Additional information to be considered by Scrutiny Board (Health and Well-being and Adult Social Care) on 16 December 2014

Pages 1-48: Agenda item 9: Additional information to be considered as part of the Board's inquiry into Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools

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TaMHS Expansion Evaluation 2013 - 2014

TaMHS Performance Measures and Indicator Impact September 2014

Glossary

1:1 work: regular individual support to a pupil
CAF: Common Assessment Framework
CBT: Cognitive Behavioural Therapy
CCG: Clinical Commissioning Group
CLA: Children Looked After
Consultation: Professional advice from a specialist mental health practitioner to a family, staff member. This includes the CAMHS '2+1' consultation model to families.
CPPs: Child Protection Plans
CYPP: Children's and Young Persons' Plan (for Leeds)
CYP IAPT: Children and Young Peoples Improving Access to Psychological Therapies. A service improvement programme for CAMHS.
G&S: Guidance and Support multi professional meetings
High/ Borderline/ Normal: Assessment categories for SDQ assessments. High = high level of need, one indicator of a specialist CAMHS referral
GBO: Goals Based Outcomes. Client centred target setting assessment using 0 -10 self-rating scale. 0 = need completely un met 10 = need completely met.
LAC: Looked After Children
Leeds Average: A data set is available for certain CYPP indicators. For each there is an average for the whole of Leeds
OBA: Outcomes Based Accountability
TaMHS: Targeted Mental Health in Schools Project

Summary:

- For a summary description of TaMHS please visit http://www.schoolwellbeing.co.uk/pages/tamhs-leeds
- TaMHS has expanded into another 13 clusters. As previous clusters have re commissioned their TaMHS service this now can be considered a city wide service (Garforth cluster have commissioned their own mental health support independently of TaMHS).
- CCGs have invested in 5 existing TaMHS clusters to pilot direct GP referral access. This is in its initial stages with a separate interim evaluation showing some early signs of success
    - South and East CCG (with one year TaMHS funding): Temple Newsam Halton and Brigshaw (September 2013 – August 2015)
    - West CCG: Aireborough, Bramley and Pudsey (September 2014 – August 2015)
- The evaluated data shows positive impact in performance measures of mental health improvement and school development. The related CYPP indicators of CPPs and CLAs do not show the previous positive impact but there are now no clusters without TaMHS to compare against.

Issues

1. (As reported in the previous evaluation) Pressure on the TaMHS service to provide a more complex, longer term service. TaMHS is commissioned, and staff selected on this basis, to provide early intervention, short term specialist mental health support. It fills a much needed gap in support. A range of factors puts pressure on the service to extend its remit which include:

i) Quite simply the extent and depth of the need in the local communities. We see most cluster G&S referrals as a request for TaMHS and most of these cases have well entrenched need. Amongst those are many cases that meet the specialist CAMHS threshold but have not been addressed due to a range of factors e.g. referrals not taking place, referrals going missing, referrals by GPs incomplete, a refusal by the client to engage with CAMHS, public transport phobia etc. it is these types of cases that TaMHS supports and improves week in, week out as it is part of the cluster remit to problem solve, find alternative ways of meeting need, offering the service in a local, well known place. It is this that best exemplifies why TaMHS is successfully placed in the cluster multi professional team.
ii) A lack of understanding by some services of the remit of school facing, short term & early intervention resulting in inappropriate referrals. E.g. referrals from social care teams
iii) A downward pressure on the specialist CAMHS budget reducing capacity.
iv) A lack of other services to fill the gap between TaMHS and specialist CAMHS where neither service is suitable for longer term, more complex need support.

2. Data recording. There was wide variation in data recording with some practitioners completing a very complete set of data and some with many gaps e.g. no attendance data. The importance of this will be reinforced going forward as it is essential prove to funders the impact of the service and the findings of CYP IAPT showing that outcome data improves distress, gives an effective measure of successful support and reduces the length of time support is needed by the client.

Clusters involved in the evaluated expansion:

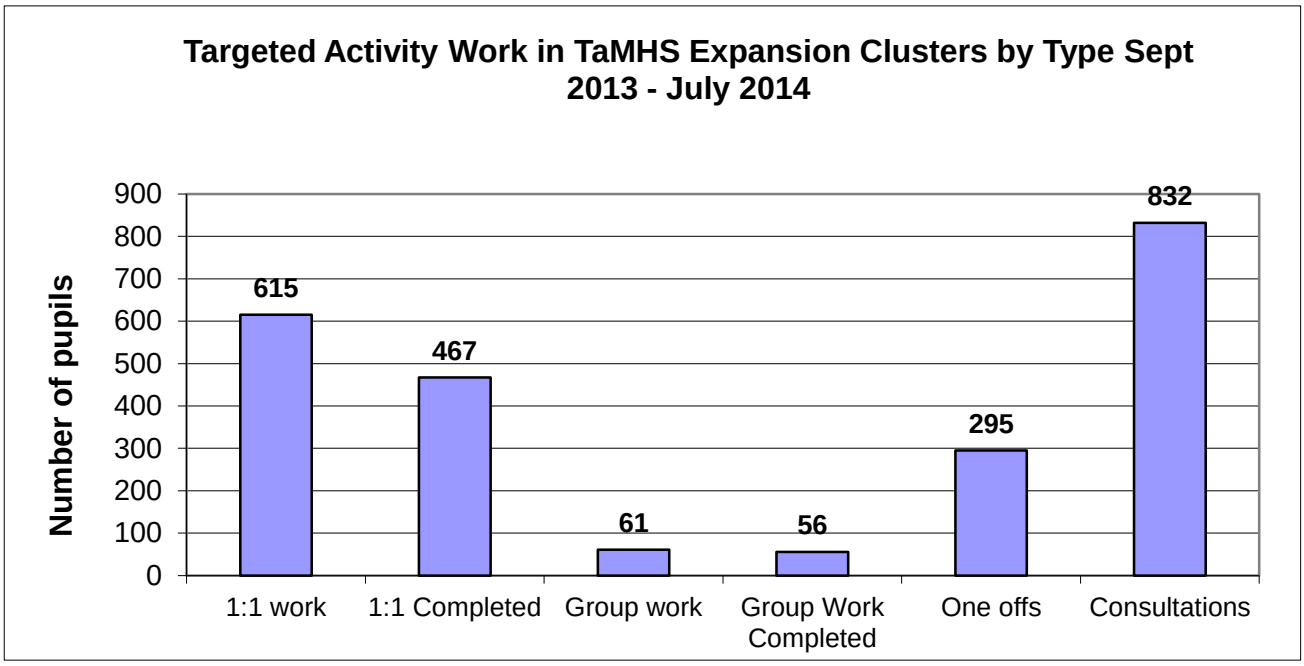
- ACES
- BCM
- Alwoodley
- Morley
- Ardsely & Tingley
- Otley
- Seacroft and Manston
- EPOS
- Rothwell
- Farnley
- ESNW
- INW HUB
- Horsforth

Contents

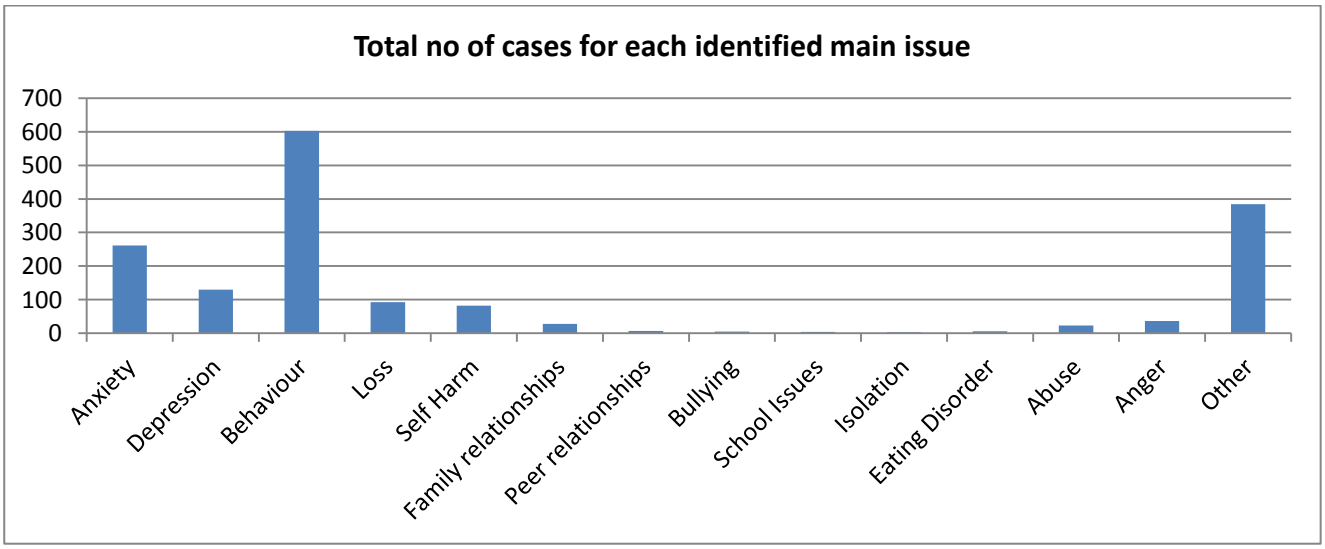
Performance Measures

How much did we do? (activity)

- **Guidance and Support Referrals** (Case Discussions) [1]: 162 Guidance and Support meetings with 1326 total referrals (not just TaMHS)
- **Targeted activity work**



This shows a total of 1803 pupils supported through direct and indirect contact (there is some double counting of pupils in this total within consultations.) Despite this, when compared to the number of total referrals to G&S, it demonstrates the high numbers of mental health issues in targeted referrals.

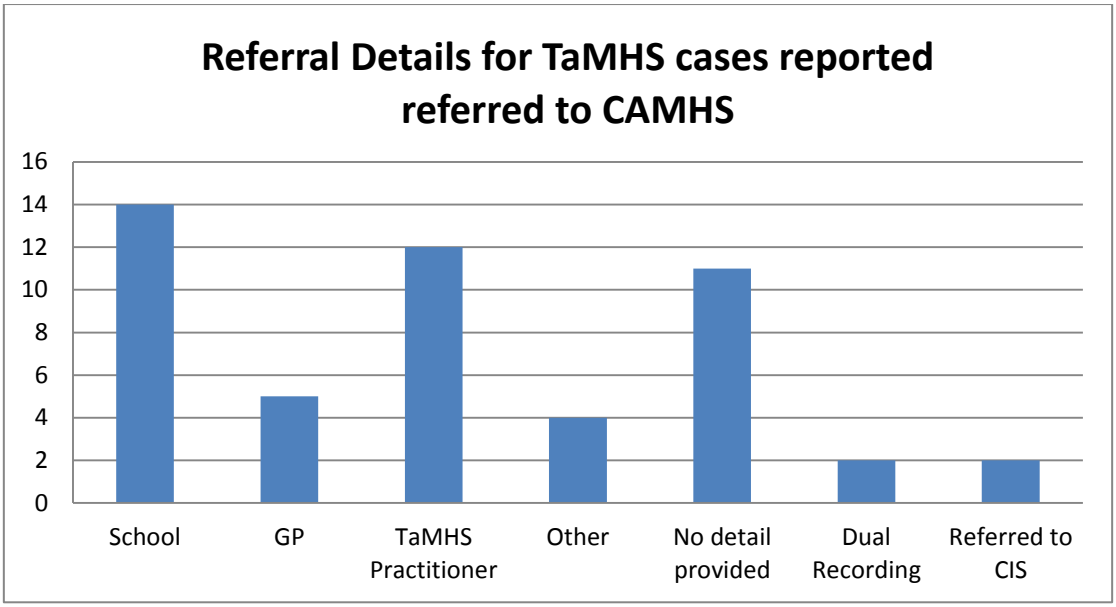


The above chart should be treated as a broad brush stroke as there is variability in using all headings of main issues and many behaviour cases as the referral reason

[1] To demonstrate effective multi agency working and outputs, including 'indirect clinical activity'.

rather than the underlying issue (as to be expected in a school facing service). More analysis of underlying issue will be requested from practitioners in year 2.

