Local Transformation Plan for Children and Young People’s Mental Health and Emotional Wellbeing

2015 – 2020

October 2017 Refresh

Version 2

01.11.2017
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Local Transformation Plan for Children and Young People’s Mental Health

In Dudley, we are passionate about the wellbeing of our children, young people and families. Our Vision is for Dudley to be a place where children and young people thrive and have the capacity to develop both physical and emotional resilience. This CAMHS Transformational Plan is about delivering that vision and driving change to improve outcomes. It sets out how we will develop our emotional health and wellbeing offer in partnership not only with the wide range of agencies in the borough working with children, young people and families, but also with families themselves. We recognise that there is more to be done to improve the mental health and emotional wellbeing of children and young people, identified locally and nationally within “Future in Mind”.

Extensive stakeholder engagement has been undertaken to establish our baseline of current service provision. We have reviewed all the actions identified in Future in Mind to establish where we are now, where we have good practice and where service gaps exist to inform the development of this plan.

A local Emotional Health and Well Being Steering Group has been established by the Health and Wellbeing Board to drive forward whole system redesign and ensure services are sustainable, outcomes focused and effective.

Our vision by 2020:-

- **Children and young people will enjoy a happy and fulfilling childhood.**
- **Children and young people will be resilient and manage their emotional health and wellbeing in their family, school and community**
- **The most vulnerable children and young people will have access to the most appropriate range of services.**

To achieve this vision, we will commission evidence based services, based on NICE guidance, that will be designed to:-

- Promote resilience, prevention and early intervention.
- Improve access to effective support.
- Improve specialist early help and Intervention for the most vulnerable.

These service developments will be underpinned by the following themes:-

- Ensuring the voice of the child is incorporated into all service developments.
- Reducing health inequalities.
- Developing the workforce.

**Aims and Objectives of Our CAMHS Transformation Plan**

The following aims and objectives have been identified across Dudley, informed by national principles to improve and transform our local CAMHS service to ensure that:-
services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people;
there will be better access to and awareness of services;
access to service are improved and waiting times reduced;
that we identify and reach out to and prioritise vulnerable group e.g. children on the edge of care; children leaving care; homeless; those with complex needs, those with substance misuse problems, the victims of domestic violence and sexual exploitation.
age appropriate support to young people and support through transitions particularly around whole life disability services;
commissioning is informed by robust data, information and outcomes reporting to enable effective and consistent service provision across all partners;
evidence based practice informs all that we do.

Building on our achievements to date, additional resources will allow us to accelerate the transformation of our local mental health and emotional wellbeing service offer over the next five years through the implementation of 10 key strategic priorities:-

1. Ensure that the “voice of the child” is incorporated into all children service developments.
2. Reduce health inequalities and promote equality.
3. Invest in prevention and early intervention.
4. Expand the existing school based Emotional Health and Wellbeing Team.
5. Ensure that a systematic and consistent application of Children and Young People’s Improving Access to Psychological Therapies programme (CY IAPT) principles.
6. Develop a CAMHS Tier 3+ service as part of our home treatment service.
7. Commission a 0-18 year old Children and Young People’s Community Eating Disorder Service in partnership with Walsall CCG.
8. Invest in services to meet the needs of vulnerable children and young people.
9. Expand our service offer for children with ASD and or/ADHD.
10. Develop the workforce.
1 Introduction

1.1 This plan sets out how all agencies will work together to improve the mental health and emotional wellbeing of children and young people in Dudley. We have identified our key priorities following a baseline assessment and needs analysis. This will be underpinned by the development of detailed action plans for each priority and the development of an outcomes and performance framework that will be closely monitored by our Emotional Health and Well Being Steering Group reporting to the Dudley Children and Young People’s Alliance Board and the Health and Wellbeing Board.

1.2 This plan describes our local analysis of need, the services that currently exist; how we will bridge the gap between existing service provision and need; how we will transform services through:-

- promoting resilience, prevention and early intervention for the most vulnerable;
- improving access to effective support;
- improving specialist early help and intervention for the most vulnerable.

2.0 Dudley Context

2.1 Dudley Clinical Commissioning Group (CCG) and Dudley Metropolitan Borough Council (DMBC) commission a range of Specialist CAMHS and emotional health and wellbeing services to identify, assess and respond to need, from early intervention through to Tier 3.

2.2 We have strengthened the partnership between:-

- Dudley CCG;
- Dudley MBC Children’s Social Care, Adult Social Care, Education and Public Health Services;
- Dudley MBC Office of Public Health;
- Dudley & Walsall Mental Health Partnership NHS Trust;
- Black Country Partnership NHS Trust
- Community and voluntary sector services;
- Local children, young people, parents and carers.

The objective of this strengthened partnership is to:-

- develop opportunities to redesign and integrate our services across the traditional Tiers 1- 3;
- develop pathways between services
- commissioning a system without tiers.

2.3 The transformation of these services is part of a system wide redesign programme across the health and care economy. Dudley is a national Vanguard site for the development of new care models. The focus of our new
model of care builds on a joined up network of GP-led, community-based Multi-Disciplinary Teams (MDTs) which enable staff from health, social care and the voluntary sector to work better together, as part of a Multi-Specialty Community Provider (MCP). We intend to use this model to deliver more integrated children’s services, particularly for those children with more complex needs. The proposed Integrated Children’s and Young Peoples service delivery model is attached in Appendix 1.

2.4 The national ambitions and recommendations within Future in Mind, including removing barriers to access, improved awareness and earlier intervention and dedicated support to the most vulnerable young people and their families has informed our approach.

2.5 This plan describes our approach to developing our services. The baseline assessment has highlighted a number of areas in which we need to improve and as such this plan articulates our short and medium term intentions.

3.0 Consultation and Engagement

3.1 Engagement has helped to shape our plan. We have gathered the views of children and young people in several different ways, as part of our work to design our services for emotional wellbeing and mental health.

3.2 Whilst we have carried out considerable engagement to date, we acknowledge the need to develop this further, to enable children and young people to actively engage in service redesign and commissioning. Appendix 2 provides a summary of work to 2013/14 including:

- Me Festival
- Youth Health Champions
- Dudley Young Health Researchers
- Holly Hall Academy engagement
- Dudley College Health and Social care students
- Phase Trust
- “Speak Up, Speak Out” Report

We have continues to ensure that the “Voice of the Child” is incorporated in to all our service developments.

3.3 The key messages that children and young people are telling us are: -

- emotional wellbeing and mental health are identified as key areas where young people aged 11-19 need support, in particular the opportunity to learn more about the impact of poor emotional and mental health on other areas of their life;
- having someone they trust to talk to about mental health, emotional difficulties and relationships is important;
- they want better information on services and how to access them;
- they should be able to self-refer to relevant services;
• they want to contribute to the commissioning and development of services;
• they want an increase in the provision of positive recreational activities;
• being able to access constant levels of support and services throughout their teenage years is important and there should be no gap in provision for those aged 16-18.

3.4 We commission jointly a post through our local Council for Voluntary Service to facilitate more effective engagement with young people.

3.5 We are also investing in the following areas to build resilience in our engagement mechanisms:-

• commissioning the “Young Health Champions” through a collaborative approach between the CCG, Dudley MBC, Healthwatch Dudley and the local voluntary sector: This work is based on the principles of services being co-designed, co-produced and/or delivered by young people so that services meet their needs and improve outcomes. The design process of discover, define, develop, deliver will be used;
• working with Dudley Youth Service to recruit young people aged between 16-25 who will help to undertake research on young people’s views about the most appropriate services to be made available to young carers and young adult carers within the Dudley borough.

3.6 We will apply the principles of person-centred care. For us this means:-

• focusing on what really matters to people; enabling them to make informed decisions about their health; be supported to manage their conditions and stay as independent and in control as possible;
• working in partnership with citizens and communities to ensure that services meet local needs; give people a voice; embrace all the resources of the community;
• engaging with citizens and communities in new ways to build collaborative relationships that recognise that different roles and perspectives are a constructive force for change and crucial when designing and delivering local services.

3.7 Our services will be built upon the ethos of person-centred care and each service user will have a personalised care plan with self-set goals and outcomes.

3.8 Our service specifications will be outcomes based. These outcomes will be developed collaboratively with services users and carers through a number of mechanisms. This will include but not be limited to a service user reference group which will advise the CAMHS Transformation Group (see Governance and Accountability below).
3.9 To ensure that we are able to measure new outcomes, including metrics such as reduced social isolation, educational attainment etc., we will use our Personal Social Impact Action Measurement System (PSIAMS) tool. It is an intervention and outcomes based system that has the whole person at its core; it uses a social triage approach to support moving the service user towards independence, self- sustainability and building social capital. PSIAMS focuses on the key issues faced by individuals with complex or multiple needs, identifying multiple needs and treating these based on their level of urgency.

3.10 We will also use Dudley’s Integrated Patient Experience Reporting System, which is now being expanded into community and primary care services (including Mental Health). The CCG’s smart phone “My experience” app provides real time feedback on service users’ experience of existing services. This will provide us with intelligence on patient experience. This will be supported by a smart phone application to capture, patient experience comments and Friends and Family Test results. This is being rolled out to mental health services in 2016/17.

4.0 Local and National Drivers

4.1 This plan is informed by local and national policy in addition to Future in Mind. This includes:-

- Five Year Forward View.
- The Care Act 2014.
- Closing the Gap (DH, 2014).
- Mental Health Act 2007.
- No Health without Mental Health (DH, 2011).
- Dudley Health and Wellbeing Strategy.
- Dudley Council Plan.
- CCG Strategic Commissioning Plan 2013.

4.2 Other relevant policy and contextual drivers include guidance from the National Institute for Health and Care Excellence; access and waiting time standards for children and young people with an eating disorder; DfE guidance on Behaviour and Counselling; Transforming Care and the Crisis Care Concordat.

5.0 Local Needs Analysis

5.1 In 2013 the Dudley population was 314,400 of which 50.8% were female and 49.2% male. A total of 75,203 children and young people aged 0 to 19 live in Dudley (National Census 2011). This is 24.5% of the total population in the area. Following a continued rise in the birth rate, there is an increasing
number of children in the early years age bands, and primary school numbers have recently begun to rise and will flow through to secondary school from 2019/20.

5.2 The proportion of children and young people from black minority ethnic groups is rising and they now represent 18.3% of the school population and 20% of 0-5 year olds. The diversity of ethnic groups has increased particularly in terms of migration from Eastern Europe. There has been a rise in the number of children for whom English is an additional language (from 10.7% in 2012 to 11.5% in 2015).

5.3 24.5% of the population (using IMD 2010) now live within the 20% most deprived areas of England compared with 22.9% in 2007. 34% of 0-17 year olds in Dudley are resident in the most deprived quintile of the income deprivation affecting children index, 2015 (IDACI). 31% of 18-24 year olds are resident in the most deprived quintile of the index of multiple deprivation, 2015 (IMD). These areas are principally in a zone covering Dudley, Pensnett, Netherton and Brierley Hill, but also include parts of Coseley, Lye, Halesowen and Stourbridge.

5.4 Child poverty has remained static in recent years, with 22.1% of dependent children in Dudley under 20 living in a household in poverty (based on low family income) - nearly one in four of all children. This is slightly higher than the equivalent national rate (20.1%) but below the West Midlands region average (22.7%). The highest levels of child poverty are clustered in a relatively small concentration of deprived localities.

5.5 As at March 2015, 93.9% of academic 16 year olds were participating in education, employment or training (close to the statistical neighbour average) and 85.5% of academic 17 year olds (compared with a statistical neighbour average of 86.5%). This is a slight fall on the previous year for both ages.

5.6 As at March 2015, 606 young people were NEET (5.5%), a reduction from 5.9% last year. This compares with 5.3% (West Midlands average) and 5.2% (statistical neighbour average). 8.9% (1,007 young people) were “not known”, an increase from 6.9% the previous year, and higher than the England, West Midlands and statistical neighbour averages.
5.7 From a social care perspective, overall demand on children’s services has been increasing over the last 5 years which accords to the national trend. The current demand is based around the following data:

- for the year to 31st March 2015, 13,681 contacts were received by Children’s Social Care Teams; a rise of 8.32% on last year;
- there are 2617 children open to social care, 1543 of which are Children in Need (September 2015);
- the rate of CIN was 447.8 per 10,000 children (at 31st March 2015), significantly higher than the national average of 346.4 per 10,000 children and the statistical neighbour average of 375.4;
- there are presently 340 children subject to Child Protection Plans (September 2015);
- historically we have had lower rates of children subject to a Child Protection Plans than comparators, however, this rate has increased and is currently at 45.3 plans per 10,000 children in line with comparators;
- Children in Care in Dudley have increased by approximately 24% over a 5-year period from 610 as at March 2010 to 755 as at March 2014;
- there are presently 727 Looked after Children (September 2015), which has reduced by 5% since September last year;
48% of Looked after Children are placed outside of Dudley.

The detail provided around our local demographics and specific emotional health and wellbeing needs of children and young people shows that Dudley is a diverse and changing borough with some specific challenges that this plan must address in its implementation:

- the spread of affluence and deprivation means that we need to have targeted approaches to influence and meet the needs of local communities – “targeted universalism”;
- the diverse nature of our communities requires us to ensure equality of access for protected groups across our interventions and reduce inequalities, particularly around meeting the needs of BME groups and reduce inequalities;
- demand for services is increasing, requiring greater focus upon preventative interventions and work around resilience.

5.8 **Social, emotional and mental health needs assessment.**

In 2015-16 we commissioned the Centre of Mental Health to undertake a Needs Assessment (NA) to further understand the social, emotional and mental health needs of our children to inform how we will transformation of our local mental health and emotional wellbeing service offer over the next five years. The identified needs were mapped across the five key themes identified in *Future in Mind* from early prevention through to specialist interventions.

5.9 Based on the NA we are redesigning our existing services and new service developments based on the model below to ensure that we remove the “Tiered” approach.

5.10 The existing LTP includes a local need analysis based on existing population and demographic data available at that time. It was acknowledged by our Local CAMHS LTP Steering Group that a more in depth needs assessment
needed to be undertaken. This was one of the key priorities for funding from the 201-16 allocation.

The approach that was taken was to investigate the following four areas:-

- An assessment of children and young people’s needs for mental health support in Dudley, using local and national data and intelligence.
- A review of existing provision for children and young people’s mental health, drawing on information from services and consultations with professionals, parents and carers and young people in the borough.
- An assessment of the gaps between current need and provision and the opportunities to improve support to children, young people and families in Dudley.
- An analysis of priority areas for action going forward and recommendations on how these might best be addressed.

5.11 Key Findings from the Needs Assessment

Based on wider mental health promotion evidence, we are applying the Centre of Mental Health’s version of assessing SEMH needs across the spectrum.

This formula aims to build strong mental health from the first spark of life, to de-escalate and restore good mental health early pending any deterioration and seeks to maximise chances of promoting improvement and recovery once children develop different severities of illness or diagnosable needs.

<table>
<thead>
<tr>
<th>Children’s mental health needs</th>
<th>Proportion of children needing help</th>
<th>Whose responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal needs</td>
<td>100%</td>
<td>Whole system</td>
</tr>
<tr>
<td></td>
<td>All children and young people and families need resources and assistance to build strong mental health in children.</td>
<td></td>
</tr>
<tr>
<td>Targeted or early help needs</td>
<td>15%</td>
<td>Whole system</td>
</tr>
<tr>
<td></td>
<td>Some children and young people need extra help to build resilience because they face greater exposure to risk. Some children also have deteriorating mental health and need early help to deescalate and restore good wellbeing.</td>
<td></td>
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<tr>
<td>Children with less complex diagnosable needs</td>
<td>7%</td>
<td>School counselling, voluntary sector high quality counselling, primary mental health support – using NICE guidance support</td>
</tr>
<tr>
<td></td>
<td>Some children will have less complex and risky diagnosable level needs</td>
<td></td>
</tr>
<tr>
<td>Children with complex and more risky needs</td>
<td>1.85%</td>
<td>Specialist CAMHS and services seeking to avoid</td>
</tr>
</tbody>
</table>
Children with highly risky, complex or specialist needs

| Children with highly risky, complex or specialist needs | 0.075% Some children will have highly complex, concerning and specialist diagnosable mental health needs. | Inpatient settings, broader system ‘step down’ services – using Nice guidance support. |

5.12 The following section describes the key findings, recommendations and proposed actions that will be considered and endorse as to how we will transformation of our local mental health and emotional wellbeing service offer over the next five years. The needs assessment has identified how many children and young people of different age groups in Dudley are likely to need support of SEMH services at any one point in time.

That said, there's no clear-cut and simple formula for working out how many infants, children and young people require what range of services across this whole spectrum of need. Many methodologies used previously to plan services are not sufficiently focused on mental health promotion and early intervention and are more focused on diagnostic presentations and the largely 'out of favour tiered system. In order to assess the scale of likely need and the extent to which this is met through current investment and resources, we are using the Centre of Mental Health’s service planning methodology. In the interests of simplicity, we have considered need across three different age bands to facilitate planning, commissioning and providing services at these different stages of need.

5.13 **0-5 year olds**

There are around 19,652 infants and children aged 0 to 5 in Dudley based on recent population estimates. During routine contact with universal primary care, maternity services and the Healthy Child Programme, families benefit from help that focuses both on the physical and emotional wellbeing of their child. This can include the role played in an infant’s development by positive attunement, which ‘jump starts’ infant’s cognitive and emotional health, sensitive and positive parenting and of attachment which helps children to self soothe and regulate emotions and behaviour over time.

Infants and toddlers frequently pass through transient socially and emotionally challenging ‘phases’ during early years which subsequently resolve as part of normal child development (Olds, et al., 1997). However, some children, exposed to high and ongoing levels of environmental and family risk, get stuck in negative patterns of relating to the world around them which can be distressing and damaging for both child and parent/carer.

In terms of what we know about families at risk during early years, based on locally available data:-
• around 500 mothers a year in Dudley will have diagnosable mental health difficulties ideally needing fast track access to Improving Access to Psychological Therapies or to specialist perinatal/secondary mental health care;
• around 3,000 mothers will smoke during pregnancy;
• around 150 parents will have under age conceptions;
• around 3,000 children in this age group in Dudley may experience maltreatment (Gilbert et al 2009);
• around 4,000 children in this age band may also be living in poverty in Dudley;
• some will experience many or all of these challenges at once.

We currently lack good quality UK data on the prevalence of pre-school diagnosable level social, emotional and mental health difficulties. The new child psychiatric morbidity survey will for the first time include under-fives in its survey reporting back in 2018. In the absence of good data, our best indicator of the scale of need comes from international evidence reviewed by Eggar and Angold, 2006 who note a midpoint of around 20% for the prevalence of these more severe social, emotional or mental health difficulties during early years. Table below estimates the number of under five year olds likely to present with diagnosable level difficulties in Dudley.

<table>
<thead>
<tr>
<th>Pre-school prevalence rates for diagnosable disorders</th>
<th>Estimated numbers of children in Dudley aged 2-5 years with diagnosable difficulties</th>
</tr>
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<tbody>
<tr>
<td>Any diagnosable mental health condition</td>
<td>20%</td>
</tr>
<tr>
<td>Hyperactivity conditions</td>
<td>4%</td>
</tr>
<tr>
<td>Any diagnosable severe behavioural difficulty</td>
<td>9%</td>
</tr>
<tr>
<td>Any diagnosable emotional difficulty</td>
<td>13%</td>
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</tbody>
</table>

Taking all of these factors into account, we have estimated the following very broad estimates of likely need based on 2015 estimates of the 0-5 child population.
5.14 **Children and young people aged 5-16**

The figures below summarise how many school aged children and young people you would expect to find presenting with various different levels of need in Dudley. All children and young people should receive some input to strengthen their mental health and well being, some will be exposed to risk factors which undermine their mental health requiring whole system responses to strengthen resilience. A smaller number will have common diagnosable mental health conditions and will require swift action to support and restore mental health.

About 8% of children in this age group will have a diagnosable level mental health need. Most needs should be met through NICE guidance compliant parenting support or primary care/targeted therapeutic services. The following table provides a rough breakdown of how many children aged 5-10 are likely to have different types of diagnosable needs in Dudley.

<table>
<thead>
<tr>
<th>Likely prevalence of diagnosable conditions in Dudley's primary school age children</th>
<th>Number of children aged 5-10 based on current population</th>
<th>Number of children based on anticipated reduction of 1% in 2020 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable level conduct problem</td>
<td>1,126</td>
<td>1,115</td>
</tr>
<tr>
<td>Diagnosable level emotional problems</td>
<td>541</td>
<td>536</td>
</tr>
<tr>
<td>Diagnosable level hyperkinetic conditions (e.g. ADHD)</td>
<td>360</td>
<td>356</td>
</tr>
<tr>
<td>Likely to meet threshold for diagnosis with autism</td>
<td>225</td>
<td>223</td>
</tr>
<tr>
<td>Likely to have other diagnosable conditions</td>
<td>90</td>
<td>89</td>
</tr>
<tr>
<td><strong>Total number of 5-10 year olds in Dudley with a diagnosable level need</strong></td>
<td><strong>1,734</strong></td>
<td><strong>1,717</strong></td>
</tr>
</tbody>
</table>

3400 more children will also have sub threshold needs or face risk factors undermining their resilience requiring early multi sector targeted help.
5.15 Young people aged 11-15 years

The figures below demonstrate the likely scale of social, emotional and mental health needs among 11-16 year olds in Dudley.

