**Appendix 1: Report on the Whole System Emotional Wellbeing and Mental Health review**

***1. The development of a clear primary prevention programme for emotional wellbeing, (emotional literacy and the development of resilience in CYP). To support this public health programme each school and Children's Centre to have an EMH champion.***

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| Recommendation | A clear primary prevention programme for emotional wellbeing. Each school and Children's Centre to have an EMH champion having undertaken additional training |
| Evidence base and economic case | There is significant evidence that early intervention can reduce the risk of later disorder and therefore improve outcomes and save money[1]<br>Having an identified champion in children centres, and schools /clusters allows training to be targeted and also offers a point of contact for distribution of communication, policies and resources to support such settings. It is envisioned that this role will also offer some advice and guidance to other professionals |
| The issue | Lack of a coherent prevention plan (primary prevention; development of emotional literacy of workforce and pupils and emotional resilience of pupils) |
| This is the evidence of extent of this as an issue (local Data) | Rejection rates for services are high implying that people are being referred where their need does not meet the thresholds for services |
| This is supported by CYP and parents who say | o More education about EMH in schools (reduce stigma and improve emotional literacy of pupils and staff)<br>o The priority is to intervene early (quote from young person presenting to Scrutiny Board)<br>o Train the parents in resilience so they can give better support at home, could include CBT and mindfulness<br>o Don't use the word 'mental' when describing services<br>o Develop a course about mental distress for parents and carers<br>o Encourage social action projects where young people spread positive messages.<br>Provide parents and carers with self-management strategies so they can help their child too |
| This is supported by professionals who say | GPs and LMC concerned about those who cannot access TaMHS |
| This is what we've done to date | Perinatal mental health priority in maternity strategy/and children and families portfolio of MH Framework<br>Best Start Plan (co-commissioning of Infant Mental Health Service)<br>Healthy Schools team have undertaken work to develop emotional literacy<br>CCG co-commissioning of TaMHS (Early Intervention) |
| Next steps | Public Health to lead development of a primary prevention programme to promote emotional literacy and emotional resilience (this has been identified as a priority area by PH colleagues)<br>Early Intervention/prevention programmes informed by evidence base<br>Children Centres to increase access to evidence based parenting programmes<br>Named champions identified, role defined and workforce plan to support created |

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

### *2. Clear local offer developed for CYP and Parents*

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| Recommendation | Clear local offer developed for CYP and parents but also useful reference for local professionals |
| Evidence base and economic case | A clear local offer that is clearly signposted will help CYP and their parents ensure that they are entering the right part of the service. This will also support referring professionals to understand the comprehensiveness of the total local offer and allow them to provide informed advice of the service to be received. This will be supported by the information available on the MindMate web site |
| The issue | Complexity of commissioning and provision – lack of join up/understanding |
| This is the evidence of extent of this as an issue (local Data) | GP referral rejection rates are high (at 40.25 % for all 3 CCGs) and GPs report that they refer to CAMHS because they are unaware of the full range of other services available, or if they are accessible to them. TaMHS evaluation shows that some young people access TaMHS who could meet the threshold for other services such as CAMHS. Children who are looked after are often referred to TSWS even though their need could be met by a targeted level service such as TaMHS |
| This is supported by CYP and parents who say | They struggle to navigate the local system<br>They want personalised and flexible services<br>o Services need to also understand parents/carers needs<br>They want a non-judgemental attitude and inviting environment |
| This is supported by professionals who say | They are not sure where to refer and can't keep a track of all the services on offer (or their changing criteria) |
| This is what we've done to date | Reviewed current service offers, working with commissioners and providers to understand current activity, criteria and experience |
| Next steps | Establish a clear local offer, alongside the development of the SPA and service redesign; communicate to all key stakeholders; use MindMate to set out for CYP and parents and carers |

### *3. MindMate website and development of digital solutions*

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| Recommendation | To maximise the opportunity the MindMate website offers, i.e. to publish the local offer and the development of the digital solutions to promote self-care/resilience and delivery as part of intervention (to link to appropriate websites i.e. LCC, Mental Health All age portal) |
| Evidence base and economic case | Young people use digital sources for their information (Taskforce, 2015). The MindMate web site will offer one source of up to date and relevant information on mental health, self-care and also the services available in Leeds. There is significant research and development underway in the opportunities digital technology can offer; this extends beyond information giving to delivery of services |
| The issue | Improve access, self-help and efficiency |
| This is the evidence of extent of this as an issue (local Data) | To date services in Leeds have made little use of digital interventions either to offer support to young people who are waiting, or for those who are in a service |
| This is supported by CYP and parents who say | Most look up advice on line and find this useful<br>o Use different interventions including web technologies |
| This is supported by professionals who say | They don't know where to send people, or what to offer to young people while they are waiting for a service |