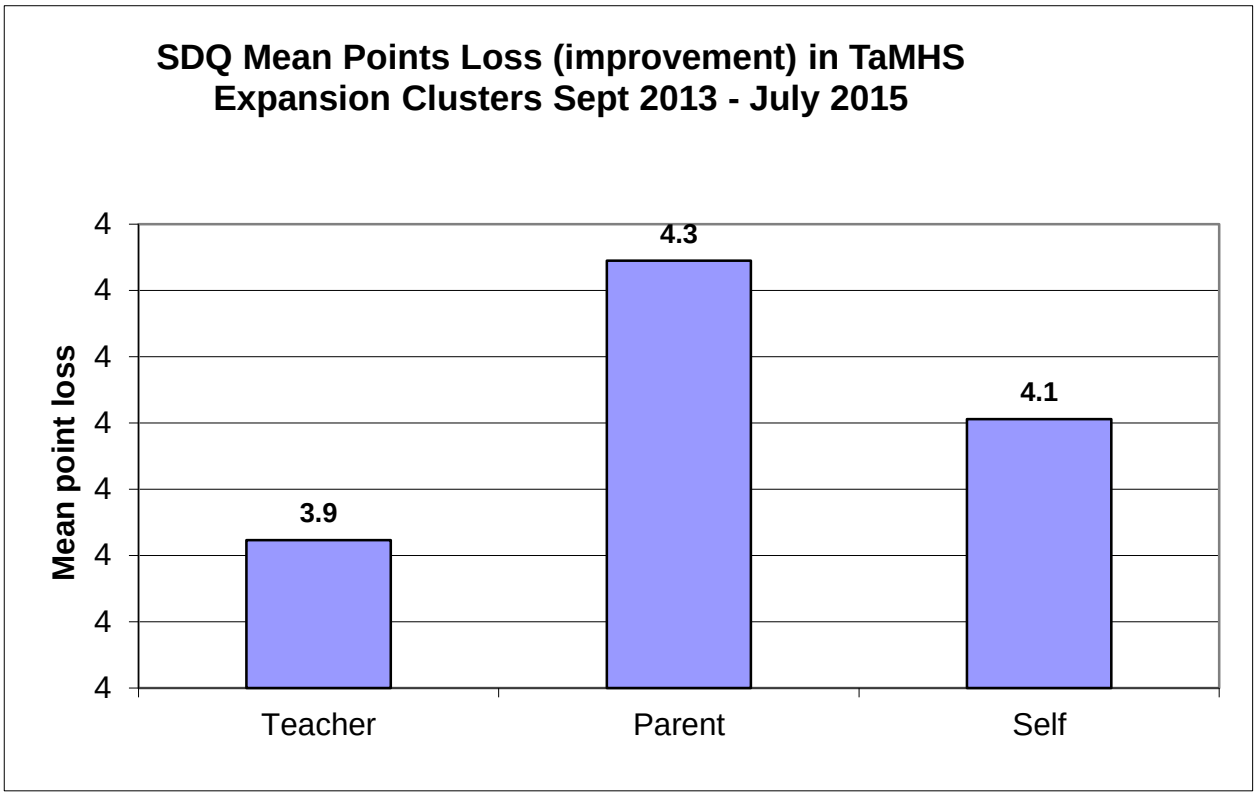
- **CAMHS referrals**:
  - 9 as identified by CAMHS service. 52 as identified by TaMHS practitioners. There is normally a mis match between the two totals. However this is much larger than previous years. Further analysis shows 12 of these were by TaMHS practitioners and all were accepted. The chart below shows a further breakdown.



- **Training & support**
  - 175 school and TaMHS staff trained in 13 training sessions.
    - TaMHS assessments (9), TaMHS staff induction (34) and Targeted Emotional Literacy (132)
  - 110 school support visits to develop in-school capacity. 107 Self review and action plans complete out of 133 schools.

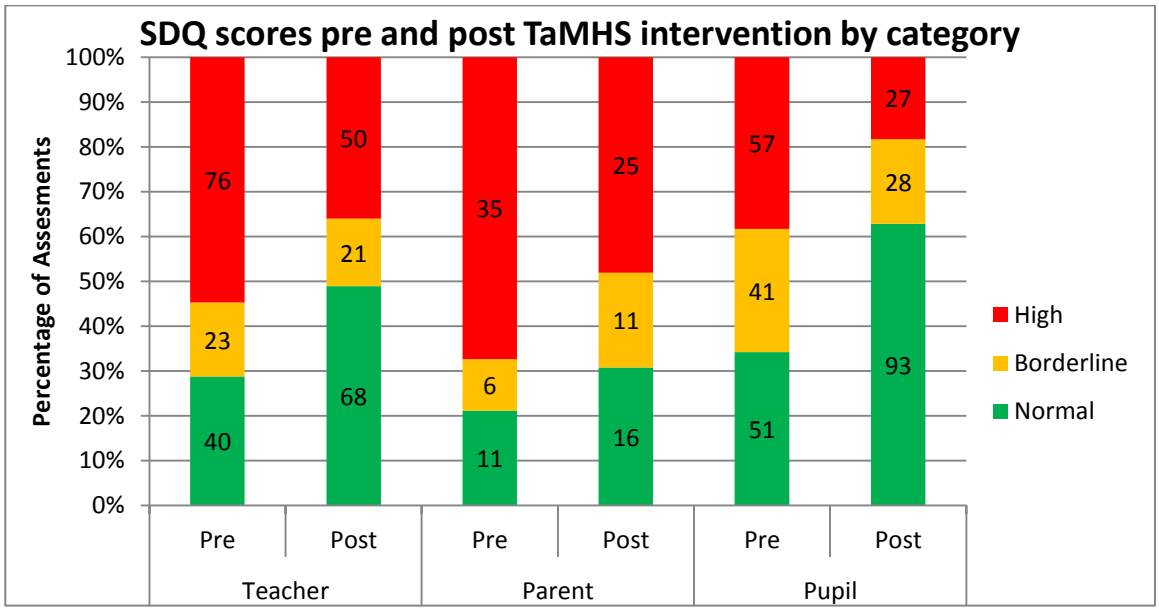
How Well Did We Do It and Is Anyone Better Off? (outcomes)

- **Pupil & Family progress**
  - **SDQ**[2]



This shows good positive change from all 3 perceptions.[3]

- **SDQ Category Analysis**



[2] Strength and Difficulties Questionnaire. Widely used validated mental health assessment www.sdqinfo.com. Point scores are all for average pupil improvement with 3 different perceptions.

[3] Comparison average improvement in last year's evaluation were: Teacher 3.2; Parent 4.3; Self (Pupil over the age of 11) 3.1 points

This shows an almost identical pattern to the previous 2 year evaluation demonstrating level of need and change. The overall trend is improvement in categorized need in all 3 perceptions. More detailed analysis in Appendix 2

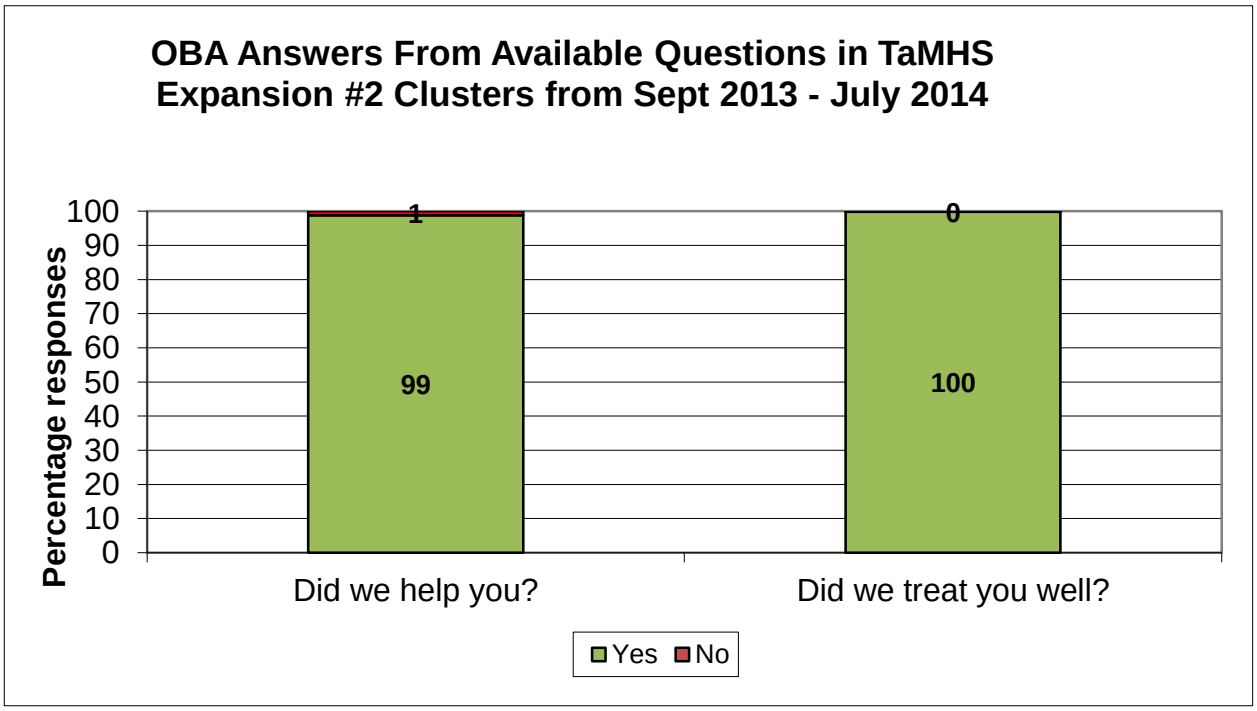
- **Emotional Literacy**

One TaMHS practitioner used Emotional Literacy assessments. The improvement rate was 6.5. This is a very good improvement.
No assessment scores have been returned from schools. This will be followed up this year. Funding is reliant on scores being returned.

- **Goals Based Outcomes** (Family Work)
  - 4 points average improvement on a 10 point scale.[4]

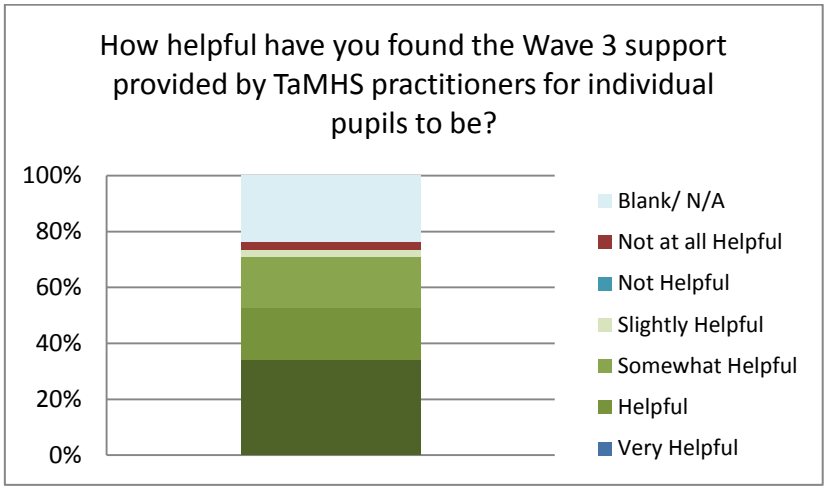
[4] Last year the overall improvement rate was 4.1. this year the current sample size is very small.

- **OBA Questions**



This shows excellent positive user feedback. 99% and 100% respectively answered yes.

Perceptions of TaMHS school leads were asked:



Case Study excerpts (Further case studies from each cluster can be found in Appendix 1)

ACES

Issues: Aggressive behaviour at home and school. His parents had expressed wanting support and were concerned about his behaviour due to young siblings being in the family home. His parents also felt they struggled to manage his behaviour and were often worried about discipline. School stated the young person was not currently reaching the necessary effort level in 3 subjects which could impact on his graduation into year 9. **Actions:** 5 individual sessions and 5 family sessions. 3 goals identified by young person. CBT approach used to help identify thoughts, feelings and behaviours.

Positive coping strategies were then discussed. In family sessions a set of rules and boundaries were developed which helped the young person to experience his emotions in a positive way and to promote the new coping strategies he had developed during the individual sessions. **Outcomes:** According to mum and dad they feel the young persons' aggressive outbursts have decreased within the home and that he now appears happier. They feel he is now able to self-regulate his own emotions much more and has responded well to the consistencies in parenting styles. The young person feels happy that his parents have listened to him and acted on his suggestions; he also feels he is able to calm himself down more effectively with the use of his chosen coping strategies. With regards to school, the young person was able to improve his effort levels in two of his lessons and was able to graduate with the rest of his class.