<table>
<thead>
<tr>
<th>Likely prevalence of diagnosable conditions among Dudley’s 11-16 year old school age population.</th>
<th>Numbers based on current population projections</th>
<th>Numbers based on 2020 population projection ( -1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosable level conduct problem</td>
<td>1,181</td>
<td>1,169</td>
</tr>
<tr>
<td>Diagnosable level emotional problem</td>
<td>895</td>
<td>886</td>
</tr>
<tr>
<td>• and who meet the criteria for PTSD</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Diagnosable level hyperkinetic conditions (e.g. ADHD)</td>
<td>251</td>
<td>248</td>
</tr>
<tr>
<td>Likely to meet threshold for diagnosis with autism</td>
<td>143</td>
<td>142</td>
</tr>
<tr>
<td>Likely to have an eating disorder</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td>Likely to have any other diagnosable condition</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Any diagnosable difficulty</td>
<td>2,058</td>
<td>2,037</td>
</tr>
</tbody>
</table>

In 2016, The Health Behaviour in Schools Survey for Dudley noted that 16% of students in this age group self-harmed, with 5% harming themselves often or always. This rate was weakly but significantly higher than in 2014. We know that young women and LGBT young people are much more likely to report self-harming than other young people. Self-harming is also much
more common among young people with diagnosable level mental health difficulties.

<table>
<thead>
<tr>
<th>Secondary school students.</th>
<th>Percentage</th>
<th>Likely number of students affected in Dudley in secondary school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-harming often and always in 2016</td>
<td>5%</td>
<td>895</td>
</tr>
<tr>
<td>Self-harming rarely, sometimes, often, always in 2016</td>
<td>16%</td>
<td>2,863</td>
</tr>
</tbody>
</table>

There is no reliable data on the number of young people with suicidal thoughts or who have attempted suicide in this age band. Overall in England in 2014, there were 4 deaths by suicide among 10 to 14 year olds and 40 deaths for 15 to 19 year olds (a rate calculated as 2.5 per 100,000 young people).

5.16 **Young people aged 16 to 24 years**

The last national adult psychiatric morbidity survey (McManus, 2007) revealed that broadly 20% of young adults aged 16-24 years suffered with a diagnosable level mental health difficulty (not including substance misuse reliance and self-harming behaviour or those diagnosed with developmental difficulties such as autism). It provided some information on the scale of sub threshold social, emotional and mental health need for some but not all conditions (e.g. this information is available for eating disorders and adult ADHD). Understanding how many young people might have rising or sub threshold needs is important as there should still be a focus at this age on supporting those with escalating difficulties. Some of these sub threshold problems will resolve themselves naturally but for others such deteriorations in mental health may be a sign that they need help to prevent distressing and damaging crisis.

Adolescent years are the peak age for the first emergence of serious mental illness with three quarters of psychiatric conditions starting by age 24 (Kessler et al, 2005). There is good evidence that intervening early is important, having potentially long term benefits to the young person, to the public purse and to society more broadly (Knapp, 2010; (Patel, et al., 2007). There is also evidence that limiting the length and recurrence of diagnosable level conditions during teenage years reduces the chances of such episodes repeating during adult years (Patton, 2014).

<table>
<thead>
<tr>
<th>Likely numbers of 16-24 year olds in Dudley with diagnosable level and sub threshold mental health difficulties based on 2016 population estimates.</th>
<th>Likely diagnosable rates (2016 population estimate)</th>
<th>Estimate of lower level difficulties/symptoms who may need some support (based on 2016 population estimate)</th>
</tr>
</thead>
</table>
5.17 Suicide and self-harm

Based on 2007 data, about 1,462 young people aged 16 to 24 years in Dudley would have made a suicide attempt at some point in their life (McManus et al, 2007). Young men are more likely to complete a suicide attempt.

Based on 2014 national suicide rate data, there is a very low chance that any young person aged 15 to 18 would commit suicide (2.5 per 100,000); in the 19 to 25 age group around 1 young person would be projected to commit suicide.

5.18 Implications of the findings from the needs assessment and future planning.

This needs assessment concludes that there is insufficient integrated activity and investment in Dudley in early intervention to promote children, young people’s and families’ social, emotional and mental health capabilities. There is a gap in resources for children and young people with common mental health problems which have led to most voluntary sector therapeutic services and specialist CAMHS in Dudley being significantly oversubscribed. There may also be a sizeable gap between projected need and the reach of services during late teenage and young adult years. Finally, some key vulnerable groups (looked after children and their carers and children at risk of or victims of child sexual exploitation) who have greater likelihood of poorer mental health are not currently receiving an adequate service.

We therefore identified our key strategic priorities for service development that will be underpinned by:-

- ensuring that the voice of the child is incorporated into all children service developments and
- reducing health inequalities and promote equality.
- developing our workforce.
Section 9 describes the work that we have undertaken and the future developments that need to be embedded by 2020 to underpin our service developments.

Details of our developments that were funded in 2015-17, to meet our agreed service priorities are detailed in Section 10.

Whilst an update on our transformational priorities are provided in Section 11.

6.0 Governance and Accountability

6.1 We are committed to transparent and accountable delivery of this plan. It will be published on the websites of the CCG, Dudley MBC, the Health and Wellbeing Board and local partners enabling wider public access to planned developments.

6.2 This transformation programme will be driven by the Emotional Health and Well Being Steering Group reporting to the Children and Young People’s Alliance Board and ultimately the Health and Wellbeing Board. The Transformation Group will also be advised by our Service User Reference Group (see consultation and engagement above). This group will have specific responsibility for the development of the outcomes against which we will measure the effectiveness of our services and provide systematic feedback and intelligence on service performance to inform the commissioning cycle. A continual process of engagement with service users to shape and develop services will be an intrinsic feature of our transformation programme. The Terms of Reference and the membership of the Emotional Health and Well Being Steering Group are attached in Appendix 3.

6.3 The Health and Wellbeing Board has agreed to develop a Collaborative Commissioning Hub that will bring together the commissioning functions across the CCG, Children’s Services, Adult Services and Public Health. This will work on a number of agreed priorities with a specific focus on meeting the Health and Wellbeing Board’s statutory duty to integrate services. The emotional health and wellbeing of children and young people is an early
priority for the team that will support this work. The team will have links with specialised commissioning, Health and Justice Commissioning, our local Transforming Care Partnership for People with Learning Disabilities and the Youth Offending Service Board.

6.4 Membership of the Emotional Health and Well Being Steering Group is as follows:-

- Director of Office of Public Health (chair)
- Clinical Lead for Mental Health, Dudley CCG
- Clinical Lead for Children and Young People, Dudley CCG
- Commissioning Manager for Children and Young People, Dudley CCG
- Finance Manager, Dudley CCG
- Strategic Commissioning Manager, Dudley MBC
- Service Manager, Strategic Partnerships, Dudley MBC
- Head of Service for Children in Care and Placement Resources, Dudley MBC
- Head of CAMHS, Dudley & Walsall Mental Health Trust
- Programme Manager for CAMHS Dudley & Walsall Mental Health Trust
- EHWB Co-ordinator Dudley & Walsall Mental Health Trust
- Assistant Director of Barnardo’s Children’s Services
- Manager of Phase Trust
- Chief Executive, The What? Centre
- Children’s Development Officer, Dudley Council for Voluntary Service
- Task and Finish Group Leads
- Performance Manager, NHS England

6.5 Task and Finish Groups

The EH&WB Steering Group has established 6 Task and Finish Groups, each with a lead to ensure that the service development within the plan are implemented within the agreed timescales and that regular updates are presented to the EH&WB Steering Groups. These are:-

- Promoting resilience, prevention and early intervention.
- Early Help and Targeted Services.
- Improving access to effective support.
- Crisis Intervention.
- Care for the most vulnerable.

Collaborative Commissioning

6.6 Opportunities for collaborative commissioning are discussed at the Future in Mind Group which is led by the West Midlands Clinical Network and Clinical Senate.

6.7 The opportunity to work collaboratively with NHS West Midland CAMHS is facilitated at the Future in Mind meetings. Areas for collaborative commissioning include:-
• working with NHS England Specialised CAMHS;
• out of Area Looked after Children’s Placements;
• health and Justice Commissioning;
• new models of care for acute and community services;
• transforming care programme;
• joint commissioning with Local Authorities.

Mental Health Sustainability and Transformation Plan

6.8 This plan will embedded in the Black Country’s Sustainability and Transformation Plan (BCSTP) as part of the Mental Health work stream. With the ‘amalgamation’ of the providers, there will be horizontal integration of services. This is being led by Wolverhampton CCG.

6.9 The STP includes high level plans by senior managers (from the 4 CCGs) that there will be the consideration commission services that cross the front print.

6.10 This opportunity provides the CCGs to develop an integrated commissioning and service delivery model and, in particular, to develop new highly specialised services in the Black Country such as Children’s Tier 4, secure services and services to manage those with personality disorders. For these high cost low volumes this will result in reducing role duplication, streamline service management and allow investment in front line staff development and up-skillling.

6.11 By agreeing common service specification/models across CAMHS, we will be able to develop standardised and potentially more cost effective solutions, roll out locally commissioned services across the Black Country and by comparing performance reduce variations. With respect to developing Black Country wide service specifications for children and young people’s mental health services:-

• Dudley CCG on core CAMHS;
• Sandwell CCG is leading on Eating Disorders and
• Wolverhampton CCG on Crisis, Intensive Community Support and Paediatric Liaison Services.

6.12 Dudley and Walsall CCGs already share a pan trust specification for the Community Eating Disorder Service and the Tier 3.5 ICAMHS. Regular contact and communication enables information sharing with the aim of aligning services provided by the same provider trust.

7.0 Formulation and Approval of the Plan

7.1 Leads where identified for each of the Future in Mind five key themes and the Project Lead met with the individuals to undertake a baseline assessment of their views as to where they thought we were, as an economy on the 49 actions identified in document. These discussions identified where we were doing well and where there were service gaps. It was also discussed have existing services could be improved and what actions needed to be
undertaken to mitigate the gaps in service provision. We also reviewed the
data in our JSNA and the available needs assessment data for children and
young people with Mental Health and Emotional Health and Wellbeing
problems. We recognise that the needs assessment data is incomplete and
an Emotional Health and Mental Health Needs Assessment is currently being
undertaken.

7.2 This plan will be approved by the Health and Wellbeing Board at its meeting
on the 13th December 2017. The CCG is issue a statement on its website
indication when the final refresh will be published.

7.3 We also have ongoing consultations with children, young people and their
families regarding the proposed service developments in this plan and agree
with them, and our partners the detail and timescale of the Implementation
Plan.

8.0 Current CAMHS Provision in Dudley - Baseline 2015.

8.1 As stated earlier, CAMHS provision in Dudley is currently based upon the
national four tiered strategic framework. The table below describes our
interventions and funding that contribute to each of the tiers from 1-4.

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Service</th>
<th>Description</th>
<th>Cost per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMBC</td>
<td>Family Information Service</td>
<td>Universal Information Directory Service</td>
<td>£139,000</td>
</tr>
<tr>
<td>DMBC</td>
<td>Children’s Centres</td>
<td>Child Development and School readiness Parenting aspirations and parenting skills Child and family health and life chances</td>
<td>£3,000,000</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudley CCG</td>
<td>The What? Centre</td>
<td>A counselling service for young people, (13-18 years old) and young people with a disability up the age of 25, with a focus on young people who may be at risk.</td>
<td>£135,000</td>
</tr>
<tr>
<td>Dudley CCG</td>
<td>KOOTH</td>
<td>An online counselling service for young people aged 11-25.</td>
<td>£62,000</td>
</tr>
<tr>
<td>Dudley CCG</td>
<td>Children’s Learning Disability Team</td>
<td></td>
<td>£178,111</td>
</tr>
<tr>
<td>DMBC</td>
<td>Education Psychology Team</td>
<td>Assessment service for children and</td>
<td>£473,000</td>
</tr>
</tbody>
</table>
young people in educational settings to identify what support children with additional needs require. This includes school counselling services

| DMBC | The Family and Adolescent Support Team (FAST) | Triple P Parenting Assessments Family Group Conferencing | £350,000 |
| DMBC | Early Assessment Team | Completion of Early Help Assessments | £107,000 |
| DMBC | Family Intervention Team | Troubled Families | £1,500,000 |
| DMBC | Connexions | 19 year service supporting young people to enter Education, Employment and Training. | £500,000 |
| DMBC | Teenage Pregnancy Team | Supporting the reduction of conception rates | £134,000 |

**Tier 3:**

| Dudley CCG | Specialist CAMHS | A mental health service for children and young people aged 0-16 years with identified or suspected emotional, behavioural or psychological/psychiatric difficulties for which specialist intervention is required. | £2,774,780 |
| Dudley MBC | Looked After and Adoptive Psychology | Specialist psychologist service for children and young people who are looked after or adopted aged 0-25 years. | £287,255 |
| Dudley CCG | Neurodevelopment Delay Service | An in depth and holistic medical and social assessment to | £221,604 |
support children, from birth up to 5 years of age, in need of additional support and input.

<table>
<thead>
<tr>
<th>Dudley CCG</th>
<th>Youth Offending Team</th>
<th>Specialist service to support youth offending team.</th>
<th>£1,295,961</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMBC</td>
<td>Young Person’s Tier 3 Substance Misuse Service</td>
<td>A Tier 3 Substance Misuse Service (drugs and alcohol) for young substance misusers that provides a range of specialist interventions that support a recovery focused treatment system.</td>
<td>£347,611</td>
</tr>
</tbody>
</table>

| Tier 4: | |
| NHS England | Highly specialist CAMHS | Day and inpatient services and some highly specialist outpatient services. | £810,000 (2014-15) |

| Total | £12,315,322 |

Prior to the allocated funding for CAMHS Transformation the total identified funding of services to support specialist mental health and emotional health and wellbeing needs of our 0-18 year old population was £12,315,322 in 2015-16.

**One Year On**, the first report from the National Advisory Council for Children’s Mental Health and Psychological Wellbeing acknowledges that the confusing language used within the sector is a barrier to service improvement and that the tiered approach should no longer be used. Therefore we have mapped our services against *universal, targeted and specialist* definitions are depicted in the diagram below.
The mapping and descriptions of the services that were available in 2015 are presented in Appendix 4.
9.0 **Underpinning Themes**

**Ensuring that the voice of the child is incorporated into all children service developments.**

9.1 We will increase children, young people and parents/carers active participation in shaping the system by:-

- expanding the Emotional Health and Well Being Steering Group to have a broader membership including wider voluntary sector representatives, parent/carers and young people;
- establish task and finish groups (including therapeutic providers, social care, parents/carers and children and young people) to facilitate better partnership between parents/carers and local therapeutic services;
- ensuring that commissioners, school forum leads, parent/carers and children will work together to create an age-appropriate social, emotional, mental health and wellbeing template which can be adapted for school/college websites. This should help local children and families access good quality information on child and youth mental health and improve signposting to help and advice.

The Dudley Governance structure for social, emotional and mental health needs to include a systematic process for children, young people and parents/carers to feed into, shape and refine developments. To facilitate this we will:-

- develop a multi-disciplinary workforce development plan and plan joint training opportunities on the social, emotional and mental health needs of children;
- work with all agencies in Dudley to develop a range of detailed whole sector pathways focusing on specific priority issues highlighted by this needs assessment including ‘supporting healthy behaviour’ (including anti-bullying activity, school exclusion and CSE prevention and de-escalation and ADHD pathway development), promoting attachment and helping children affected by trauma;
- develop approaches that support positive outcomes for children and young people’s emotional health and well-being will be built into all contracts and service specifications in Dudley;
- develop more joint commissioning arrangements and the creation of a jointly agreed social, emotional and mental health strategic framework and outcomes for supporting children, young people and families in Dudley. Outcomes should make sense to children, young people and children;
- produce a dashboard of key performance indicators tightly drawing together whole system activity. The will be reviewed quarterly by the Transformation Board and Children’s Alliance Board.
Reducing health inequalities and promote equality.

9.2 An effective system supporting the mental health of all children and young people is one that:

- Puts at its heart the strengths and needs of children and young people and families;
- Prevents problems, helps children get back on track or facilitates early help to de-escalate, manage and prevent the re-occurrence of a crisis;
- Has in place a confident and skilled whole system workforce supported by effective multi-agency information sharing and joint commissioning;
- Has in place a workforce working at different stages of the life span and across sectors by:
  - working to common outcomes and backed up by a clear shared understanding of roles and responsibilities in the system so that children and young people and their families are able to receive timely and appropriate help support and don’t fall through the gaps;
  - with competencies in understanding, promoting and preserving health, emotional wellbeing and behaviour;
- Recognises the important role that maternity services, primary care and early years support plays in building strong family mental health and emotional wellbeing – supporting early identification and treatment for parents with poor mental health, helping early maternal/infant communication and promoting healthy attachment and child development;
- Builds capacity in parents, children and young people so that they can promote and preserve wellbeing and also know how to help themselves or where to go if they need extra help (Department of Health, 2015);
- Recognises the important role that whole-school approaches play in supporting children and young people’s mental health and attainment;
- Draws together and relies on coordinated multi-agency (whole system) activity to:
  - promote mental health in children, young people and families right from the first spark of life and providing continuity through age-related transitions;
  - strengthen protective factors and assets that build strong child and youth mental health and reducing influences that compromise a child’s healthy social and emotional development (e.g. exposure to maltreatment);
  - help children build resilience to cope with and manage inevitable setbacks;
  - give extra help to children struggling developmentally, socially or emotionally de-escalating difficulties early and emotional ranges;
  - intervene as early possible to support those presenting with diagnosable difficulties.
• Provides a clear gateway with trouble-free access to an easy to understand offer of help for all children, young people and families. The offer should be:

- developed in collaboration with parents, children and young people and backed up by a single gateway to get help;
- needs-led rather than diagnosis-led or merely focused on what services or funding is available.

• Commits to an ‘invest to save’ approach: recognising that inadequate early investment stores up problems for all sectors later on, damaging children’s outcomes, reducing quality of life and building up later crisis.

• Has an effective and child/youth/family/carer friendly service design - providing ‘the right help at the right time in the right place’.

• Ensures equal parity of esteem for mental and physical health.

• Minimises the chances of children falling between the gaps of systems of care – particularly during adolescence which is the peak age for escalating mental illness.

• Works together to achieve best outcomes for all children - regardless of gender, sexuality, ethnicity, religion, class and disability (recognising that some families, children and young people face greater risk adversity and need more help).

• Recognises that some children have poorer chances of escalating mental health than others. This includes:

  - children exposed to maltreatment, neglect and/or family violence;
  - children whose parents experience poor mental health themselves or whose parents are reliant on substances;
  - looked after children and care leavers and children;
  - children with learning, neuro disabilities and long term physical health conditions;
  - children who are at risk of or victims of sexual exploitation;
  - children from some BME communities as well as those from some migrant communities;
  - children who go missing, are homeless, are involved in gangs (or have families involved in gang activity);
  - children on the edge of or in the youth justice system – particularly those with severe and persistent early starting behavioural problems;
  - Lesbian, gay, bi-sexual and transgender children and young people;
  - children who are excluded from school, who are bullied or who are both bullies and are themselves victimised;
  - children reliant on alcohol or substances;
  - whole system activity should be guided by best quality evidence to ensure what is offered has the best chance of making a difference to children, young people’s and families.
The approach we are taking to reduce health inequalities to our services is to ensure that all services adhere to the above principles to reduce health inequalities. We will also ensure that all services will audit the ethnicity of access to services. We have also strengthened the universal offer and invested in training of all professionals in contact with our children and young people that may have a SEMH need.

**Developing our workforce.**

9.3 As outlined in Section 2 the CCG is a national ‘vanguard’ site for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services. Dudley is in the process of procuring a multispecialty community provider (MCP) under the vanguard process.

9.4 Our vision is to put Dudley patients at the heart of properly integrated GP-led health and care services, with focus on improved health and wellbeing, better outcomes and a more engaged community. This demands a clinically-led, whole-system transformation of the way we commission health and social care. That aim has fresh impetus and sharper focus following our successful bid for Five Year Forward View’s vanguard status.