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| This is what we've done to date | We have commissioned the MindMate website<br>We have commissioned a digital innovation lab<br>We have commissioned YoungMinds to ensure these are coproduced with CYP<br>Part of the CQUIN with CAMHS for 2015/16 is to co-produce with young people means of support (which may include digital resources) for the young people and their family while they are waiting for an appointment |
| Next steps | Progress website and digital innovation lab developments and project plans |

### *4. Single Point of Access*

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| Recommendation | A Single Point of Access (SPA) for referrals into the system – with proactive communication to CYP and parents and carers to support whilst waiting |
| Evidence base and economic case | A SPA would provide one point in the city for GP referrals (supported by a team from key providers) to ensure that professionals, children, young people and families access the right service. Where there is a choice of service that could meet the need, young people and families will be provided with clear information on waits and the type of therapy available. This will reduce duplication and "hands offs" across the system and shorten overall waits<br>It is anticipated that this approach will be recommended by the national taskforce (Taskforce, 2015) |
| The issue | Confusion of what services are available and how to access/refer |
| This is the evidence of extent of this as an issue (local Data) | Waits are long to access some CAMHS and TSWT services and then there are further waits for those requiring more specialist assessment i.e. ADHD/Autism, or specific interventions.<br>Rejection rates for CAMHS stand at 31% for the overall service from all referrers and 40.25% for GP referrals. In the TSWS it has been calculated that a third of casework referrals don't end up in a social work attended consultation |
| This is supported by CYP and parents who say | Parents don't know how to navigate the local system and feel desperate and frustrated<br>o Ensure schools really embed mental health and work much more closely with CAMHS<br>There needs to be early contact with emotional wellbeing and mental health services: this is any intervention, whether it is in school or through a voluntary sector. Getting it right to begin with and then build on the partnership with parents' support to help the child<br>While waiting for services YP report that their condition worsened and in some cases they have attempted suicide |
| This is supported by professionals who say | They are frustrated by CAMHS referrals being rejected and don't know what service to recommend to young people and their families |
| This is what we've done to date | Improved waits to CAMHS through a waiting list initiative including access to consultation clinic and also ADHD assessment. Approved a waiting initiative to address ASD assessments within 2015/16. Tested the idea of a SPA with many stakeholders who recognise the opportunities and value of this approach<br>Co-commissioned with clusters to extend the TaMHS offer and ensure that in the future there is universal access to the service for GPs, and for children who attend private schools |
| Next steps | Progress at pace: a programme to develop and implement a SPA has agreement from key service clinicians – sign up is required from all commissioning/ provider partners. There are significant opportunities to integrate this with the Children Services 4th Floor team |

### *5. Redesign of Specialist CAMHS*

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| Recommendation | Specialist CAMHS – redesigned to have a named professional aligned to each school cluster and embedded in targeted services for vulnerable groups i.e. YOT, TSWT, TMktP – to provide swift access to expertise, consultation, supervision and co-working where appropriate |
| Evidence base and economic case | Evidence where TaMHS is provided by CAMHS in schools that a higher level of support is given in schools and that the transition into the CAMHS service (whilst good across all TaMHS services) is more joined up<br>Local experience that this model maximises capacity and capability of universal and targeted services (i.e. Infant Mental Health Service, TSWT, YOS)<br>Maximises capacity and capability of universal and early intervention services (more cost effective) |
| The issue | Lack of a citywide consistent, evidence based service joined up offer; gap between TaMHS and CAMHS |
| This is the evidence of extent of this as an issue (local Data) | GP referral rejection rates are high (at 40.25 % for all 3 CCGs) and this has been supported by GPs who have said that they refer to CAMHS because they are unaware of the full range of other services available. The TaMHS evaluation of the pilots indicates that some young people are attending TaMHS who meet the threshold for other services such as CAMHS. For children who are Looked After they are often referred to TSWS even though the need could be best met by a TaMHS service and potentially be less stigmatising |
| This is supported by CYP and parents who say | o Ensure schools really embed mental health and work much more closely with CAMHS<br>Early contact with CAMHS: this is any intervention, whether in school or through voluntary sector Getting it right to begin with and then build on the partnership with parents' support to help the child<br>There is poor communication between GP, schools and CAMHS<br>Services need to be working together |
| This is supported by professionals who say | That they know some CYP fall through the gap between TaMHS and specialist services |
| This is what we've done to date | Co-commissioned with clusters to extend the TaMHS offer and ensure that there is greater access to the service for GPs<br>There are already good local examples of this commissioning model of embedding expertise locally (i.e. TSWT, IMHS, YOS)<br>Co-commissioned the SILC TaMHS offer as a pilot (specialist CAMHS in SILCs for children with more complex needs) |
| Next steps | To develop the detail of the service model |