Alwoodley
Issues: Anxious, nervous Year 3 child who doesn't sleep well (even with prescribed sedatives). She requires constant reassurance from mum and will often phone her several times a day, asking her not to go to work or out in the evening. She would also seek adult attention with supposed injuries/ not feeling well, taking her temperature several times a day. Normally a bright, creative, loving, happy child who enjoys school but the recent increase in anxiety is beginning to affect her health, emotional wellbeing and achievement. Parent SDQ pre 21, Teacher SDQ pre 11 **Actions:** Verbal assessment with parents. Kept a sleep diary, including routines before going to sleep, any trouble getting to sleep, reasons and frequency of waking and any strong feelings which enabled and facilitated some in-depth work looking at the underlying fears and anxieties resulting in sleep problems and how these were influencing school and home life. Helped uncover a sense of separation anxiety with no clear explanation of where this came from. The counsellor agreed to facilitate a meeting in school prior to the transition to Year 4 between parents, Deputy-Head and x's new teacher and was an opportunity for sharing previous concerns with the new teacher and a chance to plan positive strategies for easing transition without X's previous anxieties returning. **Outcomes:** Teacher SDQ post 10 Parent SDQ post 16**.** X's self-assessment and feedback stated that counselling had "helped with my sleep problem and stopped me worrying". School feedback was that X's anxiety and need for adult attention had diminished and she seemed to be more integrated in class with her peers. Mum reported an improvement in x's level of anxiety. Mum had put into practice the recommendation of having a period of one-to-one time each week where x could talk through any concerns or worries. This was having a positive impact on their relationship.

Beeston, Cottingley and Middleton
Issues: A 15 year old boy who had been self harming for the previous 10 months. Had previously attended CAMHS but disengaged. Self SDQ 23, CORE 34 **Actions:** 6 sessions of 1:1 integrative counselling. Issues around underlying anxieties were explored. In particular issues around feeling safe due to an incident with local youths when he was 10 years old. Some work around 'then and there' and 'here and now' was done to bring into his awareness that he was no longer a small boy of 10 and that he was much bigger, stronger and better able to look after himself now. **Outcomes:** He stopped his self-harming behaviour and has had no relapses to date. He started to play rugby. SDQ went from 23 to 18. CORE went from 34 to 15.

EPOS
Issues: A 13 year old boy referred by school for self-harm and low mood. Initial consultation provided with school, the young person and his mother which lead to him

sharing that he had relationship difficulties with his parents triggered by him coming out as being gay. He felt that self-harm was a way of coping with his current stressors having not felt able to talk openly within his family. **Actions:** Parents declined to engage in mediation with the Beck however the young person attended individual sessions within school with CAMHS in Schools Practitioner. A risk assessment and management plan (MyPlan) was completed in collaboration with the young person regards to thoughts that life was not worth living and self-harm by cutting. Psychometric scales were used to provide an objective measure and aid professional judgment when assessing mental health problems. A Cognitive-behavioral approach to stress and low mood was taken and coping strategy enhancement work completed **Outcomes:** Goal Based Outcomes – score increased from 5/10 to 7/10 for achieving goal set at the start of treatment. No current self-harming behaviour. No current thoughts of wanting to end life. Evaluations not returned by parents and young person. Arranged for the young person to meet with the school nurse for advice on healthy eating and losing weight.

ESNW

Issues: 14 year old female pupil with reported low mood. Presented as depressed and tearful in first session. High stress levels and feeling 'out of control' in most areas of her life. **Actions:** Individual and family counselling sessions. Identified that a neighbourhood incident 4 months previously had triggered memories of an earlier attack on her father that she had witnessed. Addressed the need for her to learn how to relax and reduce her stress levels. Identified some future goals such as joining a drama group and travelling to Australia. **Outcomes:** By the end of therapy the client was able to talk about the attacks without feeling tearful – she also said that she knew she was 'over it' because she was able to laugh more with her friends and days went by without thinking of the attacks. Her Head of Year confirmed that at school the client presented as 'more confident now'.

Farnley

Issues: father's recent diagnosis of terminal cancer. Fall-outs with friends and one or two behaviour incidents in class which were 'out of character'. School attendance was falling and she was struggling with motivation. Low self-esteem and a poor body image **Actions:** counselling: identified some of the issues she was struggling with – primarily jealousy, loss and rejection. Therapeutic support helped her to develop insights into her own behaviour which ultimately allowed her to change. **Outcomes:** Pre SDQ score 17, post SDQ score 4 "I feel I have changed as a person. I'm now really happy and have a much more positive attitude".

INW Hub

Issues: Pupil presenting in school with low mood and had told her Head of Year that she was feeling depressed. Previous history of two attempted overdoses. Had been offered services in the past without engaging, so CAMHS in Schools was seen as a last resort to try and engage her in some support around her mental health and self-harm. **Actions:** 1:1 assessment. CAF and referral to social services due to ongoing issues within the family and home environment. 1:1 sessions in school to support mental health needs. **Outcomes:** Pupil reported feeling much better in terms of her mental health as a result of support given and CAF being in place.

Morley, Ardsley and Tingley

Issues: Parents concerned about his anxiety levels, and anger at home. This had not been seen at school. **Actions:** 1:1 Therapeutic work for 10 sessions, weekly. We helped him to develop an awareness of his needs, by being respectful and listening to his thoughts and feelings without any correction or control. He gained confidence

over the weeks in trusting the therapeutic relationship, which in turn helped him to begin to trust in making his own choices. **Outcomes:** The parents had noticed a difference in his behaviour at home, and it was agreed that some further work would be carried out with the young person and his parents. This is to help ri-enforce the therapeutic work, and to help with the communication and understanding within the family set of beliefs and structure**.**

Otley
Issues: difficulty appropriately managing and expressing his emotions in the client's frequent emotional outbursts, somatic expression of emotion through physical symptoms, difficulty managing his relationships with peers, as well as a fearfulness, and a lack of confidence in trying out new activities. SDQ (teacher): 23 SDQ (child): 18 **Actions:** Assessment plus 7 sessions Counselling sessions to express, explore and process his feelings and emotions. **Outcomes:** confidence in expressing his thoughts and feelings and in making decisions for himself. Appears a happier, more confident, and emotionally able child. SENCo at the School has stated that: "the client's temper tantrums have reduced in frequency, intensity and duration since referral, although they still occur. While he still complains that he has been hurt or has pain or illness, this occurs less often than before. The client frequently appears to feel unhappy and worried but he seems generally more at ease and confident since referral. He continues to need significant support and encouragement to try new activities especially if he perceives then to be difficult, to see tasks through to the end, and to maintain attention. He often finds it hard to avoid joining in disputes with other children which often brings him into conflict with his peers." The student will be transitioning to xxx in the September academic term, and I would recommend that the transition be carefully managed with additional support put in place so that the changes and new challenges do not destabilize this student. It is my intention to meet with this student in his first few weeks at xxx to support his transition. SDQ (teacher): 17 SDQ (child): 2

Rothwell
Issues: A year 10 boy was referred for counselling because his behaviour had changed in school and he felt that this was due to his twin brother dying at birth which he had never talked about. Teacher SDQ pre 15, Self SDQ pre 7 **Actions:** I met with him for an assessment and we identified feelings grief which he had previously not understood. I offered him a safe, confidential space where he could explore his feelings and work out how to manage them differently so that he could effectively attend lessons and learn how to express his feelings in other ways. **Outcomes:** As a result of our work together he said that he felt 'back on track', *Learning mentor reported that student no longer using pass out card* and school had not seen him in the behaviour unit for many weeks. Did we help? Yes. Did we treat you well? Yes Teacher SDQ post 6, Self SDQ post 2

Seacroft Manston
Issues: Female, Year 11 pupil who was suffering bouts of anxiety where she was unable to come to school or take part in activities out of school. Had some previous CBT therapy at CAMHS but was referred by Head of Year for further intervention by TaMHS **Actions:** 1:1 sessions focusing on a childhood accident after which she spent some time in a wheelchair. Used 'story telling' approach to create an autobiographical story of her life. Planned strategies for future events such as college interviews. **Outcomes:** C was able to attend school until the end of Year 11. She sat her GCSEs, attended a college interview and was offered a place for September. The pupil reported that she felt much more able to deal with any stresses that came up. She

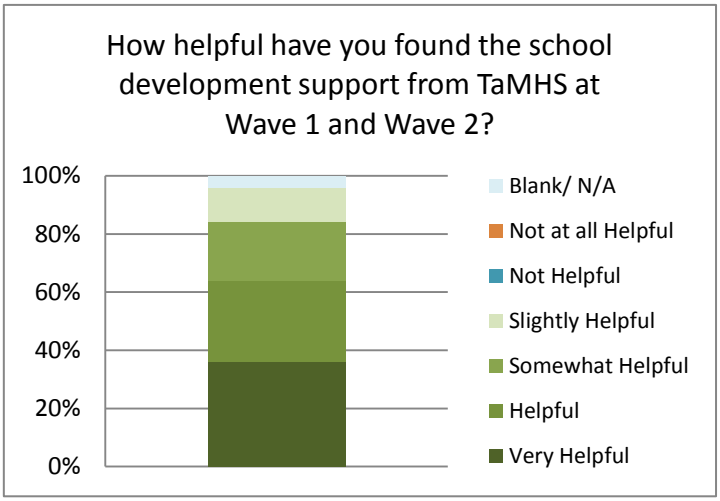
said she felt she had made sense of that part of her life and was more able to talk and think about the accident and to see that she had many other aspects to her other than it.

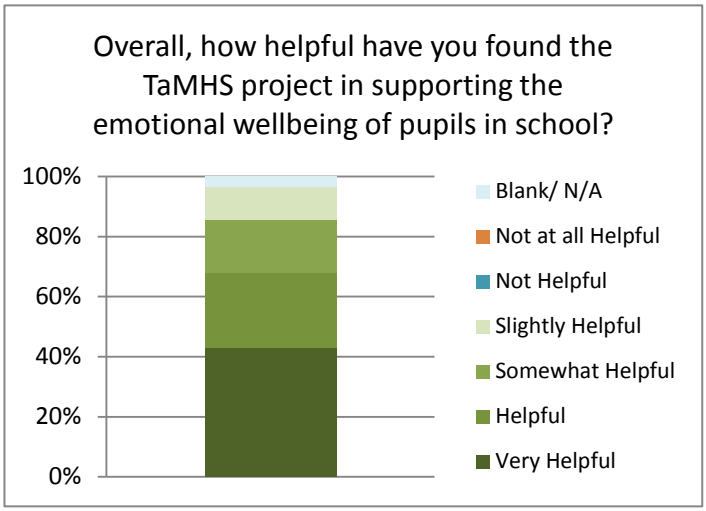
CAMHS referrals

- 100 % accepted

School Development

User Consultation An online survey was sent to all the TaMHS schools contacts. 2 questions and answers are below:





Feedback is overall positive. Some schools will have had little contact in year 1 while self reviews and action plans were completed. Year 2 should see more support from cluster meetings, training and bespoke support.

Training feedback: average ratings of OBA Questions

- Did we help? Very Good (Average score of 5.2/6)
- Did we treat you well? Excellent (Average score of 5.4/6)

TaMHS Indicators Impact

The indicators from the CYPP for the TaMHS Project are:

- Numbers of Children Looked After (CLA)
- Numbers of Child Protection Plans (CPP)
- Attendance