9.5 We recognise, in conjunction with our partners, the opportunities that exist to use this model to deliver more integrated children’s services. We will develop a more integrated response to children with emotional health and wellbeing needs and complex health care needs and unlike the adult, schools and colleges has a significant role. The intention will be to replicate integrated working across physical health, mental health, children’s social care and education services – all on the basis of a team with shared responsibility, for a shared population and shared objectives. Our CAMHS Transformational Plan is consistent with this approach and is part of a wider service redesign of our Children’s and All Age Mental Health Services and is central to our Children’s Early Help Offer for children, young people and their families. The proposed service delivery model is presented in Appendix 1.

9.6 Our local commitment to creating a new care model, part of which involves staff working in multi-disciplinary teams “without walls” will support this. We are investing in a significant organisational development programme to give staff the skills to work in teams, across organisational boundaries and create a culture where there is shared responsibility for a shared set of outcomes.

9.7 We wish to see staff working across organisational boundaries on the basis of agreed and assessed competency requirements, rather than through traditional professional silos. This will create the climate where the needs of a young person can be assessed and responded to holistically, delivering better outcomes.

9.8 This programme will include:-

- team development and change management for MDTs;
• leadership development programme;
• development of clinical leadership;
• multi-organisational collaborative leadership programme.

9.9 Service transformation is dependent upon having a flexible and adaptive workforce. We are in the process of developing a whole system workforce redesign plan to create the workforce we require across primary, community and secondary health care; social care; education and the voluntary sector. This will cover a 5 year time horizon and Emotional health Wellbeing and Specialist CAMHS transformation will form a key component of this.

9.10 As outlined in the Future in Mind document planning for mental health services for children and young people in the future requires a bottom-up consideration of the current competencies and capabilities of the existing workforce as well as an understanding of the capacity that will be required to deliver a workforce fit for the future. The role of Health Education England and Local Education and Training Boards will be crucial to establish local requirements and local practice through locally led needs assessments of current workforce capability and capacity. The CCG will be undertaking a skills and capabilities audit once the national work to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sector and independent sector has been undertaken.

9.11 In the process of undertaking the baseline assessment, through the interview process with key professionals, there is no doubt that everyone that works with children, young people and their families have ambition to deliver the best possible care and are committed to partnership working. The evidence provided in this plan demonstrates that there are a wider range of existing services available to support children, young people and their families but further work needs to be undertaken to integrate services and develop coordinated pathways with shared outcomes to realise the mutual benefits and outcomes.

9.11 Part of our approach will be to seek the views of our children, young people and their families to ask them how the workforce should be developed in a way that they understand to meet their needs. We will then engage with the professionals and ask them to audit their skills, competencies and practice against their ambitions. We have an imminent workshop with the students in one of our secondary school academies to seek their views on:

• what good/bad mental health looks like;
• raising awareness of what services/support is available;
• how they access existing services and their views of the quality of the provision;
• discuss what can affect mental health, for us to understand where there may be gaps in the services that we commission;
• where they actually go for help and support.
9.12 In the interim, an initial skills and competency framework will be developed and will be included in all new services specifications and service development as highlighted in this document. This will be tested out with children, young people and their families in subsequent workshops.

Dudley Workforce Skills Audit

9.13 Centre for Mental Health is currently in the process of completing:

- a needs assessment
- and co-producing a strategic action plan

to help strengthen and transform whole system mental health promotion and support for social, emotional and mental health and wellbeing for 0-25 year olds in Dudley.

As part of local transformation activity, the Office of Public Health have asked the Centre to investigate a methodology to assess whole-system workforce capabilities for supporting children both to thrive socially and emotionally as well as to maximise their chances of recovering swiftly from declining mental health in the borough. Workforce development in this field should not only be about building evidence-informed skills, competences and confidence; it should also be about creating a shared whole system understanding, vision and effective partnerships - creating a robust starting point for developing local pathways. It will help ensure that existing skills in the workforce are better identified and integrated across the local area and that any gaps are highlighted and addressed in strategic planning as Dudley moves forward. It will also ensure that the entire system (universal, targeted and specialist support) includes the necessary basic and specialist skills to help it move forward in a confident, evidence based and integrated way.

Methodology

9.14 The skills audit links closely with the current needs assessment and strategic planning already underway in Dudley. It uses the Child and Adolescent Mental Health Service (CAMHS) integrated workforce planning tool first developed as part of the CAMHS National Workforce Programme in 2011. It follows a recognised process set out below.

The workforce audit prioritised social care teams, school workforce, GPs and Tier2/3 therapeutic services supporting children’s mental health for completion of the tool. Further teams could adopt the tool going forward. It would include a focus on four main areas:

As a starting point for any skills and training audit, it will be important to get a better sense of the case mix for each therapeutic service (e.g. Targeted and specialist or Tier 2/3). The case mix, in combination with data forthcoming from the broader needs assessment, should provide a helpful proxy indicator of the mix of the specific skills needed locally. Detailed service data has not been readily available through the current needs assessment process for all...
services and ideally requires some short term multi-agency tracking to get a better idea of therapeutic caseload mix. This activity involved a one month audit focused just on presenting needs for all organisations working in tier 2 and 3 during September.

During the same period, we have asked all of those operating in targeted and specialist (Tier 2/3) therapeutic services to complete the online Self-Assessed Skills Audit Tool (SASAT). The SASAT is a well-established integrated CAMHS workforce tool used for those working in Tier 2 and 3 clinical therapeutic settings. This tool can be used to strengthen each practitioner's continual professional development. It also provides an overview of workforce interests, confidence, strengths and training needs at team, organisational and system level in a local area. The effectiveness of the audit process relies on getting a good response rate from local teams and would require local implementation backing and support. At the start of the initiative, we would seek to identify workforce development ‘champions’ who can promote and support this audit locally. The following teams/practitioners being asked to complete the online SASAT:

- Dudley Specialist CAMHS team
- Educational Psychology and school counselling team.
- The YOS health practitioner
- What? Centre team
- Kooth.com team
- School counsellors
- Barnardo’s counselling services for children affected by child sexual abuse
- Triple P/FAST parenting programme provider and team members
- Adult IAPT providers and teams (for 16 to 25 year olds).
Moving on to consider the skills and capabilities of the broader universal workforce, the Centre has identified a gap in the availability of an up-to-date and appropriate audit tool exploring skills, interest and confidence in social, emotional and mental health and wellbeing among those working in universal services. However, discussions with national CAMHS workforce development leads suggests scope to build further on the former Essential Capabilities developed as part of Children’s Workforce Development council in the mid-2000s and used as part of workforce development initiatives in areas such as Yorkshire and Humberside (Yorkshire and Humber Children’s Workforce leads group, 2013). We are therefore ask universal services and schools to complete an online audit exploring confidence and knowledge in respect of the following core capabilities which are deemed essential for supporting children’s social, emotional and mental health:

- Recognition of the importance of social and emotional health and their own role in promoting this.
- Understanding the local landscape of targeted services supporting social, emotional and mental health, referral routes and how to access support.
- Knowing how to communicate with children and young people including children with disabilities.
- Knowing about and recognising the importance of risk, protective factors and resilience in the face of adversity.
- Knowing about and recognising the impact of bullying.
- Understanding infant, child and adolescent development.
- Understanding the impact of parental mental health on children and young people.
- Understanding the importance of building positive emotional health, self-esteem and demonstrating the ability to incorporate this into own work.
- Ability to respond helpfully to a child or young person who is troubled, by listening appropriately.
- Ability to provide practical advice and support to parents.

Finally, current needs assessment activity has identified a number of diverse training providers in Dudley. We plan to map this provision more closely to support the creation of a more coordinated local training plan. This mapping will help identify what resources already exist but merely require better promotion in Dudley and which resources will need to be sought outside the borough.

**Workforce Plan**

The aim of our workforce plan is to ensure that all our universal, targeted, and specialised and paediatric services, and commissioners, are supported to develop their skills and knowledge in emotional health and wellbeing mental health needs of children and young people.
The Centre for Mental Health is currently analysing the returned data and comparing findings with best practice benchmarks producing an integrated and updateable workforce plan and summary report:

- identifying local strength in terms of current competencies, interests and confidence;
- identifying gaps or areas for development requiring further investment in training;
- pinpointing how competencies and expertise might link together to form clearer pathways for help benefitting local children, young people and families;
- analysing workforce demand and retention issues;
- highlighting local training needs and provision to support workforce development.

Ideally, this type of skills, interest, confidence and knowledge audit would go hand in hand with work to find out what parents and young people might value to promote their mental health literacy (e.g. knowledge about how to promote and identify when a child or young person is struggling and ability to understand what services might be best placed to help locally). This developmental work is being pursued through the Health Watch-supported Youth Researcher initiate.

We are also awaiting the benchmarking exercise that is being undertaken by the Mental Health Regional Workforce project for CYP that is being hosted by North Staffordshire Combined Healthcare NHS Trust.

A full workforce analysis and workforce plan will be completed by 31st March, 2018. A task and finish group will be established to support this work.

10.0 Transformational local developments and Improvements

10.1 Our local developments and improvements, to bridge the gaps identified in our needs analysis, are described under the following areas of service delivery: -

- Promoting resilience, prevention and early intervention.
- Improving access to effective support.
- Improving specialist early help and intervention for the most vulnerable.

10.2 Promoting resilience, prevention and early intervention

Promoting resilience, prevention and early intervention is a one of the key themes in Future in Mind. Investing in prevention and early intervention is one of our top 10 priorities and we have agreed to: -

- invest in and shift whole-system activity from dealing with mental health crises to earlier intervention. This will give children and young people the best start, will help build resilience and will help facilitate early help
to restore good mental health and benefit the public purse. Improved outcome data should be collected and monitored to evidence that this shift has taken place;

- to address the high numbers of Children in Need and Looked after Children in Dudley all commissioners will consider jointly implementing more evidence based early intervention approaches to reduce abuse;
- we will increase the number of children with early onset severe behavioural difficulties aged 2-10 years whose parents are reached by Triple P and other NICE guidance compliant parenting interventions;
- support schools and colleges, as key settings for children and young people to access universal and targeted support. Whole School Approaches, social and emotional learning and anti-bullying programmes will be supported to promote strong resilience;
- increase investment in talking therapies to address the current shortfall in pre CAMHS resources by implementing the Integrated Emotional Health and Wellbeing teams that will be located in and working closely with schools/colleges, the broader workforce in day-to-day contact with children/young people and with GPs. This team would allow Dudley to intervene earlier with around another 200 children a year.

10.3 The specific developments to meet these aims are described below.

**Early Help**

10.4 Our Early Help Offer for children, young people and families comprises of a Single Point of Access (SPA) that will “triage” all enquiries from any professional. A multidisciplinary team will be in the SPA that will assess the needs of children and young people who may benefit from a whole range of early help services and/or interventions. Children that require a mental health intervention will be referred to either CAMHS or, those not meeting the CAMHS thresholds, will be referred into the locality based multiagency Early Help Allocation Meetings and provided support or signposted accordingly to services other. Our Early Help Offer model is shown at Appendix 5. This is currently being updated.

10.5 Our Early Help offer reflects a collaborative approach rather than simply a provision. We believe that an effective early help offer has the following elements and we have plans to develop our approach in each area to ensure robust arrangements are in place. The strategy defines our arrangements and plans for:-

- operating consistent thresholds for accessing Early Help;
- ensuring that children and families who would benefit from early help are identified;
- providing effective arrangements for accessing Early Help;
- delivering Early Help in localities;
- workforce development.

10.6 There is no single service responsible for Early Help in Dudley. It is the responsibility of all services working with children and families to identify
where additional support is needed. There are, however, under the Council’s new model for children’s services, a number of existing services, economy wide that have a core responsibility in delivering services and support. Dudley’s Early Help offer is designed to contribute to the following outcomes:-

- children and young people are safe from harm in the home, outside of the home and online;
- children and young people have the best start in life and are ready for school;
- children live healthy lives;
- children and young people learn well;
- young people make positive transitions into adulthood;
- families are supported to provide safe and supportive homes for their children.

10.7 To measure progress against these key desired outcomes, we will put in place an Outcomes and Performance Framework with outcome indicators and performance measures to monitor the extent to which we are contributing to these population outcomes and determine whether our strategy has been effective. This will be shared across health and social care to ensure we are effectively monitoring the whole safeguarding system across all levels of need, and the extent to which thresholds between those levels of need are effectively applied.

Dudley MBC, as agreed by the Early Help Steering Group, are currently developing this Outcomes and Performance Framework

**Early Years**

10.8 The CCG is working closely with the Council and our providers of children’s health services to develop an integrated pathway and service delivery model for the 0-5 year olds. The transfer of the commissioning responsibility of Health Visitors to the Office of Public Health has presented an ideal opportunity to integrate the service into Children Centres. This service redesign is ongoing, as part of the CCG’s MCP developments for an Integrated Children’s and Young Peoples service delivery model.

10.9 Aligned to this model is the service redesign of the Children’s Assessment Service for children, aged 0-3 years, with a neurodevelopment disorder. This service has now been transferred, from its former acute setting into the community. It is our intention to transfer it into locality based children centres, expand the age range up to 5 years and integrate the service with the 0-5 psychological assessment service that currently sits within CAMHS.

*Progress on this ongoing development is described in Section 11.*

10.10 Our community midwife service has also being reconfigured around the Children Centres and there will be a named midwife for each locality with aligned teams. Within the service there are nominated specialist for the following areas: -
• safeguarding
• vulnerable women including teenagers
• breast feeding
• long term conditions
• screening
• practice development
• risk and governance

10.11 They have a significant role in supporting our vulnerable children, young people and their families. The integrated approach to service delivery for 0-5 age group will result in the delivery of the following objectives:

• closer integration between the Healthy Child Programme and the Early Years Foundation agenda;
• contribution to the delivery of successful early help and early intervention to address inequalities;
• integration of evidence based services and pathways (including high impact areas for Health Visiting services which include Transition to parenthood and the early weeks, maternal mental health and school readiness);
• identification of the appropriate skill mix in the 0-5’s workforce and develop a model of reform to enable seamless services and transition for families;
• having a standardised method of performance management with the 0-5s workforce and for contract management to ensure best practice and cost effectiveness;
• creation of a workforce development plan to ensure that the services around the family are fit for purpose.

Multiagency Safeguarding Hub

10.14 The Multi Agency Safeguarding Hub (MASH) has been in existence since May 2016. The MASH is the single point of contact for all safeguarding and early help concerns regarding children and young people in Dudley. It brings together expert professionals, from services that have contact with children, young people and families, making the best possible use of their combined knowledge and information to keep children safe from harm.

10.15 The MASH:

• Is a ‘front door’ to manage all safeguarding referrals;
• Provides a secure and confidential environment for professionals to share information;
• Enables early identification of potential safeguarding concerns and facilitates access to timely and effective interventions;
• Prioritises referrals using Red, Amber & Green (RAG) rating;
• Refers cases to other agencies where appropriate;
Where necessary, activates ‘immediate response’ social work services to provide protection for a child or young person(s).

101.6 When the MASH receives a referral, the MASH Screening Officers first check if the child is already known to a CYP Service e.g. Social Care, Early Help and Youth Offending before taking forward a proportionate and consistent response. For Children and Young people with emotional health and well being needs the MASH will ensure that children and young people receive the right support at the right time.

**FAST and Parenting Assessment Service**

10.17 The Council is in the process of remodelling the FAST Team and the Parenting Assessment Service. As part of the Early Help Offer and the MASH the team offers a range of services to families who are experiencing difficulties in parenting their children. The team aims to work in a solution-focussed way by encouraging families to recognise their own strengths and resources, do very time limited pieces of intensive work to prevent young people from going into care. The Parenting Assessments is a separate service but will also include Family Group Conferencing and works very closely with Social Care to help support and build family assessments in preparation for court. The Council is in the process of remodelling the FAST Team and all the parenting assessments.

**Targeted Services**

In 2016-17 we reviewed the existing services that were designed to strengthen our service offer for CYP with emotional health and wellbeing issues that did not meet the threshold for Specialist CAMHS. These are described below.

**School Age and College Settings**

10.18 We recognise that one of our weakest areas of support for children and young people is the number of and access to Tier 2 level services as they are not universally available. We also recognise the frustration schools face in knowing how to support children and young people in a timely manner, wanting to be better equipped to identify issues at earlier stages and then knowing how or where support is available.

Our initial response to this gap was to support the remodelling of the School Health Nursing (SHN) service to better define the role of this public health workforce and its contribution to a much broader agenda in addressing health inequalities. The future service is to be dynamic, forward thinking and able to adapt and be shaped by the changing needs of the Dudley population of children and young people, emotional health and wellbeing being of children and young people being a key priority.

Taking learning from our TAMHS initiative we have invested in and developed an Emotional Health & Wellbeing Support Team (EHWT) based in schools and having a close relationship with CAMHS. The team is currently
commissioned to support schools and SHNs in meeting their universal role of addressing emotional health and wellbeing needs but also with a strong emphasis on providing a more 'hands on' non stigmatising service. The current model is based on SHNs continuing to provide Tier 1 services, but where a SHN or school comes in contact, either directly or through referral, with a child that may require more structured intervention they will refer the child to this team. This team will work with the child/family to provide Tier 2 interventions after an assessment. They may also liaise with CAMHS if the child’s needs span Tier 2 and Tier 3 provision. This service model was developed in consultation with school staff, The School Heads Forum and children and young people. Young people from the Children in Care Council have been active participants in recruitment to the service.

The expanded Emotional Health and Wellbeing service was designed to meet the following objectives:-

- provision of a responsive and accessible emotional health and psychological wellbeing service to help support the increasing number of children and young people with mild to moderate emotional, mental health needs;
- a team of skilled workers (primary mental health workers) delivering evidence based models of therapeutic and holistic emotional health and wellbeing support in both educational and community settings aimed at children and families who are at risk of or experiencing emotional health and wellbeing problems;
- actively address the emotional health needs of those children with identified problems, through delivery of individual or group based therapeutic work with children, which may take place in a range of settings including school, at home or at another location;
- targeted support for the most vulnerable children.

The proposed model was based on the national recommended CY - IAPT approach so that staff have access to training required to improve skills and knowledge in evidence based interventions, introduce new ways to involve children and young people in decisions about their care, recording outcomes session by session.

In 2015, the EHWT comprised of three specialist workers (primary mental health workers). Our original commissioning intention was to fund 2 additional posts and 2 team leaders. The additional posts will enable us to provide targeted emotional health and well being support to children and young people in the community and not just those in educational settings.

The team will consist of a multi skilled workforce who are trained to deliver therapeutic interventions, this may include a team with a range of backgrounds e.g. mental health nurses, youth workers, social workers but the emphasis being on developing a workforce that has the appropriate skills, competencies and experience to deliver an effective tier 2 service. We also recognise that we require a gender and age balance in our workforce.
The service was designed to take into account what CYP have previously told us in consultation and engagement events but we are conscious that CYP and service users and carers need to be more actively engaged through the process of service design. The Children in Care Council are keen to be involved in the development of this service and we will be using this as one route to help us develop, monitor and evaluate the service model. The EHWT would also be in the ideal position to actively engage and consult with children and young people to develop a local social media campaign to support any nationally led campaigns on anti-stigma and raising awareness of emotional health and wellbeing services. Social marketing concepts will be resourced including apps to help sign post children and young people to information and support services.

The team will work with a range of partners to help scope alternative methods of self-support and self-management. The team will work to a locality basis and in educational settings and mirror the Early Help service delivery model.

An update of this service redesign is presented in Section 11.

10.19 Improving access to effective support

Improving access to help was a major concern of the majority of those consulted through this needs assessment. To address this we agreed that we will:

- work with all our providers and our GPs to agree an “open access” pathway;
- simplify and clarify referral processes to specialist CAMHS;
- work with regional partners to implement a Children and Young People’s Workforce IAPT training initiative to support the work of all organisations providing therapeutic services in Dudley;
- reduce waiting times to specialist CAMHS
- ensure that no referral to CAMHS is bounced back to the referrer.

Specialist CAMHS

10.20 The CCG, in 2016-17, undertook an all age service redesign of the mental health services that we commission from our acute provider D&WMHPT. Our proposed new model is attached in Appendix 6. Pertinent to this transformation plan for specialist mental health services the following aspects are detailed below.

10.21 In the old model, referrals to CAMHS were rejected for children who do not meet the “Choice” criteria thresholds for a specialist service. The condition of these children can deteriorate, without any primary emotional health and wellbeing support, until they do meet the thresholds. Thus, as part of our new model all children and young people referred will have a holistic assessment and they will be signposted to appropriate therapies and/or other support service in our Early Help Offer at an early stage of problems.
thereby preventing deterioration. Crucially there would be no exclusion criteria to CAMHS.

