It will also be crucial for this team to maintain their links with the generic CAMH service to support joint working, maintain the skills of both services and to avoid unnecessary transitions and barriers for young people and families.

7.8 Young people will be allocated a case worker who will endeavour to follow their care in whatever setting it is delivered including at the home and in medical and mental health inpatient settings.

7.9 Whilst there is an aspiration to develop this service beyond 18 years this will not be in place immediately. Consequently transitions will need to be managed on the basis of the needs of the young person and family.

7.10 Robust performance data compliant with the Mental Health Minimum Data Set (MHMDS) will be gathered including routine outcome measures and service user experience and this will be reported on monthly through the CEDS steering group and to commissioners. Arrangement of outcome measures will be utilised but as a minimum the following will be utilised:

Health of the Nation Outcome Scales for Children (HONOSCA)
ED symptoms
Weight and body mass index
Experience of Service Questionnaire (ESQ)

The expected outcomes for this service are:

- A more equitable and standardised level of provision for children, young people and their families
- More timely access to evidence based community treatment
- Fewer transfers to adult services
- Earlier step down and discharge from inpatient settings
- Reduced use of both medical and mental health inpatient services
- Reduction in crisis presentations and re referrals to specialist services

- Increased awareness and skill within the community including families/carers and peers
- Extend the Early Help offer to include lower level eating disorders
- Release capacity within generic CAMHS to enable shorter access times into the service

Evaluation of the service

Evaluation of the service is essential to ensure sustainability and test the model of service delivery for efficacy, safety and experience. This will be achieved by utilising a range of methods:

- Monthly performance monitoring of KPIs between the providers and CCG
- Routine service evaluation questionnaires
- Bespoke use of consultation ad user satisfaction tools
- Robust feedback about operational delivery via a steering group with embedded representation from young people and parents/carers.

8. Cost of delivering the service

Costing Option 1 -£836,388 (One hub only)

Costing Option 2 -£946,154 (North and South Hub)

Costing Option 3 -£810,991 (North and South Hub)

8.1 Set up Costs will be agreed once an estate is identified to house the services.

Set-up Costs		
Mobile Devices	Dell Latitude E5450 x 14	£24,752.84
Estates	TBC	-
Furniture/Fittings	TBC	-

Please note set up costs cannot be finalised until accommodation is identified

Risk and Key Issues

9.1 Further review of the overall CAMHS resources in the context of the whole transformation programme will need to be undertaken alongside the evaluation of the effectiveness, safety and user experience of this model during its pilot phase. It is

envisaged that this approach to delivering services will be utilised for other care pathways particularly those for long term conditions and this will release some capacity within specialist services

9.2 The new investment allocated is insufficient to develop a CEDS that fully complies with the guidance. A shared view will need to be reached between ourselves and commissioners about the pace and scope of the pilot service development

9.3 The development of the referral pathway will need to closely align with the work of the CQUIN around access which is supporting the development of a SPOE in a public service hub for all emotional wellbeing and mental health referrals

9.4 Recruitment will need to begin early to ensure the quality of the staff and adequate preparedness for the service to commence on 1st April 2016. The key leadership posts should be recruited by January 2016. This process may impact on the skill mix of the generic CAMH services and the inpatient service and this will need to be managed within the recruitment process and timescales. Early release of funding for key posts and set up costs would be required

9.5 The true need for this service is not currently known and there is a risk that demand exceeds capacity despite the new investment. There will need to be close scrutiny of demand and capacity and early alert of a significant imbalance in flow and contingency strategies identified to redress this.

9.6 A stepped care approach is required to ensure that resources are deployed across the pathway consistently and for the right activity. It is essential to achieve right blend of early intervention and support with intense treatments for very unwell young people and this will require robust leadership and coordination.

9.7 The guidance describes the need to specify medical input into the pathway through existing service specifications. This requires interface with the NHS acute care providers in the South hub and a shared agreement about how the medical component of the pathway will be delivered.

9.8 A decision has not yet been made in regards to provision of estates to accommodate the new teams therefore costs for set up cannot yet be clearly articulated.

9.9 We are unable to quantify capacity released in generic CAMHS and tier 4 at this stage but will commit to undertaking a review of IROR and the impact on capacity over the next 3 -6 months .

9.10 A number of concurrent work streams will need to be concluded in order to ensure resources are safely, effectively and equitably deployed across the whole emotional wellbeing and mental health pathway.

These include in the short to medium term a review of Tier 4 and the IROR team; the operationalization of the output from the Crisis Care Concordat and work with AMHS around all age needs led service delivery.