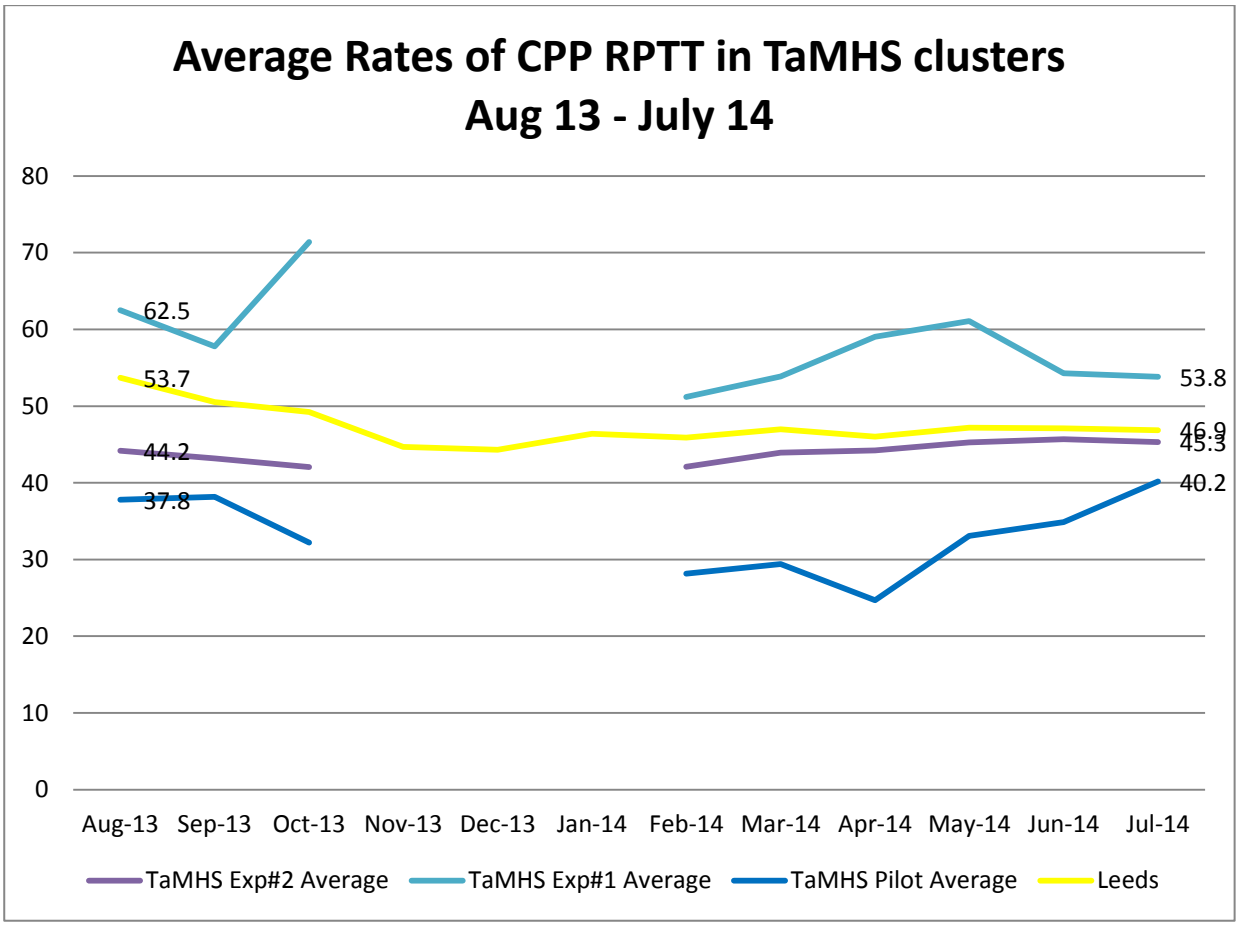
Cautions

- As TaMHS is now a city wide service there is no non TaMHS clusters for comparison as previously and the Leeds average will be influenced by previous and existing TaMHS cluster impact.
- TaMHS works indirectly on these indicators alongside other targeted, cluster based support, hence the mental health focus of the performance measures. As TaMHS is early intervention few pupils who are on a CPP or who are Looked After are directly supported. It is the prevention of early mental health issues escalating into more enduring issues that TaMHS focuses on.
- TaMHS is a targeted project. Attendance is a universal measure. Hence attendance data pre and post TaMHS support is also included for a more direct measure of impact.

CPP & CLA Indicators

Rates per Ten Thousand (RPTT) children have been used for comparison.

CPP



TaMHS Expansion #2 clusters: outperforms but worsens with the Leeds average from -9.5 to -1.6 RPTT

TaMHS Expansion #1 clusters: gap narrowed with the Leeds average from 8.8 to 6.9 RPTT
TaMHS pilot clusters: outperforms but worsens with the Leeds average from -15.9 to -6.7 RPTT

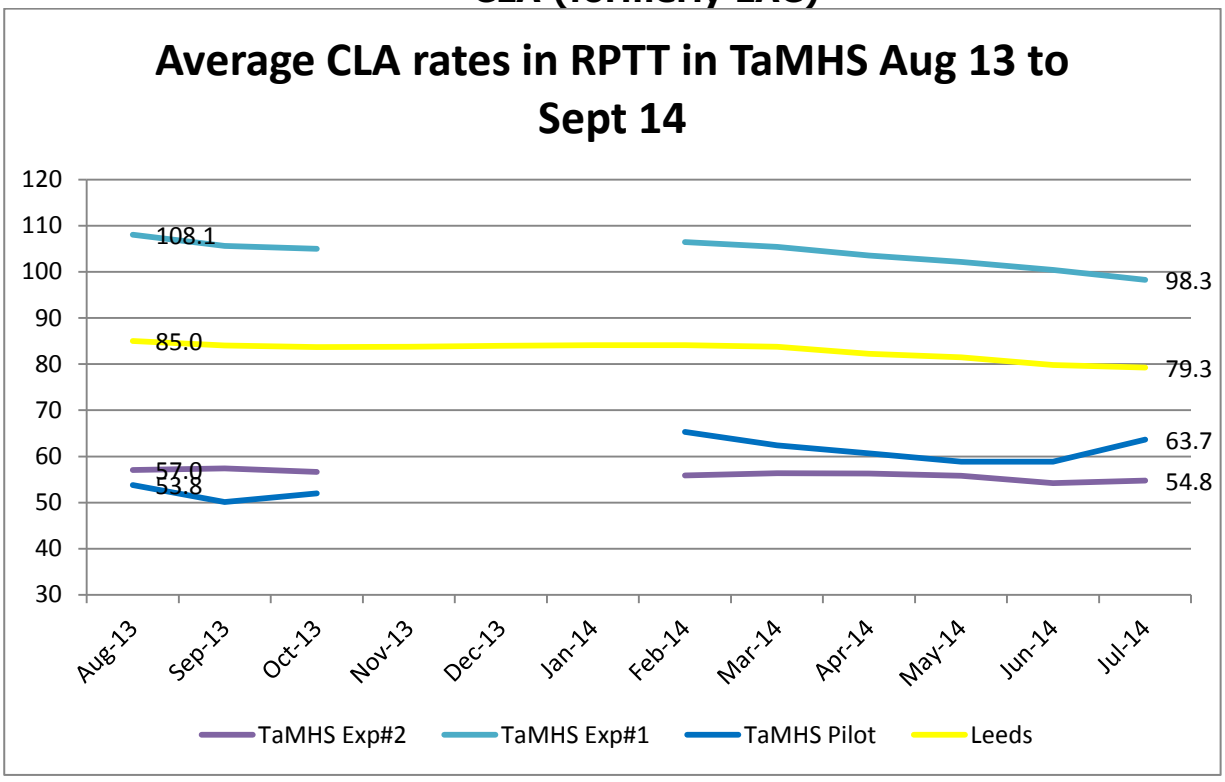
The gaps in the above chart are due to gaps in reporting during the switch over to frameworki.

TaMHS expansion #2 clusters decrease by just over 1 RPTT while TaMHS expansion #1 decrease by almost 10 RPTT. TaMHS pilot increase by just over 2 RPTT.

In previous evaluations rates of CPP have come down. This set of supported clusters the rates have gone up slightly while the Leeds average has come down.
The information is difficult to analyse as:

1. There is no comparison as no clusters do not have TaMHS (Garforth data is incomplete)
2. The pilot clusters rates have gone up
3. Expansion #1 clusters rates have gone down which will be the reason for the Leeds average decrease.

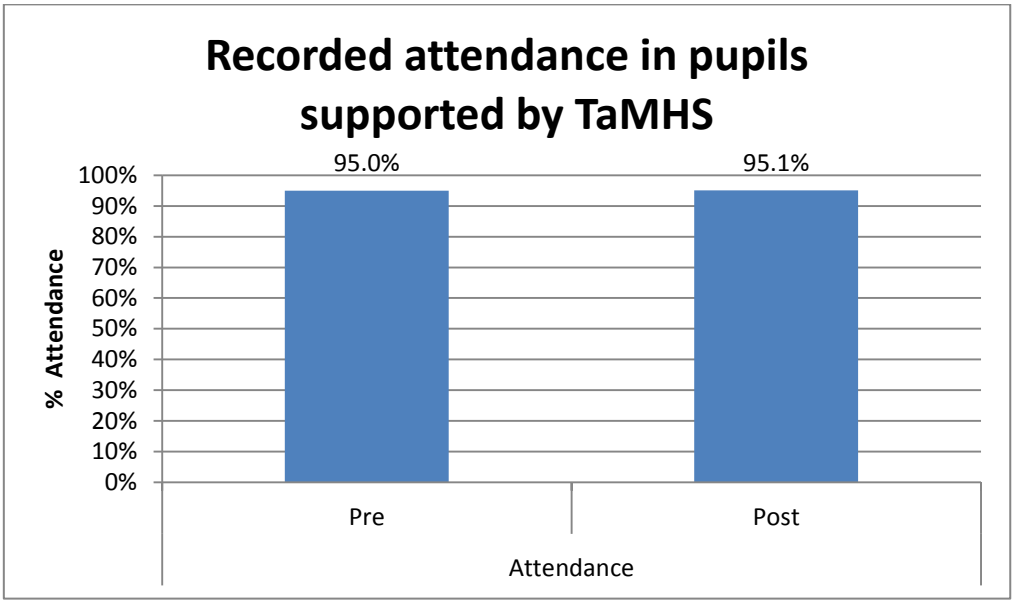
CLA (formerly LAC)



TaMHS Expansion #2 clusters: outperforms but worsens with the Leeds average from -28 to -24.5 RPTT
TaMHS Expansion #1 clusters: gap narrowed with the Leeds average from 23.1 to 19 RPTT
TaMHS pilot clusters: outperforms but worsens with the Leeds average from -31.2 to -15.6 RPTT

TaMHS expansion #2 clusters decrease by just over 2 RPTT while TaMHS expansion #1 decrease by almost 10 RPTT. TaMHS pilot increase by almost 10 RPTT
This is a similar trend to CPP data. No impact on LAC in one year or less is expected for TaMHS.

Attendance:
Attendance data is only available up to HT1-2 13/14 i.e. end of December 2013 so no comparisons can be made.



Pre attendance is at a higher level than in the last set of supported pupils. The increase is negligible at 0.1%. The attendance reporting from clusters was very variable with 4 clusters with no attendance data and others with just once case with pre and post data. The Leeds average increase is 1% and 1.1% for Primary and Secondary respectively.

Primary attendance[4]	**Primary attendance**[4]	**Change**	**Secondary attendance**[4]	**Secondary attendance**[4]	**Change**
HT1-4 12/13	HT1-2 13/14		HT1-4 12/13	HT1-2 13/14	
95.3%	**96.3%**	**1%**	**93.7%**	**94.8%**	**1.1%**

Appendix 1

Case Study excerpts

Alwoodley

It's nearly stopped me from self-harming and given me more confidence. Self SDQ pre 25, post 19

EPOS

Needs: 15 year old girl referred by her GP for anxiety symptoms leading to missed exam and home issues. Struggling also with low self-esteem and confidence which is impacting on feelings of loneliness and low mood. - Mood & Feelings Questionnaire, total score 14 (a score of 8 or more may indicate possible depression in young people): **Actions:** solution focused approach with initial consultation with the young person, mother and school; A CAMHS Consultation Clinic (3 sessions) was offered to the young person and her parents within school. resources around self-help and relaxation to better manager physical symptoms. **Outcomes:** no physical symptoms of anxiety over the past two weeks. Person and mother reported improvements in confidence and functioning and declined any further individual work. 3. SDQ scores showed significant reduction over a 2 month period in the following areas: Overall stress: 17 to 4 (mother) and 19 to 7 (young person); Emotional distress: 9 to 2 (mother) and 9 to 3 (young person); Hyperactivity and concentration: 7 to 2 (young person); Impact on the person's life: 6 to 0 (mother)

Farnley

It was helpful to talk to someone who isn't my mum. Self SDQ pre 20, post 15

I was able to say stuff that I couldn't say to anyone else. Self SDQ pre 12, post 7. Attendance pre 96% post 97%

It's been helpful. I have not been in isolation for 6 weeks. I used to have 9 comments each week, now I only have 2. Self SDQ pre 10, post 9. Attendance pre 87% post 91%

According to mum, he is happier and takes jokes better. Teacher SDQ pre 14, post 11.

INW Hub

Needs: P was on the verge of permanent exclusion and school were at a loss as to how to support P. There was heavy involvement from Family Intervention Service and a chaotic home situation for P. Two siblings who had been in prison and younger siblings with behavioural difficulties. Mum also had mental health difficulties and appeared to be inconsistent in her implementation of boundaries. School felt that P needed some therapeutic work with to help her to control her angry outbursts; however, home life was so chaotic that it wasn't clear whether therapeutic work was appropriate or indeed would have any impact. **Actions:** Liaised with Family Intervention Service: P had been referred to Specialist CAMHS via her GP. no sign of the referral so I contacted the GP and asked that this referral could be re-sent. I forwarded a summary of the information I had collected from different professionals to CAMHS to back this referral up. The referral was accepted. I suggested to school that they create a bespoke plan for P and share this with home. A plan to help contain and manage P in and out of school. **Outcomes:** P is now getting 1-1 support from a worker at Family Intervention Service. I have facilitated a quicker referral to CAMHS and supported this referral with information I have gained through consultation with different professionals. I suggested to Family Intervention Service that they ask a worker to begin to meet with P on her own to find out her wishes, views and feelings

on her situation and offer that 1-1 emotional support. Ongoing support to school for containing and managing P in school as well as interim support before specialist CAMHS support is taken up.