10.22 It is also important to note that whilst the service is classed as “ageless”, this does not mean a generic service for all. Age appropriate expertise has to be embedded within the team so that assessments of children and young people would be done by individuals who would have previously done this with CAMHS specialist services. These individuals would maintain links with social services, schools and specialist CAMHS services. Thus, our approach will ensure that any individual’s needs are met irrespective of their age and that by having an all age service we will identify a child’s needs as early as possible and ensure that they get appropriate intervention service. Furthermore, although the new service delivery model will be all age the delivery of the service will be age appropriate and transition pathways will ensure that there is continuity of service provision.

Again it is important to emphasise that therapies to children and young people would be delivered by therapists with the relevant expertise in conjunction with already established voluntary sector providers of talking therapies to this age range.

This redesign would open up therapies to all CYP who have a need whereas currently some services such as Family Therapy are only available to CYP who have been accepted into CAMHS Tier 3 services. The pathway between the Therapeutic Hub and our existing counselling services, the What?Centre and KOOTH, will need to be developed. It is envisaged that there is a need for another provider to be commissioned in the north of the borough. Therapies would be time limited and will integrate with other services as required.

The all age model is being progressed as part of the MCP procurement exercise.

An update the service redesign for our CAMHS and CYP therapy services, including CYP IAPT, is presented in Section 11.

Crisis Intervention

10.23 A priority in Dudley in 2015 was to address pressing gaps in early intervention to prevent children’s escalation into crisis.

10.24 Walsall CCG commissioned a pilot Tier 3+ service from Dudley and Walsall Mental Health Partnership Trust in 204-15. Evaluation of the service demonstrated that only 4 children were referred, in 2015 to date, to Tier 4 in patient settings compared with 14 the previous year. Our plan was to work with Walsall CCG and commission a similar service in 2016. We developed a Business Case and, in consultation with the trust, started to design an I-CAMH Service.
10.25 Our plan was originally to work with Dudley and Walsall Mental Health Partnership Trust to redesign all our crisis services and our plan is that they will be integrated to provide a cohesive all age 24/7 assessment service that is easily accessed by all professionals as required (GPs, A&E/UCC, police and LA) and that it is fully integrated with other acute care provision, namely the home treatment and inpatient teams as well as robust links with the planned care and primary care teams. The actions in our plan were mapped against, and are consistent with, the actions in our Crisis Care Concordant Mental Health Action Plan submission. In addition, we were exploring converting two Extra Care Area beds in our in-patient facility to CAMHS beds so that young people in a crisis can be admitted into a “fit for purpose unit” and providing a designated place of safety. The CAMHS tier 3+ team would staff this unit when occupied and occupation would be time limited allowing for discharge to return home for on-going care or tier 4 bed.

An update on the Crisis Intervention Service is presented in Section 11.

Eating Disorders

10.26 In 2015 Dudley provided a limited eating disorder service within the specialist CAMHS service. Based on the needs of the population we intend to develop the current provision to enable a greater focus on early intervention, support for universal and primary care services and fewer referrals into Specialist CAMHS and Acute Inpatient services.

10.27 Dudley’s children and young people had access to 0.5 Band 6 Specialist CAMHS nurse, if they meet the threshold for intervention. Primary care services and universal children’s services have responsibility for screening and early identification is. A disproportionate amount of this practitioner’s work is to facilitate discharge from Tier 4 services.

10.28 The plan for Dudley was to commission a service in partnership with Walsall CCG and utilise investment to fund the development of a full time Clinical Lead (Band 7) and full time Specialist CAMHS Nurse (Band 6) who will assess and hold case responsibility for all potential Eating Disorder cases presenting to Specialist CAMHS. Further investment will:-

• create capacity within Out-Patients Clinics for psychiatry support, to enable the management of complex cases, physical health and prescribing;
• provide dedicated sessions of Clinical psychology to support complex cases and the provision of NICE recommended interventions;
• provide a dedicated family therapy clinic for Eating Disorders in accordance with NICE guidance.

10.29 The service will be founded on the CYP-IAPT principles of evidence-based care and routine monitoring of outcomes and will be expected to engage fully and be responsive to those accessing the service. The approach would
enable the formation of a dedicated MDT that would meet regularly. Interventions offered will include:-

- dietary counselling
- NICE recommended psychological treatment, including amongst others CBT, CBT-E, CAT, eating disorder specific Family Therapy;
- pharmacological treatment.

10.30 The workforce will need to be:-

- competent to identify and treat eating disorders;
- competent to provide clinical supervision;
- able to respond to presenting physical problems;
- qualified in delivering appropriate NICE recommended therapeutic interventions;
- responsive and flexible to the needs of CYP and their families;
- operate in a range of clinical, universal and domiciliary settings;
- able to provide expert advice and guidance to those working in the universal CYP workforce and primary care, particularly in relation to early identification, signposting and pathways.

10.31 In accordance with the principles of CYP-IAPT outcomes will be:-

- supported by service managers and supervisors
- input via appropriate available systems
- determined collaboratively with CYP and their families and reviewed regularly
- explained fully to the CYP and their families, including standardised measures
- used in accordance with locally agreed thresholds.

An update on the Eating Disorder Service is presented in Section 11.

Specialist Perinatal Community Psychiatric Team (SPCPT)

10.32 The evidence is clear that maternal mental health not only has an impact on the mother but also on the mental health and wellbeing of their child and the rest of the family. Women in pregnancy, with pre-existing mental health illness will usually be under the care of other Adult Mental Health Services, and those with more severe and enduring mental illness referrals are made to the Specialised Mother and Baby In-Patient Unit in Birmingham. Post discharge the mother receives her community care in Birmingham. For less severe cases our existing Primary Mental Health Services liaise with specialist midwives and provide supervision and pathways into services. The CAMHS under 5’s service offers intervention for attachment and relationship disorders.

10.33 Our collective view is that if a specialist community services were in place treatment could be provided locally and reduce the need to travel women to
Birmingham for post discharge care. The local service would link with all relevant local agencies that can support these women, their families and children supporting good long-term outcomes for the women and their children.

10.34 It is proposed that the SPCPT will provide intensive home support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. They would assist in the detection and proactive management of women who are at risk of developing a serious postnatal mental illness and provide advice and assistance to primary care, maternity and psychiatric services on the treatment and management of serious perinatal mental illness. Funding for this service needs to be sought within the CCG.

10.35 Wolverhampton CCG is leading on submitting a bid, to NHS England, for the Black Country STP footprint.

Care for the most vulnerable

10.36 There are some children and young people who may be considered at more risk of developing mental health and emotional health and wellbeing needs, these would include those children and young people who: -

- live away from home (including those known as looked after children or in care);
- have been adopted;
- care leavers (moving into adulthood after they have lived away from home and been considered a looked after child);
- have a special educational need;
- have a physical or learning disability;
- are within autistic spectrum (AS);
- are in contact with the youth justice system including those in prison;
- are in alternative educational settings;
- are young carers;
- are part of communities considered vulnerable; such as gypsies, Roma and travelling communities, recent migrants, and those with higher deprivation factors;
- have parents with a mental health need and its affects them;
- live in a household where there is domestic abuse;
- who have been sexually exploited and/or abused.

10.37 Funding was allocated I 2016-17 to support the following vulnerable group:-

- children and young people that are at risk of CSE;
- children and young people that have been sexually abuse
- looked after children that have emotional health and well-being issues;
- young children with challenging behaviour and learning difficulties and/or neurodevelopmental disorders;
- young people and adolescents in contact with the youth justice system including those in prison.
Child Sexual Exploitation and Missing Person’s Service

10.38 Vulnerable Children and young people that are either victims or at high risk of sexual exploitation have needs which are unmet in Dudley.

- in 2016 we committed to convene a task and finish group (made up of specialist CAMHS workers, primary mental health support workers and outreaching voluntary sector organisations) to develop the CSE/vulnerable children pathway.
- The task and finish group will also consider how well the needs of other more vulnerable children and young people are met in Dudley – particularly those underserved or overrepresented in the local population (BAME young people, LGBT young people, children at risk of or excluded from school, those with learning disabilities and with non-statemented SEN needs).
- We also committed to consider the potential of the MCP and MDTs to support children and young people with the most complex long term physical health and co-existing social, neuro-developmental and emotional conditions who require more integrated care.

10.39 In 2016 we allocated funding to start the work to map service provision and develop pathways to and appropriate interventions to prevent, reduce and support young people that have experience sexual exploitation.

An update on the CSE/CSA services is presented in Section 11.

Looked After and Adopted Children (LAAC) Psychology Service

10.40 We are working with Dudley and Walsall Mental Health Partnership Trust and Children’s Services, in the council, to integrate the LAAC psychology service with the Specialist CAMHS.

10.41 The LAAC Psychology Service has developed a referral pathway with the CAMHS service to address the continuum of mental health care of looked after and adopted children. This will include developing a seamless specialist assessment service and longer term therapeutic support, where necessary. There is also a current service gap for young people at critical transitions points, such as leaving care (16+) and how their psychological needs are met. Consideration is being given to the provision of a specialist mental health nurse based within the leaving care team (currently the 14+ team).

10.42 This will directly impact for young people on sustaining tenancies, engaging in employment and education opportunities and reducing social isolation resulting in better life chances overall.

10.43 The school nurses will implement comprehensive holistic annual health assessments that are undertaken with all children & young people 0-19 who have a child protection plan. They already provide these for Looked after Children. As well as other health issues this approach will help identify the emotional health and mental health needs of some of our most vulnerable
children and young people, including flagging up and monitoring children that may have greater vulnerability risk factors for mental health issues. This in turn will identify those children that will benefit from direct intervention and support from the EHWT who will provide tier 2 interventions to our most vulnerable children.

10.44 We also plan to work with Virtual Schools in supporting not just educational outcomes of our Looked after Children but to address mental health outcomes. We will also be exploring the possibility of extending the assessments to Children in Need (CIN).

An update on LAC developmental work is presented in Section 11.

Challenging behaviour and learning difficulties

10.45 The increasing demand of young people requiring assessment for ASD and other neurological delay disorders has had significant impact on the waiting times for the 0-5 specialist CAMHS Service and the Neurodevelopment Delay Service. We plan to enhance the 0-5 specialist CAMHS Service to include a diagnostic clinic. It is proposed that the new Clinic would include clinical representatives from Paediatrics, Speech and Language Therapy, Psychologist, Psychiatrist, Psychotherapist, Early Years Service being the core professionals with additional members from the generic ASD Clinic supporting the clinicians to do the full range of assessments. This includes OTs, Psychiatrist and Nurses.

10.46 The clinicians involved in the clinic need to have expertise in training in working with children under 5 and this would include using observations of play, specialist school observations and good understanding of the screening tools used for under 5s including M-Chat and CARS questionnaire and the ability to adapt the existing ADOS assessment for toddlers. Clinicians will have to have experience of using cognitive assessments as 60% of children with ASD in this age group will have learning difficulties.

10.47 As this group of children have co-existing conditions such as visual / hearing impairments, motor difficulties including cerebral palsy they will ongoing liaison with paediatricians for continued input. The clinician need to incorporate the flexibility as the assessment in Under 5s is different from over 5s in that it needs an element outreach assessment method including 3 or more nurseries / school observations during structured and unstructured times, home observations to allow a clear picture to develop as such the assessments may need more time commitment than for over 5 assessment. Thus the service will be integrated with the existing Neurodevelopment Delay Service and pathways developed accordingly. We will be auditing the existing caseloads to inform to ensure that children and young people and their families are able to access the services quicker and receive timely support as needs arise.
An update on challenging behaviour and learning difficulties developmental work is presented in Section 11.

Young people and adolescents in contact with the youth justice system

10.48 There is representation from the CCG on the Youth Offending Service Management Board which is hosted by the LA and chaired by the Director of Children’s Services. The CCG commissions Clinical Nurse Specialist and a Speech and Language therapist to support the Youth Offending Service.

10.49 The current challenges faced by the services include:-

- transition issues post 16 – high risk target group of 17 and 18 years not covered by CAMHS services;
- limited ability to develop longer term case work role and other interventions i.e. anger management group work, staff training.

10.50 The CCG and Walsall CCG submitted a bid to the NHS England Health and Justice Commissioning Teams ‘Collaborative Commissioning Network’ in 2016 to address these challenges. This bid is currently being revised in response to the additional funding being made available.

11 Update on Transformational Local Developments and Improvements and plans for the future

11.1 This section summarises the progress that has been achieved in 2017 to date.

11.2 The recurrent and non-recurrent work steams funded from our 2016-17 allocation are presented in Appendix 7.

11.3 The Financial Profile for 2016-2018 is presented in Appendix 8. This does not include how the available funding for 2017-18 (£122,000) will be allocated.

Promoting resilience, prevention and early intervention.

Developing the Universal Element

11.4 Good progress has been made in expanding our universal service to support CYP with emotional health and well-being concerns as presented in the Action Plan in Appendix 13. The main aim was to develop the EHWB skills, knowledge and awareness of staff that provide universal services.

Early Help and Targeted Services

11.5 There is an Early Help and Targeted Services Task and Finish Group to lead on the integration and development of our early help and targeted services offer. Service updates are presented below.
The Dudley Early Help Strategy was endorsed by the Children and Young People’s Alliance in 2016. The Early Help Steering Group adopted the Early Help Operating Model in November 2016 which was predicated on partners undertaking Early Help Assessments which are discussed at multidisciplinary fortnightly Allocation Partnership meetings. These meetings are designed to agreed support is needed, and from whom, to meet the identified needs of children and families. The Early Help Operating Model is now well embedded in all five clusters with a wide range of partners attending the Allocation Partnership meetings.

An Early help and Strengthening Performance Report is presented to the Early Help Steering Group on a monthly basis.

**Positive Steps**

11.6 This is the new integrated “Tier 2” service had has been fully operational since September 2017 provided by our CAMHS service. It consist of several multi-skilled staff trained to deliver therapeutic interventions that will also have a specialist role in supporting both universal staff and school nurses in meeting the emotional health and wellbeing needs of children and young people in educational/universal settings. The service model is based on the national recommended children and young person’s IAPT approach so that staff have access to training to improve their skills and knowledge in evidence based interventions to address emotional health and wellbeing needs in children and young people. It introduces new ways to involve children and young people in decisions about their care, recording outcomes session by session, that will supports the outcomes based commissioning approach used to develop this service.

The service consists of a team of seven multi-skilled staff trained to deliver therapeutic interventions that will also have a specialist role in supporting universal staff and tier 1 staff including school nurses to meet the emotional health and wellbeing needs of children and young people. There will be an additional staff member working at a universal level to ensure that universal services are strengthened and supported in relation to the emotional health wellbeing of children, young people.

The team also provides targeted support to individuals and families. They contribute to supporting the school nurses in their role of addressing emotional health and wellbeing needs and contribute to early help assessments, and family support plans. The team:-

- identifies early manifestation of problems in universal settings and supporting timely appropriate referral;
- Assesses and supports children and young people with emotional and, mental health needs that are appropriate for support at tier 1 and tier 2;
- provides support to parents to access group parenting and family support programmes, including support within the home learning environment and peer led support;
• work in partnerships with CAMHS tier 3 specialists to review individual cases and identify support and intervention appropriate at tier 1 /tier 2 levels and to ensure timely referral into tier 3 if needed and planned exist from tier 3 services.
• the team is aligned to the adolescent primary care service
• the team also contributes to the development of the therapeutic pathway for Dudley’s most vulnerable children including victims of child sexual exploitation.

Referral in to the service is determined through agreed pathways and criteria in partnership with other services. These include depression, (mild-moderate, moderate-severe), panic disorders (with or without agoraphobia), post-traumatic stress disorder (PTSD), generalised anxiety disorder (GAD), Health anxiety, Somatisation/somatoform disorders, stress, obsessive compulsive disorder, social anxiety or social phobia. Current pathway development includes timely targeted interventions for our most vulnerable CYP including SEN, CiN, LAC and CSE.

The team is co-located with Educational Psychology and Counselling Service and the band 6 posts have been aligned to the Early Help Clusters to aid effective communication and liaison with Early Help Colleagues where appropriate. The team works on a locality basis across a variety of settings including educational settings and mirror the 5 Cluster Early Help service delivery model. The integrated service delivery model is depicted below.

**Tier 1/2 Early Intervention Model**

**Therapy services and CYP IAPT.**
11.7 The CCG and D&WMHT have joined the CYP IAPT Midlands Collaborative and have established a CYP IAPT Strategy Group that is supported by the collaborative.

The D&WMHT’s CAMHS Project Co-ordinator Programme is our designated lead. Professionals have been identified to attend the following courses:-

- Leadership course – 1 from CAMHS;
- CBT in Anxiety and Depression - 2 from CAMHS;
- Systemic Family Practice for Anxiety and Depression – 2 from the What? Centre;
- Systemic Family Practice for Eating Disorders - 1 from CAMHS and 1 from the What? Centre;
- Enhanced Evidence Based Practice - 1 from CAMHS.

**GP Liaison Service**

11.8 Additional funding, for 2017-18, has made it possible to commission a **GP Liaison Specialist Team** to support GPs in the Dudley borough. The GP Liaison Specialist team consists of a Clinical Specialist GP Liaison Lead and a GP Nurse Liaison.

As this is a new service our aim is to provide a service similar to the Adult Mental Health Gateway Worker. The GP Liaison Specialists will work with the practice to triage referrals, if requested, to CAMHS (except emergencies) in sessions held at the surgery and also offer help and advice when needed to manage children and young people in primary care.

The GP Liaison Specialists will provide education and information to GPs helping to prioritise the urgent cases and the links that are required to make sure that information is cascaded appropriately. They will be available in the GP surgeries to offer assessments, joint appointments and advice.

A pilot will run for approximately 6 months with 20 GP surgeries across the borough who have expressed an interest in wanting to receive further support from CAMHS and benefit from our service during the implementation of this new service.

An audit will be carried out at the end of the 6 month period by the GP Liaison Specialists of the work undertaken in each of the surgeries. Once the 6 month period has been completed, and following of a review the service delivery model, a proposal will be made for additional funding to expand the service to all practices.

**Improving access to effective support.**

The current CAMHS Team Structure is attached in Appendix 9. There is a single point of access and the service has developed pathways for all the teams so that there is an integrated service delivery model that ensures that no referral is “bounced back”.

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The current activity and waiting times are presented in Appendix 10 which clearly demonstrates that despite referrals increasing the waiting times have reduced. The non-recurrent funding that was made available in 2016 was used to put more resource into service enabled the reduction. However, recurrent funding will need to be made available to sustain the present waiting times.

One exception is for the ASD and ADHD clinics. It has been proposed that 2018-19 funding will be used to develop these services.

Crisis Intervention

11.8 The I-CAMHS has been fully operational since January 2017. The service has very clear key performance indicators such that all deliberate self-harm (DSH) referrals received from the Russells Hall paediatric ward has to be responded to within four hours of receipt.

If a young person in crisis is referred after these times then they will remain on the paediatric ward for their own safety and the team will respond the following morning or if over the weekend they will attend on Monday morning. If a young person becomes an extremely urgent case outside of working hours then the adult psychiatric liaison team will respond on ICAMHS behalf. There is also an agreed pathway in which a priority appointment is kept available every day in the ICAMHS diary in order for a child or young person (CYP) whom presents at their GP practice in crisis can be seen the same day, this is so the CYP does not have to present at Russells Hall Accident & Emergency Department.

Any child or young person that is assessed by the ICAMHS team due to self-harming behaviours will be seen for a seven day follow up appointment. In some cases the presentation is too severe or complex for them to be discharged from the paediatric ward without additional support from the outset. In these types of scenario a package of care has to be put in place which could involve as often as daily intensive input from both the clinicians and medic involved in the service.

The ICAMHS team also provide training and support to the staff on the paediatric ward at Russells Hall to help them develop the essential skills to help the complex children who are admitted.

We committed that by August 2017 we will have conducted a baseline audit of the Crisis Response and Home Treatment activity of children from 0-18 years of age. The key futures of this audit are presented below:-

- 366 referrals have been received to date;
- 50% were received from the Paediatric Ward;
- 8% were received from CAMHS;
- 36% were received directly from a GP;
- 66% of the referrals were girls;
• 46% were aged between 14 and 15;
• 89% were white British young people;
• 22% of referrals were from not registered with a Dudley GP.
• Only 2 referrals were received outside the 8am -8pm core hours.

The presenting problems are indicated in the table below.