In the longer term over the next 5 years the benefits predicted from the new ways of working and upskilling and building capacity in the wider children's workforce will release capacity in specialist and acute services and improve access to earlier help and support. There are also opportunities through GM Devolution to share exemplar practice and scale up effective models of care across traditional geographical and agency boundaries.

Summary

Pennine Care welcomes the opportunity to work in partnership with commissioners, the wider children's workforce and young people and their families/carers to develop an innovative, evidence based community based eating disorder service.

Mobilisation Plans

Eating Disorder Service development action plan
October 2015

Objective	Actions	Timescale	Person Responsible	Progress Report	RAG Status
Contract Management	Identify Project Team and individual responsibilities	Nov 2015	Directorate Manager		
Contract Management	Identify any issues that require clarification prior to contract sign off	Nov 2015	Directorate Manager		
Contract Management	Agree and sign contract	Nov 2015	CCG Contract Manager and Pennine Care Contract Manager		
Workforce	Identify all staffing requirements and recruit key posts by Jan 2016 and remainder Jan – Mar 2016	Nov 2015	Directorate Manager		
Workforce	Scope staff training needs in each locality	Feb/Mar 2016	Appointed Operational Manager		
Service Pathways	Establish pathways with medical services – Adults and Paediatrics and identify a link person per hub	Mar 2016	*Leadership Team, CCG and Acute Providers		
Service Pathways	Scope opportunities for developing medical champions to link with pathway	Jan 2016	*Leadership Team, CCG and Acute Providers		
Service Pathways	Scope opportunities to develop ring fenced medical beds in the hub locality reaching up to 18 years	Jan 2016	*Leadership Team and CCG		

Objective	Actions	Timescale	Person Responsible	Progress Report	RAG Status
Service Pathways	Establish pathways with Education services	Jan-Mar 2016	*Leadership Team and Local Authority		
Service Pathways	Establish pathways with wider children's services	Jan-Mar 2016	*Leadership Team		
Information Media & Technology	Identify resources required to set services up including IT set up costs	Jan-Mar 2016	Directorate Manager and CCG		
Information Media & Technology	Ensure systems in place and compliant	Jan-Mar 2016	Directorate Manager, Pennine Care Estates and IT		
Premises	Identify all delivery locations	Jan-Mar 2016	Directorate Manager, Pennine Care Estates and CCG		
Premises	Ensure all locations are of required standard and compliant	By end of Mar 2016	Directorate Manager, Pennine Care Estates and CCG		
Marketing & Communications	Develop and implement a consultation and engagement strategy with young people and their families / carers	April 2016	Directorate Manager and Pennine care Patient Experience Lead		
Marketing and Communications	Develop marketing strategy with Communications team	Nov 2015	Pennine Care Communication Team and Directorate Manager		
Marketing and Communications	Identify communication requirements of all stakeholders	Nov 2015	Pennine Care Communication Team and Directorate Manager		
Marketing and Communications	Develop a range of information and advice leaflets e.g leaflets, posters, website updates	Jan 2015- Ongoing	*Leadership Team and Pennine Care Communications Team		
Capacity Review	Review of IROR and impact on capacity	Oct 2015- Mar 2016	Directorate Manager		

*Leadership Team- Clinical Lead, Psychiatrist and Operational Manage

References

NICE guidance, Jan 2014 Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa and related eating disorders, NICE

Junior MARSIPAN, January 2012 Management of Really Sick Patients under 18 with Anorexia Nervosa, Royal College of Psychiatrists

Gowers SG Clark AF,The TOuCAN trial, 2010, A randomised controlled multicentre trial of treatments for Adolescent Anorexia Nervosa including assessment of cost-effectiveness and patient acceptability - the TOuCAN trial.

Gowers S, Clark A, Roberts C, Griffiths A, Edwards V, Bryan C, Smethhurst N, Byford S, Barrett B,2007 Clinical effectiveness of treatments for anorexia nervosa in adolescents, Br J Psychiatry, Future in Mind

James Lock, Sep 2010, Treatment of Adolescent Eating Disorders: Progress and Challenges; James Lock, Minerva Psychiatry

McCartney, Hart and Watt How can socioeconomic inequalities in hospital admissions be explained? A cohort study; BMJ 2103:3, Access and Waiting Time Standard

Treasure J, Russell G,2011, The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. British Journal of Psychiatry.

Byford S, Barrett B, Roberts C, Clark A, Edwards V, Smethurst N, et al,2007 Economic evaluation of a randomised controlled trial for anorexia nervosa in adolescents. British Journal of Psychiatry.