Otley
Feedback from Headteacher: This student sought me out in School to thank me for finding him Bo to talk to. The student stated that he felt happier after talking each week with Bo. The classroom teacher reported that the student was happier and calmer after his sessions with me.

This student is much improved in attitude since his time with you. He no longer sulks, and seems more able to take problems in his stride. He is a natural performer, so he still tends to 'entertain' when he feels he has an audience, but this is impacting less upon his work than it did. Thank you for your support for x - it has really made a difference.

Thank you so much for the time you have spent with this student recently. She remains a delightful young lady with a very old head on her shoulders. Since being in Year 3 and even more recently she is making progress. At the start of the year she had no confidence in her ability and relied heavily on the input and support of an adult. This has changed over the past months as she seems a little more resilient to making mistakes and much more willing to 'have a go' herself first and to ask for help later.

Feedback from Headteacher: This student's behaviour is much improved, and we are very impressed with his efforts to behave appropriately in School. Feedback from classroom teacher: this student's temper tantrums have reduced in frequency, intensity and duration since referral. He generally seems more at ease and confident since referral.

Rothwell
MST starting work with the family once therapy ended Self SDQ pre 19, post 10 Teacher SDQ Pre 10 post 13 Attendance pre 92% post 92% Did we help? Yes. Did we treat you well? Yes

Mum reported that child has started to want friends over and to go to friend's houses again. Staff member reported that pupil seems happier in school. Pupil reported that the sessions had helped her. Did we help? Yes. Did we treat you well? Yes Teacher SDQ pre 16, post 11

Seacroft Manston
Needs: Witnessed parent death. **Actions:** 13 sessions of 1:1 Person-Centred Art Therapy **Outcomes:** end-of-year school report was very positive, his relationship with his Dad had greatly improved, able to express his own feelings around the loss of his mother.

Needs: Changes in behaviour had been noticed both at home and school. Pre SDQ: self and parent 'Abnormal' category, teacher 'Borderline' **Actions:** face to face assessment with both mum and the child's teacher where goals were set: Time and space for X to express his inner world, Opportunity for X to explore and develop an understanding of the complex relationships of the adults in his life, For X to develop a positive self-image, To reduce X's need to respond to others with aggressive outbursts. In the sessions 'X' was able to express and process his grief of a family bereavement that he felt was at the core of his changes. As a result of this expression, he was able to gain an understanding and move on. Through a new sense

of self, he was also able to learn other ways to express his emotions without it resulting in a fight. **Outcomes:** School reported a dramatic decrease in the number of incidents. All post SDQ scores: 'Normal' category. Teacher Pre SDQ -11 Post SDQ - 6; Parent Pre SDQ - 17 Post SDQ – 9; Child Pre SDQ - 17 Post SDQ Child- 10

I have gained confidence and it helped in making decisions Self SDQ pre 10, post 4 Teacher SDQ pre 14, post 10 Did we help? Yes. Did we treat you well? Yes Attendance pre 97% post 99%

Feeling more confident and less anxious Did we help? Yes. Did we treat you well? Yes Attendance pre 94% post 96% Self SDQ pre 19, post 10Teacher SDQ pre 6, post 2

Appendix 2
TaMHS Expansion #1 SDQ Category Analysis

Completed to help demonstrate the range of need coming into TaMHS and the outcomes we can expect in terms of reducing high and borderline categories of need according to SDQ assessments. Overall it shows that:

1. *The majority of Teacher and Parent pre assessments were in the High category (one indicator of 'clinical' level of need and CAMHS referral)*
2. *Most pre scores from all perceptions were in the High category. 'Normal' scores still feature in TaMHS referrals. This and High scores demonstrate that assessment scores alone cannot identify relevant referrals. The multi professional discussion is essential.*
3. *The High category was reduced and the normal category increased from all perceptions in post support scores.*
4. *A high majority of pupils attending TaMHS support showed an improvement.*
5. *Of Teacher High pre scores just under half improved a category or more. Of borderline scores over half improved to normal, a small number worsened.*
6. *Of Parent High pre scores over 1/3 improved a category or more. Of borderline scores half improved to normal*
7. *Of Self High pre scores, over half improved a category or more. Of borderline scores over 2/3 improved to normal, a small number worsened.*

Teacher scores

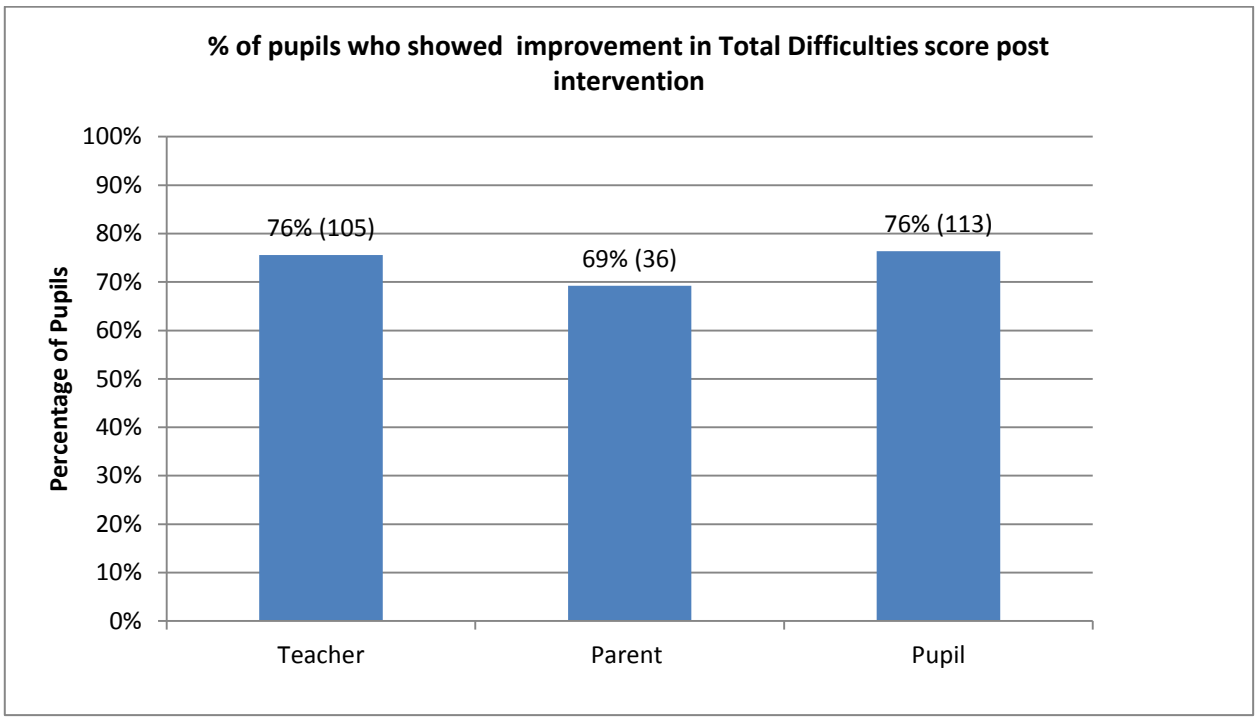
55% were in the **high** category pre intervention	**17%** were in the **borderline** category pre intervention	**29 %** were in the **normal** category pre intervention
Post intervention:	**Post intervention:**	**Post intervention:**
13% moved to **normal** **8%** moved to **borderline** **34%** stayed **high**	**11%** moved to **normal** **4%** stayed **borderline** **2%** moved to **high**	**25 %** stayed **normal** **4 %** moved to **borderline** **0 %** moved to **high**

Parent scores

67 % were in the **high** category pre intervention	**12 %** were in the **borderline** category pre intervention	**21 %** were in the **normal** category pre intervention
Post intervention:	**Post intervention:**	**Post intervention:**
10% moved to **normal** **13%** moved to **borderline** **44%** stayed **high**	**6%** moved to **normal** **2%** stayed **borderline** **4%** moved to **high**	**15%** stayed **normal** **6%** moved to **borderline** **0%** moved to **high**

Pupil Scores (Age 11+ only)

39 % were in the **high** category pre intervention	**28 %** were in the **borderline** category pre intervention	**34 %** were in the **normal** category pre intervention
Post intervention: **12%** moved to **normal** **10%** moved to **borderline** **16%** stayed **high**	**Post intervention:** **19%** moved to **normal** **7%** stayed **borderline** **1%** moved to **high**	**Post intervention:** **32%** stayed **normal** **2%** moved to **borderline** **1%** moved to **high**



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Integrated Commissioning Executive	
Meeting – 2nd December 2014	

Title of Report:	Whole system review of C&YP emotional and mental health services in Leeds.
Author(s):	Dr Jane Mischenko, Paul Bollom
Date finalised:	24:11:2014
ICE Lead:	Matt Ward/ Sue Rumbold
For further information contact	Jane Mischenko on Jane.Mischenko@nhs.net 0113 8431634
The purpose of this paper is to…	Highlight report for ICE on the progress of the whole system review of C&YP emotional and mental health services in Leeds.
It is recommended that the Integrated Commissioning Executive…	Note the contents of the report (including attached for reference the Scrutiny Board paper that sets out the current provision, strengths and risks in the city and the review project plan). Note progress to date. Note interim recommendations of the review: 1. Support waiting list initiative (CAMHS) 2. Support CCGs to co-commission TaMHS with clusters to increase capacity, and strengthen whole system approach 3. Support continuation of TaMHS management support (LA contribution)
Risks: (to Clinical Commissioning Groups, Local Authority and NHS England)	**Financial** The need in the city is more than is commissioned and provided for (nationally and locally recognised). Challenging financial pressures in Local Authority poses risk to services that contribute to emotional and mental health wellbeing (i.e., targeted youth work). Risk to sustainability of whole TaMHS cluster offer, given competing demands on school funding; however, to date all have continued to invest due to positive outcomes and impact on school attendance and achievement. Co-commissioning proposal above will mitigate risk of fragmentation.

1.0 Summary

In September, ICE endorsed the need for a whole system review of C&YP emotional and mental health services in Leeds. This report sets our progress to date, interim recommendations and next steps.

1.1 Progress to date:

- Project management and business intelligence personnel recruited
- Project plan complete
- Joint Steering group established and has met twice to date
- Initial stakeholder engagement undertaken with key providers
- Plans to engage young people, carers and parents completed
- Analysis of data sources undertaken
- Analysis of present activity, capacity and demand commenced
- Identification of current spend in the city undertaken (see Appendix A)
- Applications underway to bring resource into the city (DFE grant and co-commissioning pilots)
- Work underway for partners to support TaMHS SILC pilot

1.2 Interim recommendations:

From the work two issues have been identified which require immediate attention:

- Address waiting times in CAMHS
- Build sustainability of the Early Intervention (TaMHS) cluster model and ensure whole system of services work together through a co-commissioning arrangement with educational clusters. If based on the proviso clusters retain their existing investment, this will increase capacity in the city, and encourage engagement with the whole system model (pathways, data flows and quality measures). This includes the commitment of the LA to continuing to fund the central TaMHS management team.

1.3 Next Steps:

By the end of December the following reports will be produced:

- A refresh of the emotional and mental Health Needs Assessment
- Modelling of the current patient flows through the various emotional and mental health services in Leeds (identifying gaps, barriers and blockages)
- Assessment of current services offered against the evidence base (policy and NICE)
- Benchmarking value and outcomes against available comparators
- Modelling tools for predicting how changes of services may affect demand and capacity will have been considered

- Synthesis of key messages from CYP, parents and carers consultations

And the first workshop will have been held with clinicians and providers of CYP emotional and mental health services in Leeds. Key proposals for testing out and developing are:

- One point of access for GP referrals into whole system
- More effective modelling of specialist CAMHS i.e., alignment with Educational clusters

2.0 Main Issues

2.1 Funding

The picture of funding and delivery for emotional wellbeing services across Leeds is complex (see attached appendix 1 and for further detail see Scrutiny Board paper).