<table>
<thead>
<tr>
<th>Additional Information</th>
<th>Jan-Aug 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Harm – Hanging</td>
<td>10</td>
</tr>
<tr>
<td>Self-Harm – Overdose</td>
<td>74</td>
</tr>
<tr>
<td>Self-Harm – Cutting</td>
<td>Mainly to arms</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>10</td>
</tr>
<tr>
<td>Other including:</td>
<td></td>
</tr>
<tr>
<td>Low mood</td>
<td></td>
</tr>
<tr>
<td>Hearing voice</td>
<td></td>
</tr>
<tr>
<td>Anger issues</td>
<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td></td>
</tr>
<tr>
<td>Behavioural</td>
<td></td>
</tr>
<tr>
<td>Suicidal Intent</td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>37</td>
</tr>
</tbody>
</table>

A proportion of the referrals received where from vulnerable young people children: -

• 7 on the child protection register;
• 29 Looked after Children
• 3 Youth Offenders
• 2 Early Help

Analysis of the looked after children indicated that ten young people who were admitted due to self-harming behaviours later presented on one other occasion with a similar presenting problem. A further eleven young people who did belong to the Dudley borough were also re-referred at a later date with 64% of them coming back through the hospital based paediatrics pathway. An in depth review of these cases indicated some intelligence around a group of teenage girls who were reflecting each other’s behaviours and displaying repeated self-harming activity. There has since been a robust plan of action put in place with schools throughout the Dudley borough on how they should respond to superficial cutting and since this time there have been no further presentations at Russells Hall Hospital.

Over the last 6 months there have only been 4 young people who have remained on the ward for more than 24 hours. For 3 this is due to them not being medically fit and the other for social care reasons.

The number of non ED Tier 4 referrals is tabulated below demonstrating the impact that the service has had on reducing Tier 4 admissions.
<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Average bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>19</td>
<td>123</td>
</tr>
<tr>
<td>2015</td>
<td>20</td>
<td>108</td>
</tr>
<tr>
<td>2016</td>
<td>14</td>
<td>94</td>
</tr>
<tr>
<td>2017</td>
<td>8</td>
<td>66</td>
</tr>
</tbody>
</table>

Three young people were supported by the team post Tier 4 in patient discharge.

The I-CAMHS team have received feedback from various sources and the positive feedback has been on the following areas:-

- level of support provided
- weekend working
- quicker referral times
- reassurance to paediatric ward staff, parents and children
- consultation on the more challenging young people in the service

The Escalation Process is attached in Appendix 11.

11.10 We know that across our STP there are current gaps across our crisis and intensive community support and paediatric liaison for children and young people in terms of 24/7 coverage 365 days of the year. There are also capacity issue to offer intensive support on the paediatric wards and in the community.

11.11 Although the CCG works with the Trust and NHS England to identify Tier 4 beds, there admission and discharge procedure would benefit from addition resource to improve the process.

11.12 Across the STP footprint, our collective experience is that the needs and requirements of the CAMHS population has changed over time in a manner which requires response that can deliver an emphasis on a more local solution whilst benefitting from sub-regional collaboration.

11.13 Our aim, in the Black Country, is to bridge hospital and community services to deliver a dynamic CAMHS ‘Whole System’ to build upon and develop local and sub-regional capacity and capability and utilise a set of standardised care pathways that are NICE compliant utilising the framework of the Care Programme Approach as the overarching delivery model.

11.14 We will build on the developments in terms of our CAMHS LTP Crisis investments which have seen a reduction in admissions to Tier 4 in 2016/17 across our footprint and also make making essential connections and care pathways between Children and Young People’s Secure and Criminal Justice and Youth Offending Services.

11.15 This will ensure improved responsiveness and access across the system and a focus upon integration and early intervention and prevention and reducing the impact on the Acute and Community Trusts – Paediatric and
Adult Services and Social Care and Education all of which is often less visible to specialised commissioning than it is to local commissioners and providers.

11.16 To this end the CCG has financially contributed the application that was submitted to NHS England by Wolverhampton CCG, on behalf of the Black Country and West Birmingham 4 CCGs for funding for Mental Health Crisis, Intensive Community Support and Paediatric Liaison Service for Children and Young People.

11.17 We also committed that by August 2017 we will have reviewed our Self Harm audit and conducted a baseline audit children and young people who present to CAMHS experiencing a first episode of psychosis to ensure that they receive treatment within two weeks of referral and receive a package of care that meets the NICE recommended guidance. This audit is presented in Appendix 12.

11.18 **Community Eating Disorder Service**

This service has been fully operational since January 2017. To date 41 referrals have been received.

- 23 were received from within CAMHS
- 15 from GPs
- from hospital based consultant paediatricians

There has been 100% compliance with Eating Disorders performance indicators, one week to be seen for an urgent referral and four weeks for a routine referral.

**Improving specialist early help and intervention for the most vulnerable**

11.19 **Child Sexual Exploitation and Missing Person’s Service**

This is a new service development in Dudley and provides a more co-ordinated and consistent approach to protect this very vulnerable group of children and young adolescents. The service comprises the following staff:-

- Integrated youth support worker
- Representative from the Runaways project
- Representative from Teenage pregnancy team
- Police CSE coordinator
- Early intervention social worker
- School health advisor
- Voluntary Organisations; Streets Team, Phase Trust, Barnardo’s

The CSE Co-ordinator, from the LA, has worked with the services above to start developing an integrated service delivery model. The following progress has been made:-
the full time staff member has been employed by Barnardo’s and now sits in MASH working with young people at threshold serious and significant;

5 intensive family centre practitioners have been trained to work with those at risk and lower end of significant;

6 ART practitioners have been trained to complete assessments and to work with those who are at risk and lower end of significant;

the referral pathway from the MASH for CSE concerns into family centres has been agreed.

Tier 2 CAMHS (Positive Steps Team) have now been recruited they will offer additional wrap around services. One member of the team is a CSE specialist and will work with a small case load.

Areas that still pose a concern or have not been actioned to date include:-

recruitment of the psychotherapist within CAMHS, additional funding has been made available to increase the staff grade;

the remit of and referral process to the psychotherapist is still to be agreed;

further training is required for wider family solutions team to expand their expertise this might be how to deliver the 8-10 week delay programme that is already delivered in Dudley.

A new Task and Finish Group will be established to ensure that we get some further traction on this very challenging agenda. This will be led by the LA’s Head of Safeguarding.

As tabulated below we have allocated significant funding this year to further support this vulnerable group. In total this is £214,000 which is approximately 25% of the total funding allocated to our CAMHS LTP.
11.20 **Services to support Looked After and Adopted Children**

An Emotional Health and Well-being Modernisation Group has been established by the LA’s Head of Service for Children in Care and Placement Resources who reports to the Emotional Health and Well Being Steering Group.

The current service delivery model is very disjointed with psychotherapy services being provided by D&WMHT and psychological and residential services being provided by the LA. The CCG also commissions a Consultant Psychiatrist to provide support in a local residential setting.

The aim is to develop an integrated service model and modernise the delivery of emotional and wellbeing services by:

- ensuring that the emotional health needs of children and young people are satisfactorily identified and met;
- children and young people are screened comprehensively and promptly to support their needs;
- children and young people benefit from a focused therapeutic service that meets their psychological, emotional and mental health needs as soon as they are identified;
- developing a team of multidisciplinary clinicians to work with young people, foster carers, adopters, residential Staff, social workers and schools;
- develop a screening tool to identify need;
- develop a range of assessment tools;
- develop robust training programmes for foster carers, adopters and residential staff (needs to be linked into the Workforce Development Programme).
This work programme will be completed by 31st March 2018 and the new service delivery model will be commissioned from one service provider.

Services to support Challenging behaviour and learning difficulties

11.21 Our CAMHS provider has recruited to the psychotherapist liaison post and our provider of children’s community services has appointed to the additional occupational therapist post. There is now an integrated pathway between the 0-5 CAMHS clinic and the Children’s Assessment Unit. Twelve CYP have been referred from the CAU service into CAMHS for the following:

- assessment inconclusive, query attachment, sensory processing or both;
- diagnosis of ASD, ongoing behavioural management difficulties;
- ASD post diagnosis sessions;
- ASD post diagnosis sessions centred on parenting approaches;
- explore Parenting with Mother and Father;
- no ASD, has behavioural needs;
- ASD post diagnostic sessions;
- no ASD, requires assessment for attachment, anxiety difficulties;
- not ASD, ongoing behavioural difficulties;
- post diagnosis sessions;
- further input in regards to attachment difficulties;
- Asperger's diagnosis, struggling with behaviour management.

Developments for 2017-18

11.22 A number of proposals have been received for funding from our 2017-17 allocation. The total is in excess of the £122,000 allocation. The proposals are summarised in the table below. The recurrent pick up for 2018-18 is also included.

<table>
<thead>
<tr>
<th>Proposal</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>£16,530</td>
<td>£50,000</td>
</tr>
<tr>
<td>Clinical Psychotherapist – top up</td>
<td>£5,000</td>
<td></td>
</tr>
<tr>
<td>CYP IAPT</td>
<td>£28,000</td>
<td>£62,000</td>
</tr>
<tr>
<td>CAMHS Waiting times</td>
<td>£36,602</td>
<td>£87,850</td>
</tr>
<tr>
<td>MH Crisis, Community Support and Paediatric Liaison Service</td>
<td>£9,700</td>
<td>£62,000</td>
</tr>
<tr>
<td>GP Liaison Service</td>
<td>£0,000</td>
<td>£185,700</td>
</tr>
<tr>
<td>CSE Case Manager</td>
<td>£42,000</td>
<td></td>
</tr>
<tr>
<td>Care and Share (Psiams roll out)</td>
<td>£10,000</td>
<td></td>
</tr>
<tr>
<td>Early Years/Intervention Resilience Worker</td>
<td>£40,300</td>
<td></td>
</tr>
<tr>
<td>What? Centre - LGBT support</td>
<td>£9,000</td>
<td></td>
</tr>
<tr>
<td>What?Centre – 9-12 Counselling Service</td>
<td>£12,000</td>
<td></td>
</tr>
<tr>
<td>Phase Trust Mentality (sports, creative arts therapy)</td>
<td>£15,000</td>
<td></td>
</tr>
<tr>
<td>Top Church (Young Men’ Group)</td>
<td>£10,000</td>
<td></td>
</tr>
<tr>
<td>Consultation with BME population</td>
<td>£5,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£235,132</strong></td>
<td><strong>£447,550</strong></td>
</tr>
<tr>
<td><strong>Total Available</strong></td>
<td><strong>£122,000</strong></td>
<td><strong>£348,532</strong></td>
</tr>
</tbody>
</table>
11.23 Following the publication of this refreshed plan a meeting of the Task and Finish Group Leads has been convened to consider the proposals in light of the progress to date and outcomes of our existing service developments.
Appendix 1 - MCP Model for Children and Young People

The MCP provides an opportunity to realign, redesign and integrate a number of services for children and young people, some of which are the responsibility of more than one provider.

Child health has changed – over the last 45 years mortality data show an epidemiological transition away from acute infectious illness towards chronic long-term conditions and away from biomedical and biopsychological problems. However, the way health and care services are provided is still heavily hospital focused, reactive and fragmented across physical health, mental health and social care.

A new model of care needs to address:--
- the increasing use of hospitals to treat conditions that could be dealt with in other settings and related financial pressures;
- primary care being under severe pressure in terms of capacity, confidence, knowledge and skills;
- the often disjointed care provided between hospitals and the community, as well as other non-health services and;
- dis-satisfaction amongst children, young people and their families.

Current Services

There are a wide and range of services currently commissioned by the CCG and the Office of Public Health that will be included within the whole population budget.

These can be separated into 4 main categories: -
- acute paediatric services;
- community paediatric services;
- emotional health and well-being services;
- young people's wellness service;

The services that comprise these categories are listed below.

Acute paediatric services
- Outpatient Paediatric Service for general paediatrics, neonatology, diabetes, respiratory, neurodevelopment and emotional/behavioural clinics.
- Community Medical Officer clinics.
- Paediatric Advice and Triage Service.
- Paediatric Assessment Unit.

Paediatric community services
- Health Visitor Service including Family Nurse Partnership
- School Health Advisor Services
- Children’s Community Nursing Service, including LD nurses;
- Paediatric Speech and Language Services;
- Paediatric Occupational Therapy;
- Paediatric Physiotherapy Services;
- Enuresis and Encopresis Service;
• Haemoglobinopathy Service;
• Children’s Assessment Service;
• Special School’s Nursing Service;
• Children’s Continuing Care.

Emotional health and well-being services
• Positive Steps (Tier 2);
• Community CAMHS;
• I-CAMHS (Tier 3+);
• Community Eating Disorder Service;
• CYP IAPT;
• The What Centre Counselling Service;
• KOOTH on line Counselling Service.

A number of factors need to be considered in developing a new care model. A whole population approach to meet the needs of children can be stratified into 6 broad patient levels of care.

<table>
<thead>
<tr>
<th>Level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy child</td>
<td>Advice and prevention i.e. immunisation, emotional health and wellbeing, healthy eating, exercise.</td>
</tr>
<tr>
<td>Child with social needs</td>
<td>Safeguarding issues, self-harm, substance misuse, complex family and schooling issues, children looked after.</td>
</tr>
<tr>
<td>Child with complex needs</td>
<td>severe neurodisability, Down’s syndrome, multiple food allergies, child on long term ventilation, type 1 diabetes.</td>
</tr>
<tr>
<td>Child with a single long-term condition</td>
<td>Depression, constipation, type 2 diabetes, epilepsy.</td>
</tr>
<tr>
<td>Acutely mild-to moderately unwell child</td>
<td>upper respiratory tract infection, viral croup, otitis media, tonsillitis, uncomplicated pneumonia</td>
</tr>
<tr>
<td>Acutely severely unwell child¹</td>
<td>E.g. trauma, head injury, surgical emergency, meningitis, sepsis, drug overdose.</td>
</tr>
</tbody>
</table>

Level 1 - prevention is a key feature of the MCP care model and there is an opportunity to prevent physical and mental ill health, as well as improving educational and social prospects in adult life, by improving the health of children and young people.

There are also a number of cross-cutting elements that are common to many or all of the 6 levels of care e.g. equal access to care, mental health, school issues, transition and safeguarding.

Common features of the new models of care that are emerging include:-

• having a focus on understanding the needs of different sections of the child population and their families, and organising care to meet these needs;
• strengthening early and easy access to appropriate expert paediatric assessment in the community;
• understanding how children and their families use the health system;

¹ These services are outwith the MCP scope
• helping them use it more effectively and actively working with them to design and improve the quality of services;
• making more of the range of community settings in which health care and wellbeing can be provided;
• encouraging early, proactive intervention;
• improving communication between primary and secondary care services; and
• addressing the wider needs of children and their families by working in multidisciplinary teams and joining up health records.

An ‘ideal’ child health model is one:-
• that understands children, young people and their families’ specific needs (including the broader determinants of health) and is designed to address them;
• where there is access to high-quality paediatric and child health expertise and multidisciplinary teams in the community;
• that has linked-up timely information, communication, data and care (different forms of integration) to allow for continuous quality improvement and;
• where health literacy and education for children, young people and their families, as well as professionals, is prioritised.

In developing a new model of care it is also important to understand that children differ from adults in at least four important ways:-
• developmental changes as they grow older;
• dependency on parents and other carers;
• differential epidemiology (e.g. different health, illness and disabilities); and
• different demographic patterns within an economy (e.g. socio-economic determinants).

Furthermore:-
• children’s use of health services is also different to other age groups, for example the rate of acute, short-stay hospital admissions in children is higher, and rising;
• children may need to be transitioned from paediatric to adult services, and have constantly changing needs in relation to their developmental stage and age;
• education is especially important, in addition to social care, and there is a greater dependence on the family than social care, compared to adults.

**Developing Pathways**

The Family Friendly Framework describes 5 generic components to developing pathways. These are:-
• prevention
• recognition
• assessment
• intervention
• transition
These components need to be considered when developing pathways for the 6 levels of care described above.

**Proposed Service Model**

There are four important stages that need to be undertaken to test the 6 broad patient levels of care that stratification of the needs of children.

We need to understand where children currently receive services and therefore need to gather information on activity and access.

We need to understand where, when and why families access services for their children, in particular General Practice and the Emergency Department.

A mapping exercise needs to be undertaken to fully understand the existing KPIs and outcome measures for the 6 levels of care.

A shared patient based outcomes-based model needs to be agreed. The work associated with these four stages needs to be scoped and an action plan agreed.

**Child Health Access Hubs**

The service model should be based on the creation of local Child Health Access Hubs to accommodate more services in the community and to provide opportunities for greater integration across children’s services, including physical, mental health, early help and health services that support children in schools. This will ensure that expert clinical knowledge is easily accessible without the need for assessing acute care. Child Health Access Hubs will include primary and community services, along with paediatric consultant led out-patient services.

The MCP will be expected to develop these hubs so that they provide extended access 7 days per week. Not all services will be expected to be available at all times but each hub would be expected to include:-

- primary care urgent access;
- health visitor service;
- school health advisory services;
- paediatric therapy services;
- emotional health and well-being service;
- links into early help services in family centres;
- a facility for regular paediatric consultant out-patients/clinics;
- community paediatrician clinics.

A scoping exercise needs to be undertaken to determine which services, based on population needs, are best delivered on a practice, locality or borough basis.

**Children’s MDTs**

The new service delivery model needs include children’s MDTs which need to take a more holistic approach to ensure that physical, emotional and mental health, social and educational needs of children are met to improve the outcomes as stated above.
The MDT model should have four key components:-

- improved communication, information sharing and shared learning;
- specialist outreach, with specialists from the hospital and mental health providers working alongside primary care professionals, community services and the wider community;
- open access, with GPs having access to specialist advice via email and telephone;
- Multi-disciplinary care planning.

How, in practice, children’s MDTs operate, how they link into GP practices and fundamentally which cohort of children are discussed, and how MDTs align with the Child Health Access hubs, needs to scoped.

**Specialist Outreach**

Consultant Community Paediatricians will provide out of hospital care for children and young people, as well as a range of statutory duties in relation to child protection, medical advice for special educational needs, and health assessments of children in care.

Community paediatricians need to work within the wider health network of therapists and nurses, with the local authority Children and Young People’s Services and the voluntary sector. The role of the paediatrician involves prevention, identification, assessment, diagnosis, treatment and support. Many will also have specialist skills/interests in addition to their general work (see below). They must be closely networked with acute general paediatricians and other Specialist Community Clinicians, such as CAMHS, Physiotherapist, Occupational Therapist and Speech and Language Therapist.

It is expected that children and young people with the following conditions will be seen by Consultant Paediatricians in community clinics:-

- concerns regarding a child’s development such as developmental delay or disordered development;
- neurological disability;
- children with coordination or fine motor difficulties;
- behavioural problems;
- Autistic Spectrum Disorder;
- ADHD;
- significant learning difficulties/disabilities;
- sensory impairment;
- visual impairment;
- hearing impairment;
- symptom management in palliative and end of life care.

Most of these would need an MDT approach with CAMHS and children’s community services.

**Acute services**
Both Secondary and tertiary services need to be outward facing and who they network with the MCP.

**Paediatric Triage**

The CCG commissions a remote Paediatric Triage Service from Paedsdirect Limited, which is based in Somerset. The service provides an advice and guidance service to all Dudley GPs prior to automatic referral for an outpatient paediatric consultation.

The service is accessible to all GPs within Dudley CCG and triages all paediatric outpatient referrals that are set by GPs and recommends the most appropriate referral pathway based on the clinical need of the patient. The overall aim of the service is to reduce the number of referrals for secondary care paediatric consultation, to improve the knowledge and expertise in paediatric care for both parents and GPs across the borough, and to provide more appropriate care for patients closer to home.

The number of GPs that use the service has increased year on year and the latest audit demonstrates that approximately 50% of out patient referrals have been reduced.

An in depth audit is being undertaken for the period 2016-17 to ascertain which GPs are referring to the service, reduced out-patients referral by GP and a breakdown of the specialities that result in out-patient appointment. How this service is aligned to the children’s model of care needs further discussion.

Open Access
All practices must agree to provide their patients with same-day access to paediatric advice from a GP or senior nurse, and a same-day appointment for under-16s if needed. GPs also have access to specialist advice via a 24-hour email hotline and a telephone hotline (12pm–2pm weekdays), both run by paediatric consultants from DGNHSFT.

**Care Planning**

Each child or young person that is known to the services delivered by the MCP should have a named Key Worker/ Care co-ordinator. This person should write up the proposed care plan with the patient’s agreement. This plan should then be reviewed as agreed by the MDT. Modifications to the care plan should be written in the patient’s record and a member of the MDT nominated to agree it with the patient at the earliest opportunity.

The ideal care plan would be electronic, easy to update, accessible to the MDT and the patient (and acute services, education and social care when needed) and would holistically identify the person’s care needs. The care plan would be agreed by the MDT and patient together.

It is proposed that key workers should be identified for the cohort of children that are agreed to be discussed in the Children’s MDTs. Initial thoughts are that these could be children with:-

- neurodevelopment delays
- epilepsy

The role of the key worker needs to be further developed.

**Integrated young people's wellness service**

The development of a young person wellbeing promotion and treatment service should include both generic and targeted support interventions to meet the varying needs of children and young people in Dudley borough. The provision should holistically assess each young person’s needs, (taking a no wrong door approach) to tailor the most relevant and timely range of advice and support, complementing any existing models of support for young people, including synergies with the Healthy Child Programme.