House J, Schmidt U, Craig M, Landau S, Simic M, Nicholls D, et al, 2012, Comparison of specialist and non-specialist care pathways for adolescents with anorexia nervosa and related eating disorders. International Journal of Eating Disorders.

NICE December 2013 – Surveillance Programme, Surveillance report for GE

APPENDIX: 4

Tameside Template action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat

1. Commissioning to allow earlier intervention and responsive crisis services					Q2 Updates	RAG
No.	**Action**	**Timescale**	**Led By**	**Outcomes**		
Matching local need with a suitable range of services						
1	To set up street triage service as an enhancement of the current RAID provision.	**April 2015**	MP/KM/PM	To secure ongoing funding for the project post March 2016. To deliver on effective outcomes, reducing the use of 136/135 power, improving the experience for the service user, police and paramedics as well as health staff.	Street triage is ongoing in Tameside borough Funding agreed until March 2016 Robust data and evaluation template in place supported by CCG Commissioner Pat McKelvey	
2	Ongoing commissioning of the RAID service offering crisis assessments and follow up work to support service users through a crisis.	**March 2016**	MP/KM/PM	Secure permanent funding of the RAID team to offer ongoing outcomes to service users/carers and other pathways in the service.	RAID permanent funding being considered by CCG after end March 2016	

3	Gain access to dataset of breach information to be shared with Pennine Care on a daily basis for all mental health breeches.	**June 2015**	MP/KM	To assist Pennine Care in being responsive to Tameside Acute Trust around support of their breech target.		
4	To review Service User and Carer stories about how they manage a crisis at home.	**August 2015**	GM	To review Carer and Service users stories to improve outcomes in crisis care.	Ward Manager to bring 1 patient story positive or negative to each meeting	
	Improving mental health crisis services					
1	As part of Phase 4 Care Together Programme explore crisis provision.	**September 2015**	KM/MP/PM	To have the provision of nurse led crisis beds to offer an alternative environment to hospital admission for the service user in a non-medical crisis requiring a time limited secure environment including overnight stays.	This still being explored with CCG Commissioners	
2	Development of	**September**	Partnership	To develop, with third sector	The Sanctuary self-	

	a sanctuary facility to support service users in a crisis during the night.	**2015**	Group	providers, the provision of a sanctuary facility, non-bed based with a view to offering support during the night for the vulnerable person in a crisis that do not require medical intervention.	help service is now in place for Tameside	
3	To ensure the principles in the new homelessness protocol are adhered to by all stakeholder.	**May 2015**	Partnership group	To implement principles within the protocol.	This is being shared within CBU and partnership meetings	
4	Safe and sober to be scoped out for implementation in Tameside.	**March 2016**	KM/VW	Safe and sober is to be scoped out via a Pennine CQUIN 15/16. This process will seek to engage the Tameside Acute trust into the pilot for a safe and sober unit on the Tameside Acute site from April 2016.	Initial scoping discussions have taken place with TGH	
Ensuring the right numbers of high quality staff						
1	Scope out interface between probation, courts and diversion panel. To review the staffing resource in the	**October 2015**	Local re-design groups and work with CCG	Correct numbers of staff available to meet the demands of the services. To include prison health and preventative work with pre-offenders.	Currently fulltime Criminal Justice Mental Health worker in place Further discussion over next year with Local Authority re: Review of staffing	

	Criminal Justice Mental Health teams.					
2	To secure the permanent funding of the A&E RAID service based in TGH.	**March 2016**	CCG and Pennine Care services	To secure permanent funding of the RAID service in the borough to continue to offer 24/7 response to A & E as well as street triage from April 2015.	RAID permanent funding being considered by CCG after end March 2016	
3	To continue to build a good working relationship between mental health services and the police SPOC.	**Ongoing**	NP,MP,BR,BC	To meet regularly with new SPOC Nana Pabby. To share incidents and good partnership working stories.		
Improved partnership working in the Tameside locality						
1	Review in Tameside monthly Police Partnership meetings. Continue to share practise issues outside of the group.	**Ongoing**	Partnership group	Monthly action plans and issue addressed Partnerships: • Communication • Signposting • Re-launch partnership meeting (assess membership) • Scoping (include signatories for	Partnership meeting in place every month Every 2nd meeting to be focused on Crisis Concordat AQuA support for information sharing being explored	