### *6. To ensure there is a focus vulnerable children and young people receive the support and services they need*

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| Recommendation | To ensure that vulnerable CYP (identified as children in the care system and care leavers, children with complex needs and disability, children in the youth justice system and CYP belonging to vulnerable BME groups) have access to necessary support |
| Evidence base and economic case | A consultation and mental health liaison model is recognised as best practice (Taskforce, 2015). This is where consultation and liaison teams advise staff dealing with those with highly complex needs, which include mental health difficulties (such as those who are looked after, have been adopted, those with sexually harmful behaviour and those in youth justice system). With fast track to specialist mental health services where needed and proactive follow up of those that do not attend appointments. |
| The issue | There is a fragmented system with multiple commissioners. The system not is not always joined up, resulting in some young people caught between service offers |
| This is the evidence of extent of | Many services in Leeds are offering support but there are long waits, different referral criteria and gaps between services. There is evidence of |

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| this as an issue (local Data) | some young people falling between the gaps in services or deteriorating whilst waiting |
| This is supported by CYP and parents who say | More targeted consultation needed to hear from CYP in vulnerable groups<br>Poor communication between GP, schools and CAMHS<br>Better communication between inpatient services and community services<br>Services need to be working together |
| This is supported by professionals who say | That they know some CYP fall through the gap between targeted and specialist services |
| This is what we've done to date | Co-commissioned with clusters to extend the TaMHS offer and ensure that there is greater access to the service from GPs<br>CAMHS psychologists embedded in TSWT<br>Co-commissioned with SILCs TaMHS in SILC offer for children with complex need<br>Commissioned specific service for care leavers from the Market Place |
| Next steps | Redesign of specialist CAMHS service offer as described earlier. Review of existing pathways and offers for vulnerable CYP (involving health, education, social care, youth justice and targeted service leaders) and ensure follow best practice and integrated with wider children service offer |

### *7. Strengthen transition arrangements*

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| Recommendation | Strengthen transition arrangements |
| Evidence base and economic case | Transition between children and adult services is known to be poor and this links to poor outcomes and lack of engagement with adult services and a "lost tribe"[2]. "You're Welcome standards" have recognised the needs of children with emotional issues specifically[3] and the recent model service specification[4] sets minimum standard for good transition |
| The issue | Concern about transitions |
| This is the evidence of extent of this as an issue (local Data) | Adult services offer a different model to that available in services for children and young people and not all young people transfer to a service from CAMHS and TSWS. There is good practice locally but this needs to be strengthened. A team of two people support transition (from 17.5 years upward) from CAMHS and the inpatient team to adult mental health services. For adult IAPT services 1082 young people aged 17 – 25 entered treatment in 2013/14. This is an increase of 34% in the numbers entering treatment since the previous year. Leeds Survivor Led Crisis Service (DIAL house) report that their biggest cohort of people attending for support is in the 16 – 25 year old age bracket. TSWS offer support for young people who are care leavers up until the age of 25 |
| This is supported by CYP and parents who say | Parents and young people want to be involved in decisions<br>o Transition should be well planned and happen smoothly<br>Better informed around transition, when and how<br>At 17 young people have reported that their interaction with the GP changes in terms of GPs saying there is no point referring and offering of anti-depressants |
| This is supported by professionals | They "hold onto children" when they know that there are no adult services |

[2] Lost in Transition?, McDonagh, 2006 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1382525/
[3] You're Welcome quality standards available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

[4] Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)" (NHSE December 2014)

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| who say | "Cliff Edge"<br>What about those not in CAMHS at age 17?<br>What about vulnerable groups i.e., care leavers?<br>When the CAMHS transition workers are not involved in a young person's move to adult services the experience is less satisfactory |
| This is what we've done to date | A protocol has been developed between LCH and LYPFT in order to provide a universal standard for aiding the transition between CAMHS and AMHS. This has been modified following feedback from Young Minds and qualitative interviews undertaken by the Transition Team<br>CCG commissioners of CYP and Adult emotional wellbeing and mental health services have prioritised this as an areas to improve during 2015/16<br>Initial scoping of the current offer is underway |
| Next steps | Review and strengthen existing arrangements and work to personalise and strengthen the transfer between CYP services and adult services<br>Be informed by recent NHSE publications<br>Consider commissioning some YP services up to 25 |