Central Local Authority budgets have historically made a significant contribution to emotional health and wellbeing services in the city. This has been through a combination of joint investments in core NHS delivered CAMHS services and third sector provision. The local authority also resources direct delivery of services supporting emotional health (e.g. MST, Therapeutic Social Work). Continuing reductions in the local authority element of public expenditure will shortly bring forward proposals in children's services of up to £29m of reductions for 2015/16 against a 2014/15 budget of £128m (net expenditure). Likely further reductions will follow in 2016/17 and 2017/18. The budget decision of the council in February for 2015/16 cannot but include profound implications for the shape of early intervention and targeted services for young people and younger children. The impacts on the emotional health and wellbeing work programme are likely to be threefold:-

i. There will be a strong appetite for rapid redesign and remodelling in partnership with school and health colleagues which acknowledges changing funding flows

ii. Changes to wider local authority funded provision may reduce capacity for promotion of emotional wellbeing, for instance in youth or careers services

iii. There may be potential for increase/spike demand as services are remodelled and alternative support is sought for individual young people

Alongside the above changes the increased budgetary delegation to schools seen in the previous 10 years is likely to continue. Although there is a diversity of constitution for schools (e.g. academies, trusts, maintained) and regular changes for national funding policy for schools the consistent direction of travel provides for local decision making at school level. The advent of pupil premium, a substantial grant available to

schools on a per head deprivation basis, provides additional impetus to this. The estimated pupil premium for both phases of education in Leeds is estimated at £32m for 2015. Broad choices in this context are to support and use mechanisms which aggregate commissioning across schools (such as clusters, and at a city scale potentially schools forum). For provider services (LA, NHS and third sector) the implication is an approach (such as trading) which allows/promotes 'bottom up' funding for an increasing proportion of services.

The work of the review is in parallel to conversations between LSECCG and LCH re CAMHS and how to achieve efficiencies whilst delivering to the service specification and engaging fully in the whole system review and redesign.

2.2 Analysis of patient flows (Waiting Times)

Initial analysis has shown a growing area of concern in relation to waiting times for CAMHS services (see appendix 2); these are unacceptably long and show significant variance in different areas of the city. These waits include access to consultation clinics and more specialist clinics (i.e., autism, ADHD and CBT level 3). LCH performance is good for those CYP requiring urgent assessment and intervention.

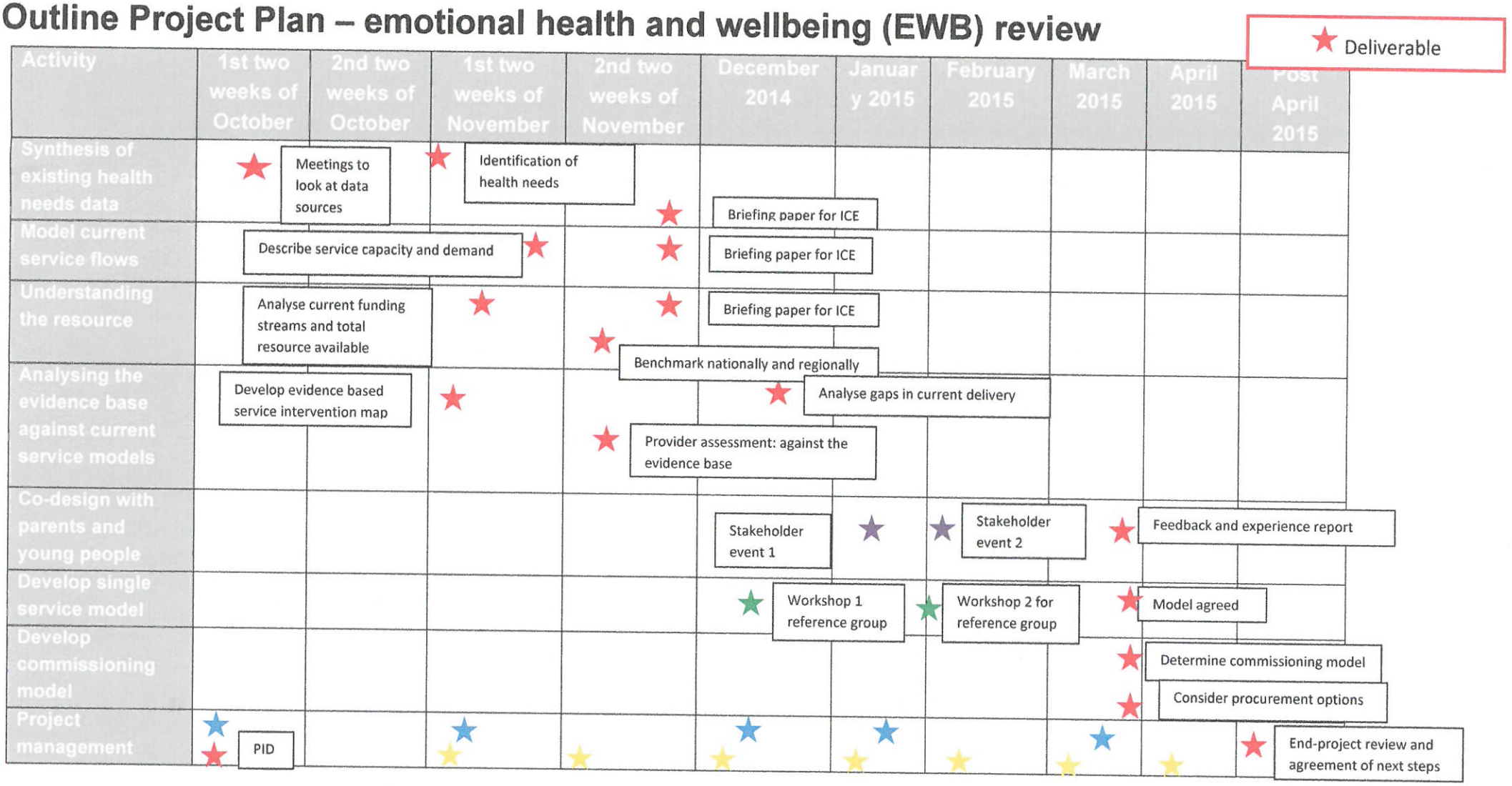
LSECCG are working closely with LCH to ensure a waiting list initiative addresses these concerns.

3.0 Recommendations

Note progress of the review to date, project plan and next steps:

- Support waiting list initiative in CAMHS
- Support recommendation for CCG co-commissioning relationship with Education clusters (for TaMHS) and for LA to continue to provide TaMHS management as contribution to whole system.
- Expect end of review report in March 2015

Outline Project Plan – emotional health and wellbeing (EWB) review



★ = commissioning steering group meeting (dates 6th November 9.00 – 10.30, 11th December, 2.00-3.30, 20th January 2015, 9.00-10.30, 5th March, 9.00 – 10.30)

★ = workshops with young people and parents to co-design service models

★ = workshops with providers to test out service delivery options

★ = identification of gaps, and risks (clinical, political, financial).

Terms of reference for Joint Commissioning Steering group for Children and Young People's Emotional and Mental Health Services in Leeds

1. Background

The current multiple commissioning of the services for children and young people's emotional and mental health does not maximise the value of every Leeds pound spent. Whilst there are examples of innovation and excellent teams in the city, there is too much variability and the whole system does not function well together. This therefore introduces inefficiencies, poor experience for children and families as they try to navigate the system and frustration for professionals (those referring into and delivering within the system). This is evidenced by the noise in the local system (from LMC, complaints, Councillors, MPs, GPs, teachers and more recently Scrutiny).

The Integrated Commissioning Executive (ICE) has approved the proposal to redesign and potentially re-commission emotional and mental health services in Leeds (CCG, LA and School cluster commissioning responsibilities). The scope includes increasing the capacity and capability of universal services and settings, to respond and to develop an effective coordinated system to facilitate joined up pathways from universal through to targeted and specialist services, as required.

A key action is to establish a dedicated Joint Commissioning Steering group to oversee the delivery of the programme.

2. Principles

The principles for this piece of work are:

- Co-design with parents and young people
- To encourage the development of a city-wide public health programme to support emotional intelligence and resilience
- To maximise the digital opportunities to enhance self-care, improve access and facilitate flexible service provision
- Further strengthen early intervention (TaMHS); work to ensure a consistent standard of offer and the sustainability of this provision (explore co-commissioning)
- Create one point of access for referrers of children's mental health services
- Develop, integrate and strengthen the local cluster service delivery model (after all this is where the young people are), by redesigning the use of the current specialist CAMHS and Therapeutic Social Work service (training, supervision, swift access to advice, joint working)
- In addition to the local offer, ensure a strong city centre provision (for young people)
- Use the available evidence and champion innovation with robust evaluation
- Ensure best value for every Leeds pound spent
- Align and protect resource; identify commissioning and contracting opportunities to effectively deliver the coordinated system

3. Scope

To redesign and explore commissioning options to deliver a coordinated system of emotional and mental health services for children and young people in Leeds (to include universal, targeted and specialist services).

This includes services directly commissioned and provided by the Leeds CCGs and LA (identified below)

- CAMHS, 3rd Sector (e.g., Market Place) and Therapeutic Social Work Service

And influencing the wider service offer (identified below)

- Co-commissioning between CCGs/LA and Clusters
- Co-commissioning between CCGs and NHSE (tier 4)

4. Work programme

The work that will be overseen by the group falls into three categories and is supported by a PMO function.

4.1 What do we know?

Analyse and synthesise the significant resource of information already held:

- Refresh the HNA;
- Review performance data;
- Review and interrogate national and regional benchmarking reports;
- Review service user feedback,

And

- Model current service user flows; identify gaps, risks and pressure points
- Assess delivery against known evidence (specific interventions and evidence of early intervention)
- Understand the resource: Establish current expenditure, and planned CIPs
- Sense check above reports with clinical/provider reference group

4.2 Redesign informed by stage 1 to deliver a coordinated system

- Co-design with parents and young people
- Co-design with clinicians/ providers
- Identify and flag gaps, and risks (clinical, political, financial)
- Identify where redesign maximises value of current investment and where any additional resource would add most benefit (impact, sustainability and improved outcomes)

4.3 Develop commissioning models

- Determine commissioning models; review opportunities of aligned/pooled resource; explore partnership contracting models and the available levers and incentives to ensure delivery of the redesigned service model
- Agree performance data required to measure impact
- Consider procurement options/approaches

5. Timescales

The timescales for achieving each of the three programmes is shown below. A more detailed delivery timetable is attached as a project plan.

Objective	**Timescale**	**Deliverables**
Quick analysis	October – December 2014	Report on activity, costs capacity and demand for providers
Stakeholder analysis	November – January 2015	Analysis of the needs of providers, young people and parents and carers
Redesign	January – March 2015	Co-production of new system with young people and parents and carers
Agree Commissioning models	February - March 2015	Options appraisal of commissioning models available to the system.
Final recommendations and sign off	March 2015	Service specifications developed to describe the new system.

The first reporting milestone is 2nd December 2014 when an initial report will go to ICE; this will set out the project deliverables and timescales; and will flag some immediate recommendations for action.

6. Meetings

Members are asked to represent the views of their organization and communicate back into the organization/ stakeholder group. Members will check the work of the PMO, support the programme and will help shape the recommendations to go to ICE.

The recommendations will be taken to ICE in the first instance.

The PMO consists of a project manager, business intelligence personnel and, communications and engagement colleagues. The role of the joint commissioning steering group is to oversee the work of this team and ensure the deliverables are fit

for purpose and ensure the delivery of the programme. Whilst timescales and the scope of the project is set by ICE, the detail of the work will be agreed at the steering group.

Meetings will be held every 4 - 6 weeks and will be minuted within two weeks.

7. Governance

The joint commissioning steering group will report to the Integrated Commissioning Executive and also provide updates to the Children's and Families Trust Board via the Commissioning Lead for Children and Maternity Services and Chief Officer of Partnerships. Members of the group will feedback and seek views of stakeholders within their own organisation on any recommendation made by the group.

8. Membership

The group is made up of:

Jane Mischenko	Leeds South and East CCG on behalf of all CCGs
Sue Rumbold	Children's Services, LCC
Matt Ward	Leeds South and East CCG
Helen Haywood	Leeds South and East CCG
Joseph Krasinski	TaMHS
Lisa Oxley	Cluster Lead
Liane Langdon	Leeds North CCG
Sarah Lovell	Leeds South and East CCG
Adele Dempseter	Cluster Lead
Paul Bollom	Children's Services, LCC
Sue Robins	Leeds West CCG
Catherine Ward	Public Health
Elaine McShane	Leeds City Council
Jane Williams	Leeds North CCG
Yen Anderson	Leeds North CCG
Ruth Gordon	Project Manager

It is hoped that members will endeavor to attend all meetings. If they are not able to attend they are welcome to send apologies or a nominated deputy. The deputy should be fully briefed and able to contribute on behalf of the key member of the group.

Ways of Working

- The project will put the young person at the heart of all the work

- Young people will be actively involved in relevant parts of the work
- Young people and other key stakeholders will be consulted before recommendations are agreed
- There will be a clinical/provider reference group
- Members of the group will work collaboratively, freely sharing information and ideas

October 2014

Children and Young People's Mental Health & Wellbeing Taskforce Newsletter – Issue 1

Foreword

Norman Lamb, Minister of State for Care and Support: "There is an urgent need to take radical actions to reduce stigma and improve visibility of services so that children and young people can access the highest quality mental health and wellbeing advice and support when they need it. At the centre of this Taskforce will be the views of children, young people, families, and professionals involved in their mental health support. I'm particularly looking forward to hearing these views about what they want CAMHS to be and what we can all do to deliver that vision."