				Concordat)		
2	Frequent attenders. Set up group pulling Local Authority and Acute Trust.	**October 2015**	BR, JM, Police partnership meeting	To develop care plans for the frequent flyers in the Tameside & Glossop Borough to better manage their crisis. To link this work to the Police street triage work and access joint care plans with the police and community mental health teams.	Work has progressed re: frequent flyers into A&E and 136 led by Acute Service Manager Via Street triage / PSR Hub	
3	Voluntary and third sector – improved multi-agency working.	**October 2015**	KM,MP	To look for opportunities to engage with the voluntary and third sector around crisis care.	Acute Service Manager has invited 3rd Sector partners to future Partnership meetings	

2. Access to support before crisis point					**Q2 Updates**	**RAG**
No.	Action	Timescale	Led By	Outcomes		
Improve access to support via primary care						
1	To improve access to local GPs. Improve GPs	**Ongoing**	CCG in conjunction with partnership	To have a range of appointments available over 7 days a week including extended hours.	Further work is underway to scope out need and capacity for 7 day	

	knowledge of MH.		group	RAID post based in A&E.	appointments with RAID team	
2	Improve RAID to GP interface.	**Ongoing**	BR,MP	Write about RAID in the monthly GP newsletter. Arrange visits to GP surgeries to talk about developments in the RAID service.	KM to discuss further with T Greenhough GP Lead for Mental Health	
3	To engage third sector providers to aid in earlier intervention and prevention. Need a full scope on the availability of third sector providers in the Tameside & Glossop Borough.	**November 2015**	Partnership group	To work with third sector providers in developing crisis pathways that are effective for the service user with limited hand-offs.		
Improve access to and experience of mental health services						
1	To review current estate provision within Pennine Care and other partner agencies for fit for purpose reviews (RAID	**November 2015**	Partnership group and relevant stakeholders	Provision of fit for purpose buildings to deliver crisis provision. RAID room in A & E is of particular importance.	Further work is underway with estates re: accommodation needs to RAID or 136 suite	

	Room, 136 Suite).					
3. Urgent and emergency access to crisis care					**Q2 Updates**	**RAG**
No.	Action	Timescale	Led By	Outcomes		
Improve NHS emergency response to mental health crisis						
1	To develop protocols with NWAS	**May 2015**	MP,MW	MP and MW to meet with lead from NWAS to develop better working outcomes and to integrate NWAS into street triage service.		
2	To expand the information sharing and gain agreement across the Tameside & Glossop economy, where consent is obtained from the person	**April 2016**	MP/MW/Acute Reps/NMAS	To ensure that information is available to improve where a person is seen for the best outcome		
Social services' contribution to mental health crisis services						
1	Statutory responsibilities such as EDT/AHMP.	**Ongoing**	Complete	To provide an approved professional 24/7 for the purposes of the mental health act.	Memorandum of Understanding sent to Julie Butterworth, NWAS	G

2	Safeguarding processes.	**September 2015**	Local Safeguarding Board Tameside	Safe and robust safeguarding processes are in place in the Tameside Borough for both Children and Adults. To identify lead to represent Pennine Care at this meeting.	Naz Khadim – Safeguarding Lead (Tameside Acute) and Karen Maneely Service Line Manager – Adults both attend Tameside Safeguarding Board	
3	Recovery college – access to education and employment (recovery focused).	**February 2016**	Police partnership	Scope out possibility of recovery college.		
4	Troubled families – Wellbeing Agenda. Pilot – lead innovation into children's mental health. Improvements in non-inpatient services for children.	**Ongoing.**	Local Authority, Police Partnership.	Commissioning process / partnerships to continue work with troubled families		
Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983					**Q2 Updates**	**RAG**
Improved information and advice available to front line staff to enable better response to individuals						

1	Recognition of good work already done on reduction of numbers detained under section 136.	**Ongoing**	Police Partnership.	136 figures monitored and reviewed. Good/problematic examples taken back to the partnership meeting. Enhanced 136 service from April 2015 via the street triage service.		
2	Working with the Acute Trust regarding people who have been detained.	**Ongoing**	MM, Acute Trust	MM has been training staff in MAU and other parts of Tameside Acute Trust.. This has been well received and has increase Tameside acute trusts knowledge of mental health sections. This training will continue as part of the scrutiny work being undertaken by the mental health act staff.		
3	Response time to requests for s12 doctor.	**Ongoing**	Law Scrutiny group.	Discuss in Mental Health Law Scrutiny Group and Medical Managers in order to improve response times for s12 doctors		
Improved training and guidance for police officers						
1	Training plan to be developed and implemented through the police partnership	**September 2015**	Police Partnership group	To develop and deliver and evaluate yearly training programme as per requirements identified in the police partnership group	Robust training plan in place for next 3 months re: training for Police across Tameside & Glossop	