### *8. CYP IAPT principles to be adopted across the city as the quality framework*

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| Recommendation | CYP IAPT principles to be the quality framework for the cities providers: These are:<br>1. Use of best evidence based interventions; 2. CYP participation in service delivery/development; 3. Session by session monitoring; 4. Goal based outcomes |
| Evidence base and economic case | CYP IAPT has been nationally evaluated and endorsed. The quality framework offers a structure to ensure that good quality provision is supported, CYP participation is integral and measurement of impact is consistent |
| The issue | No explicit quality framework consistently used across the system |
| This is the evidence of extent of this as an issue (local Data) | There is variable adoption of NICE guidance; there is variable participation of CYP in service development; not all services define goals with CYP, or measure the impact of the service/intervention from CYP feedback<br>The service review has shown that services offer different length waits, different times in service and different discharge routes. Some of this is based on need and the service type but comparison between services is hard |
| This is supported by CYP and parents who say | They want services that are personalised and flexible<br>o Services need to also understand parents/carers needs<br>Services need to deliver a non-judgemental attitude and inviting environment |
| This is supported by professionals who say | They are not assured of the consistency or quality of services |
| This is what we've done to date | Undertaken a baseline assessment of providers' compliance with relevant NICE guidance. Initiated a waiting list initiative. Co-commissioned with clusters to extend the TaMHS offer and ensure that there is greater access to the service for GPs; the co-commissioning relationship will assist in the development of shared quality standards and measures |
| Next steps | Integrate the CYP IAPT principles into the commissioning framework and work with commissioners to embed in service specifications, contracts and performance monitoring. Establish a whole system monitoring methodology |

### *9. Whole system commissioning framework*

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| Recommendation | Whole system commissioning framework with clear roles and responsibilities for all partners[5]. To detail co-commissioning arrangements between clusters and CCGs; NHSE and CCGs with robust evaluation of impact across the system |
| Evidence base and economic case | We will be able to make better use of the Leeds £, ensure early intervention, better join up the system and set clear lines of accountability |
| The issue | There is a fragmented system with multiple commissioners and a lack of clear lines of accountability. On the ground the system is not always joined up, with some young people lost or shunted between services |
| This is the evidence of extent of this as an issue (local Data) | There are many services in Leeds offering support but there are long waits for some, different referral criteria and gaps between services.<br>There is evidence of some young people falling between the gaps in services, or deteriorating whilst waiting |
| This is supported by CYP and parents who say | There is poor communication between GP, schools and CAMHS<br>There needs to be better communication between inpatient services and community services.<br>Services need to be working together |
| This is supported by professionals who say | That they know some CYP fall through the gap between TaMHS and specialist CAMHS services; they are confused about what is available |
| This is what we've done to date | Developed these recommendations to act as an initial framework for the whole system commissioning strategy; CCGs are co-commissioning with clusters to extend the TaMHS offer and ensure that there is greater access to the service for GPs, and for children who attend private schools |
| Next steps | A Programme Board needs to be established to oversee; a clear lead commissioner should be agreed for the city. There should be an exploration of aligning/pooling budgets |

### *10. Establish system of tracking whole system (integrated data report), to include one unique identifier*

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| Recommendation | Develop and agree one identifier for young people across all the city's services to record data; establish a system of tracking the whole system to understand demand and capacity and impact of system changes |
| Evidence base and economic case | There is no one identifier for all children and young people, meaning we are not able to track each person through the system. Data on activity, waits and outcomes varies from service to service |
| The issue | Lack of data to track use, need and impact of services (robust data is essential for effective commissioning) |
| This is the evidence of extent of this as an issue (local Data) | There is no one identifier for all children and young people, meaning we are not able to track each person through the system. Data on activity, waits and outcomes varies from service to service |
| This is supported by CYP and parents who say | They want services to communicate better |
| This is supported by professionals who say | They want to know where the young person they have referred is in the system<br>An absence of this compromises effective commissioning of a whole system approach |
| This is what we've done to date | The different data sources and systems has been mapped as part of the review |
| Next steps | To agree and use one identifier e.g. NHS number<br>To develop integrated tracking system to enable measurement of impact of investment i.e., into TaMHS and TaMHS SILCs and redesign |

[5] NHSE; CCGs; LA; Education Clusters; LA Public Health – for the prevention agenda

### *11. Refresh HNA*

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| Recommendation | HNA refreshed once new national prevalence survey published (2016/17) |
| Evidence base and economic case | Understanding the prevalence for Leeds of mental health issues for children and young people will enable us to more effectively match the services commissioned with the level and area of need. It will also support providers to offer a service delivery model that meets the expected needs of the population |
| The issue | Services are commissioned based on historical need supplemented and enhanced by local data (last national prevalence data was 2004) |
| This is the evidence of extent of this as an issue (local Data) | Similar to the national picture. CMO has recommended the need for a national prevalence survey |
| This is supported by CYP and parents who say | N/A |
| This is supported by professionals who say | Data is critical to effective commissioning |
| This is what we've done to date | A refreshed HNA with available local data |
| Next steps | Review and refresh the HNA following publication of the national prevalence survey – expected in 2016/17 |