Jon Rouse, Co-Chair of Taskforce, Director General, Social Care, Local Government and Care Partnerships at Department of Health :"This Taskforce is a real opportunity to bring together all of the sectors involved in children & young people's mental health system, and find ways to achieve the joined up services that children, young people and families deserve. I hope it will help us realise the paradigm shift we need towards a truly child-centred approach, that allows children and young people to effectively source the help and treatment they need, when they need it, where they need it."

Martin McShane, Co-Chair of Taskforce, NHS England's Director for Long -Term Conditions : "The Taskforce has the potential to play a crucial role by identifying actionable steps that will overcome barriers and make use of system levers to create fundamental change for children and young people's mental health services. I am particularly interested in its views on how we can move towards a robust and effective data framework and measurement to underpin quality services across the system."

News and Updates

Inaugural Taskforce Meeting – 24th September

The members of the Taskforce came together for the first time on 24th September to begin to identify the priority areas which need to be worked on.

After a welcome from the co-chairs, Martin McShane and Jon Rouse, the meeting was mostly made up of discussions in small groups covering topics such as: how this Taskforce will work together; how it will be different to other Taskforces; the group's vision for CAMHS; what needs to change for this vision to be achieved; which of these should be the priorities for the Taskforce; and what members want to contribute.

Members expressed pleasure in their feedback on the meeting about the pace and energy of the meeting and the range of members they had met, especially our younger representatives and those from other sectors.

Engagement of Children & Young People

Absolutely central to informing the recommendations of the Taskforce will be the views of children and young people, and the families that support them. We are setting up a project to gather these views, and will feed them into the Taskforce as they emerge.

We are also planning a wider engagement of professionals from across the country to bring in the creative ideas of those who work closer to the ground, and who will be key to delivering the recommendations.

Co-commissioning Pilots

Alongside the work of the Taskforce, Norman Lamb announced on 14 October that we will be inviting expressions of interest for co-commissioning projects, asking local areas to submit proposals outlining how they might go further with collaborative joint commissioning arrangements for children's mental health services.

We want to support projects spanning health, social care, education and the voluntary sector and are seeking ideas on how the learning from this can be applied across the country.

This work will be closely linked into the work of the Taskforce and Taskforce members can expect to hear more about progress in future meetings. Expressions of interest will be sought by NHS England in the next week .

Recent Developments

- Jon Rouse visited Leeds CAMHS on 8 Oct, where he got the chance to engage with children and young people directly about the services there. He was particularly interested to hear about the great work happening there on transitions – useful learning for the Taskforce.
- Norman Lamb MP spoke at the CYP IAPT conference on 14 October, where he announced the co-commissioning projects that will be running alongside the Taskforce.
- Flora Goldhill spoke at Maudsley Learning's Mental Health of Children and Young People Conference on 23 October about the work the Department of Health has done so far in this area and what more we still have to do – including the opportunity the Taskforce creates to make some real progress.
- To mark World Mental Health Day on 10 October, the Secretary of State for Education, Nicky Morgan, published a joint article with the charity Place2Be highlighting her passion for improving provision and ending stigma around mental health. She emphasised the importance of working across government to ensure that health, schools and social services are more joined up and ensure that every child gets the support they need.
- The Department for Education launched a new round of government grant funding for voluntary and community groups totalling £25million on 16 October, which for the first time includes a specific focus on mental health projects. More information can be found at https://online.contractsfinder.businesslink.gov.uk or ContractFinder website

Future Events

- Norman Lamb and Jon Rouse will both be speaking at the NCAS Conference, which is being held on the 29th—31st October. If you're attending, then listen out for more information about the Taskforce.
- We will be celebrating the Children's Commissioner's 'Takeover Day' a couple of days early, as young people 'takeover' the Children's Health and Wellbeing Partnership meeting on 19 November – including a session led by them on Mental Health.

What next?

Next Taskforce Meeting – 4th November

The focus of the second Taskforce meeting will be on the work of the four Task & Finish Groups which have been set up to address the principle themes which emerged from the first meeting.

Data and Standards: the **information** to underpin decision making within the system and to drive up the quality of provision. This group will consider what data we have and what data we need to improve and inform decision making within the system. It will also look at standards of care, to see what standards are already in place and whether these are fit for purpose.

Prevention and access: The objective of the Access and Prevention Task and Finish Group is to identify ways of improving access to timely, effective and evidence-based support for children and young people whatever their mental health needs. This covers both GP and school access points; and ranges from prevention and resilience building interventions to first point of contact services (e.g. Youth Information Advisory and Counselling Services and online services) to crisis care support and transition. It includes addressing such issues as the stigma associated with mental health services, branding issues and identity.

A co-ordinated system: sectors working together to **commission and deliver services** which meet the needs of young people across the care pathway. This group will look at the way in which the system is funded, perverse incentives, the barriers which prevent appropriate commissioning and how we can address these, commissioning capability across the care pathway and how this could be improved, referral thresholds and pressures on various parts of the system.

Vulnerable groups and Inequalities: a system which works for our most vulnerable children and young people. This group will work with Groups 1, 2 and 3 to ensure that the needs of all children and young people are considered and addressed, including children who have mental health needs as a result of childhood sexual exploitation or abuse, adopted and looked after children, children with learning disabilities, children in contact with the youth justice system (and other specific groups which are identified).

All four groups will call upon further expertise from the other groups and from non-Taskforce members.

Details will also be provided at this meeting about the timescales for each task and finish group to feed into the main Taskforce report.

Further meetings of the Taskforce will be held on 4th November 2014, 13th January 2015 and 3rd March 2015.

Get in touch

If you wish to contact the Taskforce Secretariat you can:

- Email us at CYPMHTaskForce@dh.gsi.gov.uk
- Tweet us at @DHChildHealth

Stay up to date with the Taskforce by following @DHChildHealth and feed in your views by tweeting with #CYPMHTaskforce

Taskforce Membership

Children & Young People's Mental Health & Wellbeing Taskforce Membership List

Name	Job Title/Location
Jon Rouse	DH Taskforce Co-Chair
Martin McShane	NHS England Taskforce Co-Chair
Members	
Pru Allington Smith	Consultant Psychiatrist in Learning Disability, Coventry & Warwickshire NHS Trust
Matthew Ashton	Director of Public Health, Knowsley (Liverpool)
Maggie Atkinson	Childrens Commissioner for England
Mick Atkinson	Head of Commissioning Place2Be
Sue Bailey	Chair of Children & Young People's Mental Health Coalition
Laurence Baldwin	Mental Health Nurse
David Behan	Chief Executive, Care Quality Commission
Jonny Benjamin	Expert by Experience
Anna Bradley	Chair of Healthwatch England
Sarah Brennan	Chief Executive of Young Minds
Sally Burlington	Head of Programmes at the Local Government Association
Prof Mick Cooper	Prof of Counselling, CYP IAPT National Advisor for Counselling, University of Roehampton
Cheryl Coppell	Chief Executive of London Borough of Havering
Jacqueline Cornish	National Clinical Director for Children, Young People & Transition to Adulthood at NHSE
Karen Cromarty	Senior Lead Advisor for Children & Young People, British Association for Counselling & Psychotherapy
Margaret Cudmore	Vice Chair of the Independent Mental Health Service Alliance
Rebecca Cotton	Director of Mental Health Policy, NHS Conferderation
Max Davie	Community Paediatrician
Eustace DeSousa	Deputy Director, National Team for Children, Young People & Families at Public Health England
Keith Douglas	Managing Director NHS South Commissioning Support Unit
Julia Faulconbridge	Consultant Clinical Psychologist (Children, Young People and Families) - British Psychological Society
Peter Fonagy	National Clinical Lead CYP & IAPT and Chief Executive of the Anna Freud Centre
Charlotte Gatherer	CYP & IAPT Young Sessional Worker
Vivienne Griffin	Director of Social Services, Wolverhampton
Flora Goldhill	Director Children, Families & Social Inclusion, Department of Health
Ann Gross	Director of Special Needs and Children's Services Strategy at Department for Education
Sharon Gray	Head Teacher, Netherfield Primary School
Nick Hindley	Forensic Psychiatrist, Oxfordshire NHS Health Foundation
Peter Hindley	Consultant child and adolescent psychiatrist, Guys and St Thomas' NHS Trust
Matthew Hopkinson	Assistant Director, 0-25 SEN and Disability Unit, DfE
Paul Jenkins	Chief Executive, Tavistock & Portman NHS Foundation Trust
Max Jones	Director of Programme & Service Delivery - Health & Social Care Information Centre
Stephanie Lamb	General Practitioner, Royal College General Practitioners
Warren Larkin	Clinical Director, Children & Families Network, Consultant Clinical Psychologist, Lancashire Early Intervention Service
John Lees	Associate Director of Commissioning, Birmingham South Central Clinical Commissioning Group
Christine Lenehan	Director of Council for Disabled Children & Co-Chair of Child Health Outcomes Forum
Sarah Jane Marsh	Chief Executive of Birmingham Children's Hospital
Nick Mcgruer	Deputy Director for Health, Disability and Employment Directorate - Department of Work & Pensions
Paul Melody	Social Media, Communications Expert
Karl Mittlestadt	Youth Justice Board
Jane Mischenko	Lead Commissioner for Children, Leeds Clinical Commissioning Group
Paul Mitchell	Clinical Nurse Specialist, Youth Justice Board
Margaret Murphy	Consultant Psychiatrist, Tier 4 CAMHS Clinical Reference Group
Kath Murphy	Specialist Services, NHS England
Wendy Nicholson	Public Health Nursing at Department of Health
Alison O'Sullivan	Vice President of the Association of Directors of Children's Services
Nick Page	Chief Executive of Solihull Metropolitan Borough Council
Claire Phillips	Deputy Director of Children & Young Peoples Health & Wellbeing at Department of Health
Kathryn Pugh	Children & Young People's Improving Access to Psychological Therapies (CYP IAPT) Programme Lead
Sandeep Ranote (Dr)	CAMHS Psychiatrist, Lead for Specialist Clinical Networks, NHS England
Barbara Rayment	Director at Youth Access
Emma Rigby	Chief Executive of the Association for Young People's Health
Wendy Russell	Head of Operations and Development at Health Education England
Eileen Scott	Expert by Experience
Anne Spence	Policy Lead C&YP MH Taskforce at the Department of Health
Dawn Taylor	Deputy Director - Children & Young People's Mental Health DfE
Isabelle Trowler	Chief Social Worker
Teresa Tunnadine	Head Teacher at Compton Secondary School
Karen Turner	Head of Delivery, Parity & Esteem, NHS England
Kate Ward	Policy Lead C&YP MH Taskforce at the Department of Health
Jon Wilson	Norfolk Youth Service
Miranda Wolpert	Director of the CAMHS Evidence based Practice Unit, National Advisor on data for CYP IAPT Programme
Kevin Woods	Looked after Children and Adoption Policy, DfE

Some additional members, not shown on this list, have also been appointed to task and finish groups to ensure a full range of expert advice is included.