Support interventions should include a range of self-help strategies and specialist services, within a strong governance framework to identify and address safeguarding risks, promoting wellbeing and enabling young people to flourish and thrive.

The service delivery model should include: -

- a welcoming front door offering advice and support for a range of issues;
- a Making Every Contact Count approach should be embedded into staff training to ensure the provision of healthy lifestyle advice and wellbeing promotion using the 5 ways to wellbeing. All services should be fully integrated with seamless pathways to deliver coherent package of advice and support for any issue;
• open access integrated sexual health services, treatments, advice and prevention (currently provided by Brook);
• substance misuse services (currently provided by Switch), including targeted, early interventions;
• availability of smoking cessation services across a range of domains;
• pathways into CAMHS tier 2 services.

Other services for young people should be considered for future integration into this model of support, including primary care services for young people and school nursing services.

Links and referral pathways should be available to ensure young people are able to access support from a range of agencies including local authority services and community based providers, depending upon need.

The service needs to developed in partnership with existing third sector providers.

**Early Help Support**

Dudley Metropolitan Borough Council (DMBC) has been working closely with the CCG to develop the Early Help Service delivery model. A key part of the early help operating model requires “MDT Allocation Meetings” taking place in 5 locality Family Centres across the borough. Representatives from universal and targeted health, early help social services, schools and services provided by the voluntary and community sector, along with the emotional health and wellbeing practitioner are involved.

The MCP must ensure that practices then arrange for the patient cohort to be discussed in existing practice MDTs as above, with relevant professionals involved in the child’s health, educational and/or social care.

The new model should be predicated on the Connecting Care for Children (CC4C) model as depicted below.
As described above there are a number of professionals that could be delivered in Child Health Hubs as depicted below in the MDT model in CC4C.

**Figure 1** Connecting Care for Children: the Child Health General Practitioner (GP) Hub.

**Figure 2** The breadth of professionals involved in the hub multidisciplinary teams (MDTs).
Implementation Timetable

There are some key fundamental steps that need to be established before the proposed model is agreed and implemented. These are listed in the table below.

<table>
<thead>
<tr>
<th>Service Developments</th>
<th>Phase 1. 2018</th>
<th>Phase 2. MCP Contract commencement through to 2020</th>
<th>Phase 3. 2020 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test the 6 broad patient levels of that stratify the needs of children. To include auditing: • access and activity • where, when and why families access services • map existing KPIs and outcomes • Agree shared outcomes.</td>
<td>Scope and agree which pathways for the services in 6 levels of care should be developed.</td>
<td>Scope how MDTs align with local Child Access hubs. Extend the role of the Care Co-ordinator Develop the service specification for a shared outcomes-based model and commission the service.</td>
<td>Full system single point of access patient and health care professional portal go-live and implementation.</td>
</tr>
<tr>
<td>Develop the Children’s MDT.</td>
<td>Agree children’s cohort that should have a Care Co-ordinator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope which services should be delivered on a practice, locality or borough basis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Appendix 2

Engagement activities carried out with Children and Young People
April 2013 – September 2015
There has been a considerable amount of engagement activity with children and young people between April 2013 and September 2015, carried out by a range of partnership organisations across the borough.

This document collates the results of the main engagement activities. The key themes relating to the emotional health and wellbeing of children and young people that have emerged are:

- emotional wellbeing and mental health are identified as key areas where young people aged 11-19 need support, in particular the opportunity to learn more about the impact of poor emotional and mental health on other areas of their life;
- they need someone they trust to talk to about mental health, emotional difficulties, relationships;
- they need better information on services and how to access them. Young people should be able to self-refer to relevant services;
- there needs to be an increase in provision of positive recreational activities;
- they should be able to access consistent levels of support and services throughout their teenage years, and certainly not experience a void of provision when aged 16-18, fitting into neither children’s nor adult services;
- how can children and young people contribute to the commissioning and development of services?

**Dudley Youth Health Researchers**

In September 2014 prior to the Health Researchers funding we received from NHS England, Dudley Youth Council (supported by Dudley Youth Service) worked in partnership with Healthwatch. The research contacted 311 young people aged 10 to 25 from a variety of places around the borough out of school or college time.

Their research identified; 3 in 10 young people would not talk to their doctor about mental health, emotional difficulties, stress, addictions, alcohol, drugs, smoking or sexual health; 7 in 10 young people would not talk to their doctor about relationships; 6 in 10 young people
would not talk to their doctor about abuse towards a family member or domestic violence. This research was reported at the Health and Wellbeing Board.

**Work with Local Authority Youth Service Provision**

Emotional wellbeing and mental health were identified as a key area to support young people aged 11-19 by the youth service through the work the service does. This was identified as a need at the beginning of 2014. The youth service through partnership work with Time to Change trained 17 staff to run the training which helps empower young people to challenge mental health stigma and discrimination. This ‘Time to Change Programme’ was delivered to 350 young people who attend Thorns, Coseley and also a learning disability youth project held at the Source Youth Centre.

The service also received funding from public health and delivered a ‘5 Ways to Wellbeing Programme’ for identified young people with learning disabilities from targeted youth clubs who would benefit from support. These were young people who had been identified by youth workers as having some difficulty in understanding their own mental health and how they could adopt some positive strategies to help their emotional wellbeing. No young people mentioned KOOTH as way they would gain support and had no knowledge of the service.

Many young people who took part had no knowledge of the ways to wellbeing, looked at mental health in a negative way and had not before discussed theirs and others mental health in this way.

There was a lack of understanding of what mental health was – it was often perceived in a negative way. The majority would seek help from friends and family members.

**Work with the Respect Yourself Team**

The Wellbeing Programme started in August 2014 during the school summer holiday. There were initially four workshops during the day that were held at the Source Youth Centre, followed by after school sessions throughout the Autumn term, then two countryside visits during the October half term. The programme ran with a group of young women and a group of young men who attended on separate days. Sessions began with an introductory workshop about mental health where participants were encouraged to discuss and understand backgrounds to stress, how this is manifested in different young people and how it affects our mental wellbeing. Participants were involved in different games and activities to promote an informal discussion and started their own small scrap books to record their journeys throughout the project.

We worked with a total of 14 young people; five young men and nine young women. The project enabled a process of qualitative and intense work with those young people who are seen as more vulnerable and who had been referred to our team for specific work around self-esteem and wellbeing. Both groups included a diverse mix of young people from across the Dudley Borough. The young people stated that they enjoyed and appreciated discussing similar issues and supporting each other to improve their own emotional wellbeing. The programme created opportunities for those young people who are marginalised by society and who would not ordinarily have an opportunity to participate in a series of exciting and innovative activities.

Many of the young people with whom we work suffer from stress, anxiety and depression due to many different factors. The programme encouraged some of those young people to experience new, varied and different activities that explore the Five Ways to Wellbeing along with producing their own resource to share and promote their learning with other young people in the form of a series of postcards. Young people enjoyed the process of creating
these pieces which encouraged a therapeutic and supportive environment for discussing emotions, feelings and ways to improve and sustain wellbeing.

Evaluation forms were completed after each session feedback from participants were incredibly positive:-

- ‘I have never done anything like this before.’
- ‘I didn’t really want to go on the countryside trip at first but when I did; it was the best thing I’ve ever done.’
- ‘I loved how it wasn’t like school and we could talk openly and it was relaxed.’
- ‘I didn’t want the sessions to end.’
- ‘We were treated how we would treat them – like an adult.’
- ‘What was useful? ‘Getting used to talking.’
- ‘Better than I thought it was going to be.’
- ‘How to cope with stress.’
- ‘I’ve learned that keeping active will help me in the long term’.

The whole Wellbeing Programme was incredibly successful, participants commented regularly following sessions about how they felt better in themselves and how much they valued the opportunity to learn about emotional wellbeing and how overlooked this was in their day to day lives.

Me Festival November 2014

Over 180 students aged between 12/13 years attended the ME festival at Himley Hall in November 2014. The aim of the event was to build emotional resilience and build the skills and confidence to deal with ‘life’s’ issues. There were a number of interactive workshops including:

- First aid training including CPR, dealing with serious bleeds and choking.
- Loudmouth theatre performed One Too Many (looking at binge drinking) and Bully4U.
- Kick Ash Deep Breath Tour and interactive lungs – drama performance following the life of a smoker and non smoker.
- Headmasters Office – young people developing and delivering a workshop aimed at teaching staff to help them understand the issues that young people face and how health and education can work better together.
- Communic8 – a workshop to look at how young people access health and wellbeing information and where they prefer to get that advice from.
- VIP Tent – with rowing machine challenges, healthy eating, cyber dance, information from loads of local organisations such as Connexions and Healthwatch Dudley.
- In addition we were joined by the police, fire and ambulance services.

Outcomes:

We asked - who would you feel comfortable talking to if you had a health problems or a mental health problem including stress?
You said – health care professionals, parents, friends and friendly people who understand my problem
We asked – how do you think your school could support pupils’ health
You said – through better trained school nurses, raising awareness through workshops, having regular check ups, private one to one sessions, creating a club at lunch or after school where we talk about some of the problems that we might have so we can sort it out together
We received fantastic feedback from the event and requests that we do the same again next year. The next festival will take place on November 26th and again will have a variety of interactive sessions including a Let’s Get Active tent.

**Young Health Champions Project**

This year the CCG and OPH agreed to fund a scheme for Young Health Champions. This project is about early intervention – creating opportunities and outlets for young people as well as promoting healthy lifestyles and lifelong learning. With the challenges posed by an ever ageing population and the increase of long term conditions more commonly associated with poor lifestyle and increase in age, now is the time to start creating an ethos of self-help in our younger population and aspire to leaving them a legacy of a sustainable NHS and other care and wellbeing services.

The proposal is to build a sustainable network of YHCs by targeting young people aged between 13-25 years across Dudley. The funding will allow the recruitment of a Project Officer/Team leader who will be responsible for driving, developing, building and implementing a thriving network of YHCs. The YHCs will be recruited from all backgrounds using a ‘scattergun’ approach and working with willing individuals and organisations. Training will be provided by Altogether Better who have proven experience of developing and delivering targeted training with young people. Once the YHCs are trained, they will be able to take part in opportunities across the health and social care landscape and use their skills to influence decision makers, provide insight on local services and access funding for projects that they wish to undertake which will empower them and help others. The YHCs will act as signposts to their peers and wider circle of contacts including families and they will start to make connection between health and happiness and have the support they need to help them make important decisions which could affect them later in life. Our younger population is the generation of tomorrow and we need to work with them now.

**Objectives**

To recruit, engage, train and support up to 100 young people in the first year of the project, as YHCs who will become active and valued partners, working with service providers and commissioners to jointly deliver better health and wellbeing outcomes. The YHCs will:

- take forward into the future an understanding of the challenges facing the population’s health and happiness;
- have the confidence and self-belief that they can positively influence their local services for health and happiness to better serve young people;
- share their knowledge and learning with others, their peers, family, friends and the wider community.

**Outcomes**

- increased range of health and happiness activities co designed and delivered by young people; so that services are designed to meet the needs of children and young people
- improved health outcomes for young people;
- increased community capital and social value;
- better quality health and wellbeing services;
- more young people directly involved in the co-production of local services.

YHCs can be recruited from inside educational/youth settings and outside. It is anticipated the post holder will work collaboratively with a wide range of stakeholders to pull all of the strands together ensuring there is no duplication and services are joined up with up to date
signposting. The post holder and YHCs will also be asked to contribute towards the planning on the annual #mefestival and use the opportunity to recruit further YHCs.

**Dudley Young Health Researchers (by Healthwatch Dudley and Dudley Council)**

The project will recruit 20 people aged between 13 – 19 with a range of health and wellbeing experiences including those with complex needs to take part in a training and development programme. These will include young people who are carers, have life threatening illnesses, are looked after, have learning disabilities or have specific insight/experience of health services or conditions such as diabetes or cancer.

As Dudley Youth Council are a group of young people who are elected to represent the views of others and there are specific special interest representatives for health already in place 25% of the young people involved will be recruited from this group.

Views and experiences gathered by young researchers will be shared at key decision making forums across the borough, region and nationally to influence how health and wellbeing outcomes for young people and service delivery can be improved.

**Key outcomes**

Local services will have a unique opportunity to listen to the voices and experiences of young people to improve their service delivery and design.

The project is aspirational and will encourage a change in attitude to involve the voices of the lesser heard to improve health outcomes for young people and local communities and society as a whole.

Regionally, shared learning will enable partners across our youth and health networks to gain a deeper insight into effective youth involvement to influence and improve health and wellbeing outcomes and ultimately change.

Young people involved in the project will receive ongoing training and development opportunities enabling them to:

- Understand how decision making works in Dudley around health and wellbeing
- Explore what is health, what is wellbeing and what makes us happy!
- Discuss why it is important for young people to be involved with reviewing health services
- Discover the skills and qualities needed to be a good reviewer and how this is different from inspection
- Identify what should good services for young people look and feel like?
- Learn effective and appropriate methods of gathering views
- Prepare and present findings to decision makers, other young people and the wider public in a meaningful and accessible way
- Undertake master classes in using social media to involve other young people in the project
- Receive an introduction to Healthwatch Dudley and other local mechanisms, which support people to share their views, experiences and have their say to influence how local services are planned and delivered.
- Work with others and take part in team building activities
- Overcome personal challenges to build their emotional resilience
- Have conversations and support others to join the NHS England online Youth Forum so that their voices can influence service design and delivery.
The Young Health Researchers have been speaking with young people across Dudley about the issues which bother them and the top ones are:

- Knowledge of health services available to young people
- Mental health – which included:
  - eating disorders
  - effects of social media on health
  - Friendships and relationships
  - Services and support after family crisis
- Cancer treatment for young people

**Holly Hall Academy**

140 students aged between 12/13yrs attended a session that as delivered by CCG staff on emotional health and wellbeing. We wanted to understand what they knew and understood by mental health and wellbeing, where they would go for help and what support they think they would like. We also talked about the effects of social media on young people.

**Outcomes**

There was a real lack of understanding of what mental health was and how it could affect people. Students did not associate good mental health as being part of mental health and they did not have a real grasp of the factors that could cause mental health to be affected unless they were prompted. Students understood the effects of social media and the pressure that it created. The majority would seek help and support from family members or teachers if they needed support but not one student mentioned Kooth.

**Work with Dudley College Health and Social Care Students**

The team have worked with around 60 students but the theme has been more generalised around healthcare and wellbeing rather than mental health. The students are aged around 17 years and have high expectations of healthcare in terms of access. Many thought that GP surgeries should be open early in the morning until late in the evening including weekends. Many did not understand how pharmacy could help them and had used ED as an access into care which was not always appropriate

**Strategic Review of Services for Vulnerable Young People 16 – 18 who are homeless or at risk of becoming homeless.**

12 young people age 16 – 18 were recruited to undertake a strategic review of services for vulnerable young people age 16 – 18 to include accommodation and floating support services. 9 of the 12 were service users from the existing services and 3 accessed no services at all. The group had experienced complex and chaotic lives which had impacted on their health and wellbeing, they worked intensively over 16 weeks conducting survey’s, mapping existing services, conducting mystery shopping visits, interviewing their peers and staff across the services. They delivered their findings and recommendations for both accommodation and floating support that best meet the housing, health and wellbeing needs of all vulnerable young people to commissioners and wider stakeholders. Their recommendations have influenced the tender specification about to be released. Members of this group will be integral throughout the tender process until the award date and beyond.

**Youth Engagement regarding health and Wellbeing - PHASE TRUST**
Over the period from March 2014 to July 2015, Phase Trust carried out an extensive consultation with around 150 young people aged 11-16 across six areas of the Dudley Borough. The following areas were covered:

- Halesowen
- Leasowes
- Coseley
- Dudley Central
- Russells Hall
- Sycamore PRU

The aim of the consultation was to identify what the felt needs of young people were as opposed to “perceived needs” and for that to drive the focus of our work going forward.

We asked questions around: What are the trending needs in your area and friendship groups?

They said: Nothing for them to do, lots of drugs especially cannabis, nothing positive to do so never try anything different.

We asked questions around: What concerns they have about their friends?

They said: Increase in self harm, social media and internet safety, their friends sending inappropriate images to people they don’t really know, girls “hanging off” older men, increase in weed being available, increase in “hard core” girl groups brings intimidation and bullying (on-line and off-line).

We asked questions around If we could change anything for you, what could we do?

They said: PSHE does not adequately cover the issues that need addressing in sexual health, give us people to talk to about things that are worrying me that I’m not going to tell a teacher, teach boys how to treat girls properly (they think they have the right to check my phone was one comment), a member of Phase Trust around my school all the time.

Separate evaluations were also carried out to answer how we knew there was a need for our work. The following is an overview of the findings. (A full independent evaluation is currently being prepared by a consultant.)

We commissioned an independent consultant to produce a comprehensive evaluation of our existing work (October 2015). Whilst the current project allowed us to widen our approach to work with escalating issues of young people, the report showed that, although needs continue to increase, they are becoming equally complex. The report crystallised our thinking, confirming the complexity of challenges faced and the need to now deepen the interventions with targeted young people vulnerable to making risky life choices.

The numbers of young people supported by our work shows us that we are providing services that young people want and will use. Numbers are increasing through both referrals and involvement of more organisations (such as CAMHS). Individually, every user of our personal development programmes review their own programme to enable us to reshape our work and make changes where appropriate. Pilot projects involving sport and personal development have shown that this is a very effective way of engaging young people to self-reflect. Work was also undertaken with under 11’s in a tailored programme which has resulted in 3 local primary schools requesting the work. Work involving the prevention of young people being referred into the criminal justice system at an early stage is also proving successful. In September 2015 alone, 22 young people have been worked with resulting in no police involvement at all. I have now been asked to attend the Police and Crime Commissioners Board to discuss this aspect of our work.
On-going feedback and consultation with users of our sexual health programmes showed that the need for consistent contact and a journeying approach helped first time disclosures to be made by those most at risk of harm e.g. sexual exploitation. It also showed the need for a flexible, independent and safe advocacy role in working with these issues. This was also borne out by our recent victims of crime consultation (December 14-February 15) where 300 young people, aged between 12 and 19, were asked about their experiences. The resulting report produced in June 2015 showed that 63% were too frightened to disclose any incident, especially to the police or statutory services. Young people told us that our work provides a safe place for disclosure, support and aftercare for victims. The added input of utilising a professional solicitor’s services would be more than beneficial.

Consultations between March 2014 and July 2015 with young people from six areas right across the borough, including those from priority neighbourhoods, those referred to pupil referral units and those attending alternative provisions due to complex challenges. The trending issues are around all uses of social media, from bullying to exploitation, from keeping safe to consequences of the law. Also the growing lack of family support and significant adults in their lives can often lead to risky behaviour taking. There is also a perceived growth in “hard core” girl groups exhibiting “laddish” behaviours. Young people also told us of a growth in racism. They would also benefit from an increase in positive recreational activities as “there is absolutely nothing to do round here.” The local authority youth service had to stop any universal youth work across the borough on 31 March 2015. Partnership agencies tell us that they used to just get “the unwashed and uncared for”. Now they are being asked to work with young people who have been “overindulged”. We have also been told that there is not enough dedicated work in our area that tackles these issues and barriers in a way which allows their learning to progress. Many, if not all, focus on purely academic achievements.

**Work by the Children in Care Council and Black Country Children’s Society**

This piece of work focussed around a wellbeing questionnaire which identified issues which affected looked after children and young people’s wellbeing.

**Speak Up Speak Out**

This brief report highlights some of the key messages that young people shared with us between October 2013 and May 2014. It can be best understood alongside the ‘Mash Up’ that we created of children and young people speaking about their experiences of care and leaving care in the ‘Big Brother’ room.

**Aims and objectives**

We were initially asked to do some work with young people in care and leaving care. The overall aim of this piece of work was to assist Dudley in becoming an ‘outstanding’ authority in relation to listening to the voice of looked after children and young people.

The target cohort of children and young people were:
- young people who are new to care
- young people who are 1-2 years in care
- young people who have left care
- young people who are in permanent foster care

This cohort will include disabled young people, those in out of borough placements and BAME young people.
The specific objectives for this work were to work with the target cohort of children and young people to:

- Find out what children and young people’s perspectives and experiences of relationships with social workers and people that care for them.
- Understand what children and young people’s experiences and reality of contact arrangements are.
- Explore children and young people’s journey so far, including barriers and opportunities they are facing.
- Explore their understanding of why they are where they are (what do they understand about why they are in care).
- Gather and compare evidence of wellbeing using The Children’s Society Health and Wellbeing Index.
- Collect a sample of ‘authentic voices’ of children and young people which tell their story in their own words.
- Facilitate an event in March 2014 championed by an elected member to present the findings of the report.