	group. The plan to include training to officers on 136/135 and basic signs and symptoms of mental illness. The training will also include police officers training health staff on police powers and what they are and are not able to do. The package will include missing from homes, AWOLs from the unit and CTO recalls.					
2	To ensure all crisis services are aware of what is available within the Borough when a person they attend is in a crisis, such as the use of the	**Ongoing**	Police Partnership group	To ensure all services are aware of what is available in a crisis via full scoping exercise and the development of Directory of Services used via street triage, GMP, NWAS, GP surgeries and other primary care services as well as third sector providers		

	street triage, access/SPOE, third sector provision and statutory teams such as EDT and adult safeguarding.					
3	CQUIN Scoping for training needs to be brought together. Create training package across Pennine Care.	**September 2015**	KM,MP	Bring into Trust-wide Partnership Meeting		
4. Quality of treatment and care when in crisis					**Q2 Updates**	**RAG**
No.	Action	Timescale	Led By	Outcomes		
Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring						
1	Police cells	**Ongoing**	Police Partnership group	Not to use police cells, only in exceptional circumstances, for the use of the person with a mental health issue who has not committed a crime. To contact the street triage and offer alternative. If only safe option to use cells then street		

				triage to co-ordinate mental health response. Custody to be aware they can also contact the street triage if they have prisoners they wish to discuss.		
2	136 Suite	**Ongoing**	Police Partnership group	To continue to use the 136 suite as the preferred place of safety for 136/135 admissions via the police. To monitor monthly use and hopeful reduction via street triage process. To identify any practice issues and lessons to be learnt via the monthly partnership meeting.		
3	MEDACs contract to be reviewed	**April 2015**	Police Partnership group	To have a more responsive forensic medical opinion that informs the custody suite of best actions for the service user. This to include a better response if the custody suite requires the need to enact a MHS assessment. To improve the AA rota provision.		

Service User/Patient safety and safeguarding						
1	Safeguarding policies and procedures in place in all stakeholder agencies.	**Ongoing**	Police Partnership group	Each service has a safeguarding lead and these to ensure that all policies and processes are in place and followed. To ensure this is supported through relevant raining packages for all stakeholder staff and that the required paperwork is in place.		
2	CMHT response in a crisis call.		Police Partnership group	CMHT will respond in a crisis to service users under their caseloads when the service is operational. This will be done via all safe processes and practices to safeguard service users and staff.		
Staff safety						
1	Design an ASB system to ensure perpetrators can be identified and dealt with.	**October 2015**	Police Partnership group	To ensure all staff aware of the lone worker policies and procedures in their own area	Lone worker policy is in place for staff across Tameside & Glossop	
2	Pennine Care LSMS to bring	**Ongoing**	Police Partnership	In conjunction with the police partnership group to develop	Joint working and sharing of information	

	key issues regarding the management of ASB and the issuing of agreed ASBO to partnership meetings if required in order to safeguard others using the facilities.		group Pennine LSMS	agreed system of managing ASB in the hospital and safeguarding staff and other service users by managing such individuals.	in place re: complex service users Karl Adderly – Trust LSMS invited to attend Partnership Meeting	
Primary care response						
1	Greater access to GP appointments for service users in a crisis. Locality leads to raise awareness within their own localities (re-requesting more appointments for mental health service users.	**November 2015**	Police Partnership group and CCGs TG, Mental Health GP	To work with the CCGs to increase access to GP appointments for service users who are experiencing a crisis. Short notice – certain practices in the locality will take high demand patients.	KM to discuss with Tina Greenhough, GP Lead Mental Health	

2	To promote the Samaritans follow up service and to look for opportunities to increase this offer to more service users in crisis.	**November 2015**	MP, Police partnership meeting.	Meet with Samaritans and to look at opportunity to expand the offer of service.		
5. Recovery and staying well / preventing future crisis					**Q2 Updates**	**RAG**
No.	Action	Timescale	Led By	Outcomes		
Joint planning for prevention of crises						
1	All age mental health pathway including recovery plan and stay well plan.	**January 2016**	KM,MP	To look to increase the recovery offer to service users in crisis.		
No.	Action	Timescale	Led By	Outcomes		
Immediate Actions						
1	To be agreed at next police partnership meeting. To be					

	sent to CCG for final sign off.					