CHILDRENS COMMISSIONING MEETING W/C 27.10.14

CAMHS WAITING LISTS INFORMATION (as of 21/10/2014)

1. **Consultation Clinics by wedge**

WEDGE	CONSULTATION CLINIC	TOTAL
East	Mean = 10 weeks ; Median = 10 (range 1 - 25 weeks)	68
West	Mean = 12 weeks; Median = 12 (range 1 - 30 weeks)	88
South	Mean = 7 weeks ; Median = 6 (range 2 - 19 weeks)	57
	TOTAL WAITING	213
	TOTAL WAITING OVER 19 WEEKS	19 (9%)

2. **Autistic spectrum assessments by wedge**

WEDGE	AUTISM ASSESSMENTS	TOTAL
East	(range 1 – 39 weeks)	37
West	(range 1 – 44 weeks)	34
South	(range 2 – 38 weeks)	25
	TOTAL WAITING	96
	Mean = 19 weeks; Median = 18 weeks	

3. **Attention Deficit Hyperactivity Disorder Assessments by wedge**

WEDGE	AUTISM ASSESSMENTS	TOTAL
East	(range 4 – 46 weeks)	24
West	(range 1 – 31 weeks)	14
South	(range 4 – 19 weeks)	9
	TOTAL WAITING	47
	Mean = 19.5 weeks; Median = 19 weeks	

4. **Number of under 5s waiting for any type of assessment**

WEDGE	UNDER 5 YEARS	WAIT TIME
East	none	none
West	2	10 and 16 weeks
South	1	9 weeks

5. Waiting list information by CCG

CCG	Consultation Clinic		ASD		ADHD		CBT (Level 3)	
	Waiting (N)	Range (weeks)	Waiting (N)	Range (weeks)	Waiting (N)	Range (weeks)	Waiting (N)	Range (weeks)
WEST	96	1 - 32	38	4 - 44	17	1 - 31	13	1 - 35
NORTH	46	2 - 24	21	2 - 39	12	4 - 43	6	3 - 34
SOUTH/EAST	61	1 - 18	37	1 - 38	18	4 - 46	0	N/A
Total numbers waiting and Overall Waiting range	203	1 - 32	96	1 - 44	47	1 - 46	19	1 - 35

Integrated Commissioning Executive	D
Meeting – 2nd September 2014	

Title of Report:	**Emotional and Mental Health Services in Leeds: Proposed implementation of local authority funding changes in emotional health and wellbeing services.**
Author(s):	**Jane Mischenko/ Paul Bollom**
Date finalised:	**11 August 2014**
ICE Lead:	**Matt Ward/ Nigel Richardson**
For further information contact	**Jane Mischenko – 0113 8431634** **Paul Bollom – 0113 2243952**
The purpose of this paper is to…	Share the proposals for changes to the CAMHS and Therapeutic Social Work Team (TSWT) services as part of 2014/15 budget actions.
It is recommended that the Integrated Commissioning Executive…	That the Integrated Commissioning Executive notes and supports the proposals alongside the accompanying paper for future direction for emotional health and wellbeing services for children and young people.
Risks: (to Clinical Commissioning Groups, Local Authority and NHS England)	Risk of unplanned or disruptive service change if local authority does not achieve planned budget strategy.

1.0 Summary

Purpose of this report

1.1 The purpose of this report is to provide detail on recommended changes to the commissioning of CAMHS services by the local authority and changes to its internal delivery of the TSWT service to secure agreed budget strategy.

2.0 Background information

2.1 The local authority budget settlement requires a reduction of approximately £18m to be made against the 13/14 children's services budget. The budget actions agreed to deliver this planned reduction included a proposal to

reduce expenditure on emotional health and wellbeing provision by £500K without comment on how this was to be achieved.

2.2 Broadly Tier 3 arrangements in Leeds consist of two core provisions. The Leeds Community Health (LCH) provided Child and Adolescent Mental Health Service (CAMHS) team and local authority employed and delivered Therapeutic Social Work Team (TSWT).

2.3 Local authority investment in CAMHS is valued at the 13/14 outturn as circa £450K and in the TSWT £680K. The local authority investment in CAMHS is complicated by being a mixture of staff effectively seconded into CAMHS (but employed by the local authority) alongside conventional contracts with LCH which cover management posts, staff training and some specialist service delivery.

2.4 Commissioners in the local authority and CCGs have worked together to enable 2014/15 to be a transitional year to effectively support a managed process.

2.5 Given the constraints to make jointly agreed recommendations in a timely way in readiness for 2015/16 consultation has focused on the two services noted above drawing on clinical, commissioning and service planning expertise to bring forward proposals, which address the need for efficiencies. The process has run alongside the efficiencies programme driven from within LCH to meet organisational budget constraints. A workshop between both teams supported by provider management and independently facilitated produced an options appraisal contained at Appendix A.

3.0 Main issues

3.1 The following principles have been adopted in considering options for funding reductions.

- Minimising impact on provision by working smarter across both services, reducing duplication and seeking new opportunities to fund areas of work
- A focus on service delivery rather than historical arrangements or current employment arrangements
- Deliverability within the time frame whilst minimising impact on staff in post

3.2 A small steering group consisting of senior leadership in LCH/CAMHS and the LCC Social Work Service with the relevant commissioners from the local authority and Leeds CCG's has considered the options. The following are recommended for implementation with savings indicated in brackets.

3.3 **Traded Training**

3.3.1 The current training arrangements offer free multi-agency training to staff working in schools and in the VCFS sector. This training has been valued in supporting core skills development in the identification and support of common mental health presentations.

3.3.2 The preferred proposal is to cease offering training from CAMHS on a free to trainee basis and request CAMHS to consider trading training (£54K). Training will continue to be offered from the Infant Mental Health model, which has a separate funding stream.

3.4 **'Seconded Staff' and Therapeutic Social Work Team Vacancies**

3.4.1 Currently 4.5 Leeds City Council employed staff deliver part of the CAMHS provision managed and directed by CAMHS managers. There is one administrative team member also provided to CAMHS. Two vacancies are current on the TSWT structure.

3.4.2 The preferred proposal is to end the arrangement where a compliment of staff are provided to CAMHS but employed by the local authority (£140K). The local authority will put in place a small contract with LCH for continued support of the TSWT with clinical psychologist expertise and support for targeted mental health needs. The TSWT will remove the current vacant posts from its structure or otherwise reduce its staffing by a value of £80K. The net effect on staff currently employed by the local authority is that a small number will TUPE to the CAMHS service and the remainder will be redeployed within CSW posts.

3.5 **Staff Managers**

3.5.1 The current contracts for management staff for two area CAMHS teams in light of the above will be reduced as staff management requirements are reduced

3.5.2 The proposal is to cease the management contracts (£106K pa) from April 2015.

3.6 **Adoption Support**

3.6.1 CAMHS provides support to families on their adoption of a child. This support is also provided in part through an external contract Leeds City Council holds and through the TSWT.

3.6.2 The preferred proposal is that adoption support is provided through the TSWT and adoption teams in LCC and is no longer a requirement for CAMHS (£40K saving)

3.7 **CAMHS Speech and Language Therapy**

3.7.1 A contract arrangement is in place for £50K which supports the Speech and Language Therapy provision. The broad view is that the previous refocusing of additional SLT commissioning from the local authority to schools based

commissioning should encompass this contract. Further work however will be undertaken as to the impact of ceasing this arrangement.

4.0 Recommendations

ICE are recommended to:

- Note and support proposals above in progressing the required £500k saving.
- Consider these changes in conjunction with a commitment to transform EHWB services.

Integrated Commissioning Executive	E
Meeting – 2nd September 2014	

Title of Report:	**Emotional and Mental Health Services in Leeds: The case for whole system change**
Author(s):	**Jane Mischenko/ Paul Bollom**
Date finalised:	**11 August 2014**
ICE Lead:	**Matt Ward/ Nigel Richardson**
For further information contact	**Jane Mischenko – 0113 8431634** **Paul Bollom – 0113 2243977**
The purpose of this paper is to…	The paper presents the case to jointly redesign and re-commission the whole system of children's emotional and mental health services in Leeds (tiers 1-3).
It is recommended that the Integrated Commissioning Executive…	That the Integrated Commissioning Executive supports the whole system approach to re-commissioning services and to provide PMO support to deliver the proposal at pace and scale.
Risks: (to Clinical Commissioning Groups, Local Authority and NHS England)	Inadequate and ineffective emotional and mental health services at tier 2 and 3 increase demand for tier 4 services (NHS England); this ultimately increases demand on adult mental health services (CCGs) and impacts on a child or young person's educational attainment and subsequent employment prospects (LA)

1.0 Summary

Purpose of this report

1.1 One of the Leeds Joint Health and Wellbeing Strategy's key priorities is to *'Improve people's mental health and wellbeing'*

1.2 Emotional and Mental Health is recognised by ICE, the Transformation Board and the Children's Trust Board as one of the Joint Commissioning priorities for the children's programme.

1.3 In a recent joint commissioning workshop with partners and key stakeholders there was agreement of the need to completely redesign and re-commission the Leeds service model.

1.4 This paper sets out the case for this ambitious transformation of local children and young people's mental health services and the request for programme management officer support, to progress this at pace and scale.

2.0 Background information

2.1 There is national concern about the state of mental health services for children and young people. This is evidenced by the Chief Medical Officer's report (*Our Children Deserve Better: Prevention Pays, 2012*); that the National Clinical Director for Children highlights this as a priority in her programme and in the establishment earlier this year of a Health Select Committee to review current CAMHS provision.

2.2 In Leeds there is a complex picture of multiple commissioners (NHS England; CCGs; LA; and 24 School Clusters) that has led to a local system that despite best efforts is fragmented, with too many entry points (referral pathways); and too many hand offs (between a complex picture of service provision). This is confusing and frustrating for children, young people, parents and professionals.

2.3 The current economic situation has posed further challenge as partners have identified savings required within children's mental health spend but where this has been done to different timescales and therefore outwith meaningful consideration of the impact on the whole system i.e., LA disinvestment of £0.5m and LCH CIP plans of £822k in 2014/15.

2.4 However, there are also real strengths in Leeds provision. We now have an early intervention service (TaMHS) in every school cluster; this was seed funded by NHS, LA and School Forum partners in the city and is evaluating well in relation to improving outcomes; there has been the establishment of local pilots, where GPs can directly refer to this service. Leeds has also invested in the evidenced based model MST (Leeds is an award winning team).

2.5 Whilst the proposal is to redesign and re-commission the tier 1, 2 and 3 services (CCG, LA and School cluster commissioning responsibilities), there is recognition on the need to work with NHS England commissioning colleagues. The demand and delivery of tier 4 in-patient services is significantly impacted upon by the effectiveness of the local commissioned service and there are opportunities to work to co-commission the interface between tier 3 and 4 services that can provide intensive wrap around support and prevent the need for admission.

2.6 There is significant national and local evidence of the expressed needs of young people in relation to emotional and mental health support; we need to

respond to these clear messages. We have identified a local network of young people to help co-design the local service model.

3.0 Main issues

The rationale for change

3.1 The current situation summarised above does not maximise the value of every Leeds pound spent on children and young people's emotional and mental health. Whilst there are examples of innovation and excellent teams in the city, there is too much variability and the whole system does not function well together. This therefore introduces inefficiencies, poor experience for children and families as they try to navigate the system and frustration for professionals (those referring into and delivering within the system). This is evidenced by the noise in the local system (LMC, complaints, councillors, MPs, GP's, teachers).

What we need to do

3.2 Through joint commissioning workshops and a review of what service users consistently tell us there are some key principles that need to be integrated into the redesign:

- Co-design with parents and young people
- Develop a city-wide public health programme to support emotional intelligence and resilience
- Maximise the digital opportunities to enhance self-care, improve access and facilitate flexible service provision
- Further strengthen early intervention (TaMHS); work to ensure a consistent standard of offer and the sustainability of this provision (joint commissioning)
- Create one point of access for referrers of children's mental health services
- Develop, integrate and strengthen the local cluster service delivery model (after all this is where the young people are), by redesigning the use of the current specialist CAMHS and Therapeutic Social Work service (training, supervision, swift access to advice, joint working)
- In addition to the local offer, ensure a strong city centre provision (for young people)
- Use the available evidence and champion innovation with robust evaluation
- Align and protect resource; identify commissioning and contracting opportunities to effectively deliver the whole system model

3.5 Proposed key actions to progress:

- Establish a dedicated joint commissioning group to oversee the delivery of the programme
- Identify programme management support to ensure timely delivery (programme manager. project officer support, access to business intelligence and contracting expertise)
- Key work-streams are set out below – these are to progress simultaneously

Quick analysis

- Synthesise the significant resource we already hold of existing information (HNA, performance and national and local benchmarking reports, service user feedback, complaints, and outputs from stakeholder engagement)
- Model current service user flows; identify gaps, pressure points
- Understand the resource: Establish current expenditure, and planned CIPs

Redesign

- Co-design with parents and young people
- Describe single service model, adopting principles set out above and working with key stakeholders
- Identify and flag any gaps, and risks (clinical, political, financial)
- Identify where redesign can maximise value of current investment and where any additional resource would add most benefit (impact and improved outcomes)

Commissioning model

- Determine commissioning model; review opportunities of aligned/pooled resource; explore partnership contracting models and the available levers and incentives to ensure delivery of the redesigned service model
- Consider procurement options/ approaches

4.0 Recommendations

4.1 Members of ICE are asked to receive and support the recommendation to redesign and re-commission emotional and mental health services in Leeds.

4.2 In order to deliver this critical work at pace members of ICE are asked to support non-recurrent funding to provide a PMO function for 12 months, to include a programme manager, project officer and access to critical support functions, such as business intelligence and contracting expertise.

4.3 It is anticipated, if this is supported – that the redesigned service model and proposals of mechanisms to jointly commission and procure this, could be reported back to ICE by the end of 2014/15; this is dependent on speedy

establishment of the PMO resource. Re-procurement or implementation is anticipated to occur during 2015/16.