What did we do:

1. Working with the Participation Cohort team, we developed a wellbeing questionnaire based on the wellbeing work being done by The Children’s Society nationally. This was publicised by Dudley Council amongst social workers, foster carers and other professionals working with young people in care and leaving care as well as directly to young people through residential units. We received 43 questionnaires back from young people across Dudley.
2. We developed some more in-depth focus group questions. We conducted these with a further 30 young people through focus groups or one-to-one interviews.
3. We ran a two day participation event for young people in care and leaving care during February half-term, which 60 people attended. The event included a Big Brother diary room, graffiti, music and street dance workshops and a range of other ways for young people to get involved.
4. We worked with the CICC (MAD) to put together a funding application for Pot of Gold funding to organise, deliver and evaluate an event for young people in care and leaving care to celebrate their successes and achievements. The group were successful in securing £800.

What are we still to do:

Speak with young people from out of borough placements. We have been provided with contact details for social workers and young people and we are in the process of contacting them.

What did young people say:

There are over 700 young people in care in Dudley. The views and experiences we have collected, reflect that of the young people who took part and should not be used to make generalised statements about what young people think and feel. One young person when asked what was good about care in Dudley said “nothing, cos you’re in here for a reason”. This reminds us of the challenging relationship between social workers and young people who can often come up against one another.
Below we have collated some of the key messages that came out repeatedly from the young people we spoke to:

1. **Relationships with social workers.** Getting hold of social workers can sometimes be difficult. Social workers are good (mostly). Some social workers take the side of foster carers. Some social workers don’t listen to us separately. Some avoid subjects or change subjects. We have had too many social workers. Some social workers don’t visit as often as they should.

2. **All I need is love.** Some young people said that their foster carers made them feel wanted and that this was important.

3. **Foster care.** Many experiences of foster care weren’t positive. Young people suggested that there should be more time to get to know the foster family before being placed there. Some young people said that foster carers did it for the money.

4. **Freedom / choice.** Many of the young people raised issues around being monitored very closely, not being able to personalise their bedrooms, having their say at bed times and curfews, being able to be more independent (cooking etc..), having TV’s in their bedrooms.

5. **Contact.** Young people’s experiences of contact were varied. Some young people felt that they did not have as much as they would like to. Some said they could see workers dropping notes to one another during contact which made them feel uncomfortable.

6. **Opportunities.** Some young people said that care had provided them with lots of experiences that they may never have had.

**What did young people think would make it better?**

- Social workers should have a day in the life of children in care so that they know what it feels like.
- Social workers who care about children and young people.
- Time to get to know foster carers before being placed with them.

**Other areas to consider:**

- The relationship between the CICC (MAD) and the Corporate Parenting Board needs to be stronger.
- The participation cohort group should include young people and should develop as a sub-group of MAD.
- Not many young people were aware of what the pledge is – this needs to be shared with children and young people. There also needs to be a way of monitoring how well Dudley MBC is meeting the pledge.
- Some young people did not know what their rights and entitlements were.

**Since August 2014 – looking forward:**

The Children's Society has been asked by Dudley MBC to complete the following work:

- Create a participation sub-group to look at ways of engaging more looked after children and young people
- Organise an event using the funding that young people were successful in securing.
- Continue to publicise and encourage young people to complete the wellbeing survey.

During this time further observations have been highlighted by professionals and young people around some of the barriers to participation of looked after children and young people as follows:
• Information sharing between social care and other organisations is limited. Some children and young people will be unaware of opportunities that are available to them.

• Looked after children and young people highlight the stigma they sometimes feel about being labelled as looked after. Sometimes they would like to organise events that invite other children and young people (i.e. their friendship groups) rather than just for looked after and care leaving groups.

• Transportation can sometimes become a barrier for children and young people being involved and in some cases foster carers reluctance to get them there.

• Finding ways of engaging with foster carers is essential to enabling young people to get involved.

We have started working with a group of young people who are putting plans together for a celebration event to be held in January 2015.

We will also be bringing together a group of local professionals to support the young people with planning, organising, delivering and evaluating this event and the idea is that we will work collectively to do this.
Appendix 3 Emotional Health and Wellbeing Steering Group Terms of Reference

1. Introduction

The Emotional Health and Wellbeing Steering Group (EHWB) in Dudley have established a forum with multi agency attendees to deliver the priorities as set out in Dudley’s Local Transformation Plan. To improve service outcomes for children and young people and drive up change within mental health services in Dudley.

By definition CAMHS services are multi-agency involving Statutory and Voluntary Sector partners.

2. Purpose

The purpose of the Emotional Health and Wellbeing Steering Group (EHWB) is to establish a forum that will:

- Undertake work to integrate services and develop co-ordinated pathways through task and finish groups.
- Priorities and agree areas of work from the Strategic and Commissioning Action Plan.
- Provide quarterly updates on work streams from task and finish groups.
- Identify and address strategic, commissioning and development issues.
- Co-ordinate and monitor the progress of task and finish groups.
- Ensuring the “voice of the child” is incorporated into all children service developments.
- Keep members updated on decisions, outcomes from the Children and Young People’s Alliance Health and Wellbeing Board meetings.

3. Aims

The key aims of the group are to:

- Be responsible for the delivery of the agreed Strategic and Commissioning action plan based on the vision and intentions outlined in the Children and Young People’s Mental Health and Emotional Wellbeing CAMHS Local Transformation Plan.
- Agree priority actions from the Strategic and Commissioning Action Plan that are to be delivered within the agreed timescale.
- Provide help to inform the contracting process for CAMHS services.
- Taking into account the needs of other vulnerable and risk groups are being met in Dudley.

4. Responsibilities

Members of the EHWB steering group are expected to:

- Attend regular quarterly meetings to provide updates on work streams, task and finish groups and reasons for any slippage.
• Identify the task and finish group that will deliver the identified priorities from the action plan.
• Monitor risks and issues to effective delivery and ensure appropriate mitigating actions are undertaken;
• Actively participate in discussions as appropriate.
• Provide updates on action agreed from the previous meeting.
• Supply relevant and valid information, on behalf of the organisation or sector that members represent, as appropriate.
• Consult with, and seek the views of, others within the organisation or sector they represent and provide feedback to the steering group.
• Where a member is unable to attend he/she will have responsibility for deputising their role to someone with appropriate authority within their organisation or sector.

5. Membership

The membership of this group is sufficient to provide strategic leadership to deliver the programme plan and includes everyone on the list in Appendix B. Who consist of representatives from:

- Dudley Clinical Commissioning Group
- Dudley MBC Children’s Social Care, Education and Public Health Services
- Dudley & Walsall Mental Health Partnership NHS Trust
- Safeguarding
- Community and Voluntary Sector Providers
- Feedback will be sought from Engagement groups
- Guest speakers will be invited on an ad hoc as and when required basis.

6. Governance Arrangements

The EHWB steering group is accountable to the Children’s and Young People’s Alliance Board and ultimately the Health and Wellbeing Board. The task and finish groups will feed into the EHWB steering group. The task and finish groups will have specific responsibility for the development of pathways and outcomes as identified within the CAHMS local transformation plan and Children and Young People’s Outcomes framework transformation programme. These will be monitored for effectiveness of the service and provide regular feedback, intelligence on service performance that will inform the commissioning cycle.

The Children’s and Young People’s Alliance Board will report into the Health and Wellbeing Board.

The EHWB steering meeting will be chaired by the Chief Officer for Dudley Public Health or the Vice Chair in the Chairs absence.

7. Frequency of Meetings

• Meetings shall be held on a quarterly basis, and no less than four meetings a year.
Meetings will be interactive and last no longer than a minimum of 3 hours.

8. **Agenda Items**

The agenda, with attached meeting papers, will be distributed at least five working days prior to the next scheduled meeting.

Standing agenda items will include:

- Commissioner updates
- Case studies
- Task & Finish Group updates
- Service user reference group updates
- Risks

9. **Minutes and meeting papers**

The minutes of the EHWB steering group meeting will be prepared by CCG administration support.

The agenda and papers of the meeting will be distributed five working days in advance of the meeting.

10. **Ground Rules**

To ensure that meetings run smoothly and effectively, members will be expected to adhere to the following rules:

- Members will read circulated reports and other materials in advance of meetings
- Discussions should follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus; seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting
- Talk one at time; wait to be recognised by the Chair
- Turn mobile phones off, to silent or on vibrate
- Be respectful of other members ideas, views and cultures

11. **Review**

The terms of reference will be reviewed one year after approval. Any resulting changes to the terms of reference will be presented for approval to the Emotional Health Wellbeing Steering Group.
Appendix 4

The following table summarises the services that were available, in 2015, to support children and young people’s SEMH and well-being in Dudley. Additional information on the core services is described below.

<table>
<thead>
<tr>
<th>UNIVERSAL</th>
<th>TARGETED</th>
<th>SPECIALIST/CRISIS</th>
<th>SPECILAIST/ACUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening, promotional, preventative work</td>
<td>Services enhancing work of universal services for more vulnerable CYP</td>
<td>Multi-disciplinary specialist services for complex CYP</td>
<td>Specialist services for highest levels of need</td>
</tr>
</tbody>
</table>

**Early Help universal offer including Healthy Child Programme**
- Ante-natal & post-natal services (Midwifery & Health Visiting)
- Maternal mental health (Midwifery & Health visiting)
  - 'listening visits’ to track mother’s mental health
- Family Centres and health visiting
  - Solihull parenting approach
  - Child health & development reviews (Health Visiting)

**Early Help universal plus offer**
- Midwifery and Health Visiting ‘listening visits’ & targeted work
- Family Centres – targeted work
- School Nursing
- Triple P parenting support for CYP with conduct problems
- Connexions
- Improving Access to Psychological Therapies service (16+)
- Mellow Babies Counselling and targeted mental health support
  - School Counselling service – traded service via EPs
  - Other counselling commissioned

**Specialist & targeted services (assessment, intervention & treatment)**
- Child & Adolescent Specialist Service Team
- CAMHS Learning disability team
- Deaf CAMHS team (0-18 years)
- MDT neuro-developmental panel and Team
- The What Centre
- Multi Systematic Therapy (for small group on edges of or in care)
- Flipside
  - (Multi-dimensional treatment fostering)

**Highly specialist and resource intensive services**
- Tier 4 in-patient CAMHS services
- Special school provision for children with social, emotional and behavioural needs
- Social Care – Stage 4 Child Protection Services
- Continuing Care for those in OoB Placements including those sentenced to custody in the youth justice secure estate
- Family support workers
- School Nursing (Healthy Child Programme 5-19)

**Primary care services – GPs A&E**

**Schools**
- Some Whole School/College approaches (including anti-bullying approaches) - patchy
- Pastoral Care & nurture groups – valuing more support
- Personal, Social and Health Education (*gap in colleges & few SEL programmes mentioned*)
- Healthy Schools support programme & school nursing
- Head Teachers Fora and networks – support work

**Family Information Service directory of help**

<table>
<thead>
<tr>
<th>直接由学校提供</th>
<th>通过学校直接提供</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurture groups and mentoring commissioned only by some schools</td>
<td></td>
</tr>
<tr>
<td>Kooth online counselling (available only in some schools)</td>
<td></td>
</tr>
<tr>
<td>The What Centre (not commissioned for 18+)</td>
<td></td>
</tr>
<tr>
<td>Special Educational Needs provision and Education psychology service (half LA commissioned/half traded service)</td>
<td></td>
</tr>
</tbody>
</table>

### Vulnerable groups

- The Phase Trust
- Switch substance misuse service
- Social care and looked after children teams
- Alternative education provision
- CSE team
- Teenage outreach nurse
- NHS all age health point of arrest Liaison and Diversion screening (10+) Youth offending service
- Top Church Training (homeless young people)
- Dudley Foster Carers
- The What Centre’s LGBT support group

### KEEP

- Barnardo’s sexual abuse counselling
- Young Offenders CAMHS
- Children Looked After specialist CAMHS
- Families First/Troubled Families (for families facing multiple and complex challenges)
- CSE team
- Family Nurse Partnership
- Multi-Agency Safeguarding Hubs (MASH)
- Mellow parenting

- Successful anti-bullying approaches
- Whole School College approaches
- Some pastoral Care & nurture groups – valuing more support
- Personal, Social and Health Education (*gap in colleges & few SEL programmes mentioned*)
- Healthy Schools support programme & school nursing
- Head Teachers Fora and networks – support work
Description of existing baseline services as of 2015.

Family Information Service (Universal)

A4.1 The Family Information Service (FIS) is a statutory service and offers an online directory to give families a useful guide to services and organisations that support children and young people, parents, carers and the people who work with them.

A4.2 The service also has information on all Ofsted registered childcare providers in Dudley. The database includes childminders, day nurseries, playgroups, toddler groups, crèches, play schemes, after school clubs and home based child carers. Further information is available on all aspects of family life. FIS work closely with the childcare strategy team to promote good quality affordable and accessible childcare. There are 4 (FTE) staff including a manager and an apprentice and between April to Sept 2015 the service received 10705 contacts.

Children’s Centres (Universal)

A4.3 The role of the Children’s Centres is to intervene early in order to improve a family’s physical and emotional wellbeing leading to enhanced family functioning and resilience. Children’s Centres provide this largely through the Family Support Service working directly with children and parents to strengthen attachment between parent and child, help parents and children develop and maintain behaviours that support positive outcomes and prevent emerging problems becoming entrenched and more serious.

A4.4 There are currently five children’s centre clusters with twenty Children’s Centres across the borough providing targeted Early Help to children under 5 years and their families. There are 18367 children aged 0-5 living within the Dudley Borough, 10175 (DWP data 2013) of these children live within areas defined as being in the top 30% most disadvantaged within the country (IMD Data 2010).

- 15033 Children aged 0-5 are Registered with Children’s Centres across the Borough.
- 8514 Children aged 0-5 Registered with Children’s Centres across the Borough are living in areas of disadvantage.
- 905 children have had an assessment and are engaged with Family Support service. Of these there are:-
  - 34 Looked After Children.
  - 128 on a Child Protection Plan.
  - 98 Children in Need.

The What? Centre (Targeted)

A4.5 The service provides therapeutic sessions for young people between the ages of 13 and 18 and young people with a disability up the age of 25. It enables
young people to have access to early intervention with regard to their mental health. Some of the issues covered are abuse, self-harm, suicidal ideation, depression, eating disorders, bullying, low self-esteem and relationships. Short or long term therapeutic sessions are offered.

A4.6 The What?Centre has in place a qualified group of staff using a range of counselling approaches including:

- Integrative, psychodynamic and person centred counselling
- Cognitive behavioural approaches
- Play therapy

A4.7 The What?Centre provides both targeted (primary care or Tier 2) and specialist (secondary or Tier 3) services. Data suggests that 9 out of 10 young people have diagnosable level difficulties. The What?Centre Counsellors have also developed specialisms in eating disorders, working with suicidal young people and young people affected by trauma.

A4.8 The CCG has recently undertaken an extensive review of the service and has analysed all referrals, and resulting activity, for the period 2013 to 2014. The total number of referrals to The What? Centre was 311 resulting in a 398% increase in the number of sessions that are required on the current contract value. A STAR outcome measure evaluation has demonstrated the following improvements:-

- 84% improved mental health;
- 85% improved identity/self-esteem;
- 78% improvements in trust and hope;
- 66% improvements in relationships;
- 46% improvements in physical health and self-care;
- 60% improvements in work/school issues;
- 50% improvements in responsibilities;
- 50% improvements in social networks;
- 49% improvements in living skills;
- 30% improvement in gaining responsibility.

A4.9 Benchmarking nationally on STAR on line with other organisations the service found that:-

- across all scales 58% had obtained a “big increase” in improvement which can include clinical change when compared with national figures of only 50%;
- 33% had obtained a “small increase” in improvement (at least one point on each scale) compared with national figures of only 23%;
- the overall figures on the service when compared with national figures then show 91% having achieved either a small or a large improvement compared with the national figure of only 73%.

A4.10 Analysis of referrals from April 2015 to date demonstrates a similar trend.
KOOTH (Targeted)

A4.11 Kooth.com is currently an important local ‘open access’ (e.g. self-referral and open to everyone) online counselling service in Dudley and data was provided by this service for this needs assessment. The service is commissioned by the CCG for 11 to 26 year olds. Data suggested that the service was engaging with young people presenting with a range of mental health needs - mostly those needing help with social and emotional difficulties. Counselling takes place through online messaging and peer mediated fora. The service is available 24/7. The KOOTH team works in a multi-agency context, and in particular has established links with Education, CAMHS and Health.

A4.12 Data for 2015-16 indicated:

- 429 children and young people had been engaged during the last quarter of 2015/16 with an average contact rate of around three contacts per child. 357 children and young people were described as ‘active users’ of the service. The number of children and young people in touch with the service had doubled since the previous quarter. However, registrations had fluctuated considerably month by month over the last financial year.
- the average age of active users over the last year was 16 years of age with just under a quarter of young people being around 13 years of age. The ages of those contacting the service spanned 11-26 years.
- there had recently been an increase in the number of boys contacting the service. However, girls were still twice as likely to engage as boys.
- two thirds of contact was out of office hours
- 12% of those contacting the service were from BME communities (a slight decrease compared with the previous quarter from 14%)
- 100% of those using the service would recommend the service to a friend and it scored an average satisfaction score of 4.38 out of 5.
- 82% of those using the service said that they preferred online to face to face contact; this needs to be cross referenced with the wider survey completed by Young Health Researchers in Dudley indicating that three quarters of their broader sample of young people in Dudley (n=1160) preferred face to face contact.

The main presenting issues of young people approaching the service were anxiety, depression, self-worth, confidence and friendships. A small minority of young people had more serious mental health needs. The age breakdown of referral demonstrates that of the total 782 referrals 82.6% were between the ages of 0-18 and 17.6% between the ages of 18-25.

A4.13 Overall, in terms of understanding where kooth.com fits in the Dudley system of support for children and young people, it would appear that the service is building resilience, addressing early stage social, emotional and mental health needs and risk factors for poor wellbeing and de-escalating emerging need. It is also picking up a very small number of young people with more serious mental health difficulties.
**Triple P Parenting Programme (Targeted)**

A4.14 Data is available for Triple P programmes but not for broader parenting work in Dudley. Triple P parenting support is a stepped system of parenting support. The best evidence exists for Level 4 programmes (which are specifically effective for children with early behavioural problems helping parents develop approaches and techniques which help settle children’s behaviour) and level 5 programmes (for parents facing complex difficulties whose children have severe and persistent behavioural problems). However, shorter term Triple P seminars are developing a growing and promising evidence base for making a difference to children with behavioural difficulties. Although less proven, there are also Triple P programmes for parents with teenagers with behavioural difficulties. To be effective, level 4 and 5 group programmes have to be well targeted towards those children already showing signs of behavioural difficulty. They must also be implemented as they were designed and should maximise recruitment and retention strategies. In the last year:

- 380 referrals were made to Triple P
- around 200 parents completed the programme

Data was only available for one quarter of the year (and only for around 56 parents), but indicated the following findings:

- Average child and teenage Strength and Difficulty Questionnaire scores for those accessing the intervention suggested that parents of children with diagnosable level difficulties were indeed accessing these groups in Dudley.
- There were improvements in Strength and Difficulty Questionnaire scores after completion (although shifts with such a small sample are unlikely to be significant).
- There were larger improvements in parental depression rates, anxiety and stress following attendance (thus also promoting adult mental health outcomes). In almost all instances parents had started in the severe range for distress in terms of depression, anxiety and stress. After completion of the programme distress levels had reduced to moderate.

**The Phase Trust (Targeted)**

A4.15 The Phase Trust delivers interventions which support the social, emotional and mental health of children and young people in Dudley. In the last year, it has provided 59 young people (aged 12-20) with intensive 1-2-1 sessions to help them overcome emotional and behavioural challenges. This will be at the very least six sessions of between 1 and 2 hours per session. Some support was more intensive extending to 2 to 3 days per week over a 10 week period.

The majority of these young people had complex difficulties, including low-level autism and Aspergers’ conditions, ADHD, high anxiety, eating disorders, and some with histories of suicidal tendencies. Some of these young people
had experienced serious mental illness and had disengaged from formal mental health services. Many had huge gaps in their education due to mental ill health.

A4.16 The Phase Trust uses an outreach approaches and gentle persistence to engage young people and focuses on social and service user led Recovery orientated approaches. Young people have a personalised programme, which has some common content but is also tailored to their needs and aspirations.

A4.17 A further 50 young people aged 16-17 received transitional support to enable them to carry on their educational journey, into college or some other form of further education (The Step Up service). All of these had learning difficulties or complex vulnerabilities impacting on their mental health and wellbeing. 90% of these were described as making ‘a successful transition’. The intervention took the form of an intensive three week programme over the summer break, intentionally focused on dealing with issues such as handling transition and change, dealing with potential conflict, being able to speak up if they were beginning to struggle and coping mechanisms for handling anxiety and stress.

A4.18 The Phase Trust has also completed school based health promotion work with young women on sexual health and boundaries (n=170) as well as one to one sessions with at risk girls in schools (101).

**Education Psychology Team (Targeted)**

A4.19 The aim of the Educational Psychology Service (EPS) is to remove barriers to learning and includes increasing the access to education, ensuring that educational setting have a good understanding of how they can support children with additional needs and their emotional needs. The EPS is funded from two sources, core funding and income from traded work. This governs the nature of the work that is undertaken. With respect to core funding the Council has a statutory duty, under the Children and Families Act 2014, to use educational psychologists in the assessment of Special Educational Needs and Disabilities of children and young people for whom a statutory assessment for and the need of an Educational Health and Care Plan (EHCP) has been agreed. EP activity commissioned by education settings and other services includes assessments of individual children and young people; therapeutic interventions and work with parents.

**School Counselling (Targeted)**

A4.20 The Schools Counselling Service is a traded service managed by the local Educational Psychology Service. It appears to provide counselling for around 140 children a school year and covers 15 local schools. Schools either purchase counselling places on an annual basis or sometimes spot purchase what they need. Interventions involve a 10 session change approach. Outcome data shows that half of those engaged started with scores of 17 or over on the Strengths and Difficulties Questionnaire. This means that half of
their caseloads involve children likely to have diagnosable level mental health needs.

A4.21 Based on an analysis of one quarter of outcome data, analysis shows around two thirds of these children make improvements compared with their starting points and 20% move out of damaging and distressing clinical diagnosable level) ranges. Unusually, 64% of those engaging with the service are boys/males. There is no detail on age or ethnic background. Some counselling was delivered via group work. Data indicates that a small minority had issues which escalated very dramatically over a term resulting in scores suggesting a very high degree of concern and complexity. Some counselling supported safeguarding disclosures and link up to statutory services as follow-up. There were also many other referrals on to other services (Education Psychology and CAMHS) for children whose wellbeing escalated during the course of counselling. The manager explained that the service sought to advise schools on step down and provided ongoing advice on management. The service also sought to provide ‘talk to me’ times for parents and advice on strategies.

A4.22 The service offers a range of skills including person-centred/integrative counselling, cognitive behavioural therapy, play therapy and drama therapy. Counsellors are qualified and routinely provided with clinical supervision.

**The Family and Adolescent Support Team (FAST) (Targeted)**

A4.23 FAST operates above the social care threshold and currently delivers a range of services aimed at supporting families so that children can remain at home safely. The services provides:

- family support around developing parenting skills, routines and boundaries, behaviour management, health and nutrition, budgeting and confidence building through one to one and group work, refer out for Triple P, followed by 1:1 support to re-enforce it in the home;
- support to families to children on a protection plan, care plan and children in need plan;
- direct work with adolescents with social issues;
- a rapid responses service to families in crisis using a solution focussed approach (“Prevention & Intervention”);
- Family Group Conference - a voluntary family led decision making meeting;
- support to parents with a learning disability using the Parent Assessment Model (PAMS).

**Early Assessment Team (Targeted)**

A4.24 The team support agencies to undertake CAF assessments and develop family support plans, in order to identify when a problem begins to emerge within a family and prevent these problems becoming embedded or escalating. This is achieved by early identification and coordinated support to children and families across the borough. Between 1/04/2014 to 20/05/2015
there were a total of 515 assessments completed. The CAF team is centrally located and consists of two CAF officers and one part time admin officer.

Family Intervention Team – Troubled Families (Targeted)

A4.24 The Troubled Families Programme is delivered through the Family Intervention Team. The Programme has ‘turned around’ the lives of 100% of the 740 families registered on Phase 1 of the programme and received £784,800 in Payment by Results as well as £1,553,600 in Attachment Fees. Dudley achieved good performance in Phase 1 programme as one of the highest performing LA’s, and as a result were invited by DCLG to sign up to Phase 2 of the expanded programme as an early adopter. Dudley was accepted on the first wave of early adopters of Phase 2 of the programme in September 2014. Phase 2 of the Troubled Families Programme national criteria includes ‘children who need help.’

Connexions (Targeted)

A4.25 Connexions Dudley is part of Dudley Council’s Children’s Services Directorate working across the borough in mainstream schools, special schools, colleges, training providers and outreach locations. The services supports young people aged 13 – 19 (up to aged 25 for those with learning difficulties and or disabilities) providing information, advice and guidance in relation to further education and employment opportunity. The core service is delivered to the vulnerable, targeted groups of young people within schools (mainstream and special), colleges and the community. All schools have a named adviser linked to them, and all postcode areas have a named adviser working with the NEET 16-18 year olds within each area. They do this via community outreach locations and home visits.

A4.26 Throughout 2014/15, Connexions advisers saw a total of 6984 Young people in a 1 to 1 intervention, 1031 young people with their parent/carer and 646 parents/carers. This is a total of 8661 interventions with targeted vulnerable young people. From the traded service, Connexions Advisers also saw 758 young people in a 1 to 1 intervention, 69 young people with their parent/carer and 8 Parents. This is a total of 83 young people as part of the traded service to schools.

A4.27 The team is made up of 2 team managers, 1 project manager (half post), 20 Personal Advisers (FTE) and 2 administrators.

Teenage Pregnancy Team (Targeted)

A4.28 Teenage Pregnancy Team (TPT) work with young people on prevention and supports teenage mums. The service works with extremely vulnerable young people including children in Care. TPT are closely aligned to the Child Sexual Exploitation Team, both making and receiving referrals as appropriate. The core business is prevention, and this sees the team work with young people around making healthy relationship choices, understanding the law,
preventing unwanted conceptions, and all other issues concerned with sexual health. This is done on a one to one and group work basis.

A4.29 Between October 2014 and September 2015 TPT have responded to 526 referrals (prevention and support). In Dudley there were 179 under 18 conceptions (30.7%*) in 2013, down from 203 (34.6%*) in 2012 (*conception rate per 1,000 women in age group).

Specialist Child and Adolescent Mental Health Service (Specialist)

A4.30 The CCG commissions the majority of our secondary and primary health care services, including IAPT for 16+, from Dudley and Walsall Mental Health Partnership Trust. As with the national picture there is a separate CAMHS (0-16 years) and AMHS (18+ years). If a child is in the service they will continue to get support, if appropriate until they are 17. As such the age range of the service will be extended up to the age of 18 from April 2016.

A4.31 Dudley specialist CAMHS and some elements of Child Psychological Services work with children and young people with complex, severe and/or persistent needs, reflecting the needs of the child or young person. The service is delivered through a multi-disciplinary team approach. The overall aim is to provide intensive interventions to children, young people or their families that cannot be met solely through universal and target services. The service is delivered through a single point of access CAPA approach. The Service is available for Dudley children and young people and their families, under the age of 16 years with identified or suspected emotional, behavioural or psychological/psychiatric difficulties for which specialist intervention is required.

A4.32 Children up to the age of 18 also have access to the following services:-

- Out-patient clinics (all ages);
- Existing CAMHS (0-16);
- Children under 5s Clinic;
- ASD Clinic (5-16);
- ADHD Clinic (5-16);
- Early Intervention in psychosis (14+);
- Eating Disorder Service (all ages);
- Criminal Justice Liaison (all ages);
- Early Access Service (16+);
- Psychiatric Liaison (16+);
- Home Treatment and Crisis Resolution Service (16+);
- Mental Health Urgent Care Centre and the Emergency Department (all ages).

Looked After and Adopted Children’s Psychology Service (Specialist)

A4.33 The LAAC Psychology Service aims to provide highly specialist psychological support for Dudley looked after & adopted children, young
people, families, carers and other professionals involved in their care. The service aims to meet the specific and often complex psychological health and wellbeing needs of looked after and adopted children and the systems in which they are cared for. This population often have multiple, complex, high risk and/or and enduring mental health and psychological needs resulting from high levels of child abuse, neglect and trauma in early life.

A4.34 The service provides support to children and young people in:-

- foster placements;
- adoptive families;
- special guardianship orders;
- friends and family placements;
- residential units;
- secure accommodation;
- 14+ Team (young people leaving care).

A4.35 The LAAC Psychology Service offers advice, consultation, teaching, training and supervision. It does not currently offer specialist psychological assessments and therapeutic interventions.

**Neurodevelopment Delay Service (Specialist)**

A4.36 This service provides a holistic, multidisciplinary service in a dedicated environment to children that been identified as needing additional support that cannot be provided by existing community services.

A4.37 The service is managed by a dedicated Health Visitor and includes dedicated nursery nurses. There is clinical and therapeutic input from Paediatric Consultants, Occupational Therapy, Speech and Language Therapy, Physiotherapy, Audiology, Clinical Psychology and Orthoptics.

A4.38 Four – five children can attend the nursery at any one time with children being allocated to a trained nursery nurse, who has the responsibility of ensuring that the assessment is completed. Again this area would benefit from an improved performance management and data framework.

**Youth Offending Service (Specialist)**

A4.39 Dudley Youth Offending Service provides a service to all young people aged 10-17 years who come to the attention of the police or courts for criminal offences. It is a multi-agency team including 0.5 CAMHS Practitioner required to conduct mental health assessments and to sign-post young people with mental health needs to the most appropriate service. The CAMHS Practitioner is also involved in the direct provision of targeted services and in supporting the Youth Offending Service case manager in their work with youth offenders with mental health issues.
A4.40 The Substance misuse service (drugs and alcohol) is a service available for young people up to the age of 18 living in the Dudley Borough who are experiencing chaotic or harmful drug and/or alcohol use including legal highs, prescribed medication and over the counter medication. The service provides a range of specialist interventions that support a recovery focused treatment system.
Appendix 5 – Early Help Model

Overview of Proposed Dudley Early Help and Safeguarding Model from April 1st 2016

**Single Point of Access (SPA)**
Provides information and advice and refers to locality based Early Help, specialist mental health services or the MASH
- Team Managers, Social Workers
- Early Help Social Worker(s)
- Specialist Mental Health Worker
- Housing, Education
- Family Information Service

**MASH**
Refers to Social Work teams
- Team Managers
- Social Workers
- Police, Education, Housing, Health, Probation and
  -

**Social Work Service**
Assessment Teams
- Single Assessment - S17 and S47
- Care Management Teams
- Children’s / All Age Disability service
- Centrally based teams working to each locality

**Locality Based Multi Agency Early Help Provision**
Primary Mental Health Services
Schools cluster (Learning Partnership)

**Locality Based Multi Agency Early Help Provision**
Primary Mental Health Services
Schools cluster (Learning Partnership)

**Locality Based Multi Agency Early Help Provision**
Primary Mental Health Services
Schools cluster (Learning Partnership)

**Specialist Mental Health Services**

**Borough wide services**
Accessed through social work or locality teams
- “Rapid Response” (edge of care) service
- Family Group Conference Service
- Parenting Assessment Service
- CSE and Missing Service
- YOS
Appendix 6 – Proposed All Age Mental Health Model

ALL AGE MENTAL HEALTH SERVICE REDESIGN MODEL

ALL AGE EMOTIONAL AND WELL BEING PRIMARY CARE SERVICE

PLANNED CARE

URGENT CARE
## Appendix 8  Financial Profile 2016-2018

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 CAMHs/CAU service</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>88,000</td>
<td>164,000</td>
</tr>
<tr>
<td>Contribution to Tier 3+</td>
<td>150,000</td>
<td>300,000</td>
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<tr>
<td>Specialist Conferences for ED</td>
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<tr>
<td>Interim ED worker</td>
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<tr>
<td>Interim CAMHS/LAC worker</td>
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<td>Service User Engagement</td>
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<td>Independent Audit Review</td>
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<td>GP Liaison</td>
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<tr>
<td>Additional Therapeutic intervention for CSE - Phase Trust</td>
<td>15,000</td>
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</tr>
<tr>
<td>Additional Therapeutic intervention for CSE - DMBC</td>
<td>8,750</td>
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<tr>
<td>0-18 Emotional and Wellbeing Team</td>
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<td>140,000</td>
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<td>Undertake a staff skills audit.</td>
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<tr>
<td>Development of the Universal offer in educational settings.</td>
<td>20,000</td>
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<tr>
<td>Review of Parenting Programmes.</td>
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<tr>
<td>ME Festival support.</td>
<td>2,650</td>
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<tr>
<td>PSIAMS Pilot.</td>
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</tr>
<tr>
<td>Unallocated Non-Rec slippage Items marked</td>
<td>48,900</td>
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<td>Enhancing the Integrated Tier 2/Vulnerable EHWT (universal element)</td>
<td>30,000</td>
<td>30,000</td>
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<tr>
<td>Fund the Phase Trust to provide a personalised programme support to CYP with less complex difficulties.</td>
<td>15,000</td>
<td>15,000</td>
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<tr>
<td>Clinical Psychotherapist to provide therapeutic support to our high risk CSE children.</td>
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<td>45,799</td>
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<tr>
<td>Part fund Family Therapist for ED service</td>
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<td>20,201</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>357,250</strong></td>
<td><strong>507,750</strong></td>
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The following table details the aims and objectives of each of the key themes identified in 2015 to bring sustainable transformational change by 2020.

<table>
<thead>
<tr>
<th>Priority 1</th>
<th>Development of a Single Point of Access Early Help Offer.</th>
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<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>At this stage we do not have a strategy that enables services to work collaboratively together where children, young people and their families receive support in a timely way and tailored to their individual circumstances. As such we are not seeing the benefits of taking a consistent child and whole family approach</td>
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</tbody>
</table>
| **Objectives** | By April 2020:  
Children and young people are safe from harm in the home, outside of the home and online  
Children and young people have the best start in life and are ready school  
Children live healthy lives  
Children and young people learn well  
Young people make positive transitions into adulthood  
Families provide safe and supportive homes for their children |
| **Outcomes** | Working together with families to develop their capacity for change  
Taking a whole family approach  
Ensure children, young people and their families receive the right support at the right time. |
| **KPIs** | To be determined. |
| **Resources Required** | It is proposed that this will be delivered from existing resources. |
| **Future in Mind Theme** | Promoting, resilience, prevention and early intervention |
| Priority 2 | Integrate the current 0-5 years’ service provision within CAMHS with the Neurodevelopment Delay Service and transfer into a community setting. |
| **Case for change** | The existing services are delivered independently and in different locations within an acute service delivery model. The plan is to integrate the services and transfer into locality based children’s settings to align with the 0-5 year universal integrated model that is currently being developed. |
| **Objectives** | By 2020 our local offer will:  
Ensure services are responsive to meet current and future demand and need, resourced appropriately and delivered by a skilled workforce.  
Improved access and waiting times for children and young people requiring ASD assessments.  
Enables the redesigned service to operate more effectively, with less historical backlog of assessments and waits.  
Have an integrated community service. |
| **Outcomes** | Reduced waiting times for children and young people.  
Improved patient experience for children, young people and their families.  
Additional young people will be assessed by April 2016. |
| **KPIs** | 100% children having a differential diagnosis  
100% children diagnosed to be on the autistic spectrum to be referred to the Autism Out Reach Service.  
15% reduction in waiting times.  
20% increase in referrals to both services. |
<p>| <strong>Resources Required</strong> | £100,000 |</p>
<table>
<thead>
<tr>
<th><strong>Future in Mind Theme</strong></th>
<th>Improving access to effective support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority 3</strong></td>
<td>Expand the existing school based Emotional Health and Wellbeing Team.</td>
</tr>
<tr>
<td><strong>Case for change</strong></td>
<td>We wish to extend this provision to all CYP in a variety of settings and aligned to our locality early help approach.</td>
</tr>
</tbody>
</table>
| **Objectives**                   | By April 2020 we will: -  
  - have a skilled team of professionals working at Tier 2 level that will improve emotional, psychological and social wellbeing outcomes for children and young people via interventions delivered through a range of settings including schools;  
  - improve the quality and accessibility of tier 2 services for children and young people in a timely manner;  
  - prevent inappropriate referrals into specialist CAMHS;  
  - have a strong involvement from CYP in shaping and monitoring our provision. |
| **Outcomes**                     | Improve emotional, psychological and social wellbeing outcomes for children and young people via interventions delivered through schools.  
  Improve the quality and accessibility of tier 2 services for children and young people within the school setting.  
  Increase the capacity of the schools community including school health advisors to prioritise and meet the emotional health and wellbeing needs of children and young people. |
| **KPIs**                         | Within Service Specification |
| **Resources Required**           | Indicative funding – £140,000 |
| **Future in Mind Theme**         | Promoting, resilience, prevention and early intervention |
| **Priority 4**                   | Establish the All Age Emotional Health and Well Being Primary Care Service to include CYP IAPT |
| **Case for change**              | The current primary Care service is delivered by our acute setting and is for the 16+ age range. We what to redesign our service so that it is all age a primary care service and is more closely linked to our GP practices. The CCG does not have a CYP IAPT service |
| **Objectives**                   | By April 2020 we will: -  
  - have age appropriate services and support to children and young people;  
  - have a range of health care professionals trained and delivering CYP IAPT;  
  - developed pathways between all our providers of “talking therapy” services. |
| **Outcomes**                     | Increase access to “talking therapies”.  
  Earlier identification and intervention.  
  Reduction in Specialist CAMHS activity.  
  Reduced waiting times for children and young people.  
  Improved transitions for young people to enable them to access support based on their individual need and not restricted by age limits.  
  Improved family relationships  
  Increase the use of CYP principles across a range of partners who support the delivery of EH&WB services. |
| **KPIs**                         | 10 staff trained in CYP IAPT (2016-17).  
  Training curriculum chosen to include all options from the national curriculum (CBT for anxiety and depression, parenting training for |
behavioural and conduct disorders for 3 to 10 yr olds), systemic family practice for conduct disorder (over 10's) depression, self harm and eating disorders, interpersonal psychotherapy for adolescents for depression. Supervisor trained.

**Resources Required**

IAPT National Funding

**Future in Mind Theme**

Improving access to effective support

<table>
<thead>
<tr>
<th>Priority 5</th>
<th>To develop a “CAMHS” a Tier 3+ service as part of our existing Home Treatment service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case for change</td>
<td>Evaluation of the service commissioned by Walsall CCG has demonstrated the numbers of Tier 4 beds have been</td>
</tr>
<tr>
<td>Objectives</td>
<td>By April 2020 we will: provide effective, timely and accessible services for children and young people with mental health and emotional wellbeing needs; delivered using a range of evidenced based interventions delivered within the community, home and within assertive outreach practices see an increase in the number of young people supported in the community with self-harm presentations; reduce the number of young people requiring in-patient admission and support.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Improved resilience amongst young people. Increased early identification and support, to prevent needs from escalating. Increased capacity within mental health and emotional wellbeing services.</td>
</tr>
<tr>
<td>KPIs</td>
<td>20% reduction in in-patient bed days. 90% response rate for crisis support within designated times. 90% patients who are exhibiting concerns not detained in police custody. Add more</td>
</tr>
<tr>
<td>Resources Required</td>
<td>Indicative funding – £228,000</td>
</tr>
<tr>
<td>Future in Mind Theme</td>
<td>Improving access to effective support</td>
</tr>
</tbody>
</table>

<p>| Priority 6 | To commission a 0-18 year old Children and Young People’s Community Eating Disorder Service in partnership with Walsall CCG. |
| Case for change | The current provision is supported through professionals within the Specialist CAMHS Service, with limited resource to meet the current demand and needs of our local population. The development of a community based eating disorder service will enable capacity to be released from the Specialist CAMHS service to undertake additional mental health assessments for children and young people with moderate to severe mental health needs, and support the service to alleviate waiting time pressures. Capacity will be released to support the 0-18 generic specialist CAMHS. |
| Objectives | By 2020 will we: Have a community based service for young people to receive support to services close to home to meet individual needs; greater awareness amongst early intervention, prevention and universal services in the early identification of eating disorders and greater support provided to prevent needs from escalating; increased resilience amongst young people and their families. |</p>
<table>
<thead>
<tr>
<th><strong>Outcomes</strong></th>
<th>Released pressures in Specialist CAMHS and Inpatient services; Released clinician time and capacity to undertake additional assessments; Empower young people and families to manage and receive specialist support tailored to individual need; Reduced waiting times within the Specialist CAMHS service; Implementation of a stepped care community based service.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KPIs</strong></td>
<td>20% reduction in inpatient admissions for Eating Disorders. To be 100% compliant with the data recording requirements as outlined within the CEDS standards. 100% response rate in day 1 where referral is assessed as urgent. 100% response to patient/parent/carers to assess and classify risk from day referral received. 100% notification to GP on same day of referral where risk is assessed as urgent. 100% high risk/risk management clinic conducted within 5 days of referral. 100% of patients on high risk pathway receive treatment for physical risk, psychiatric risk, weight loss stabilisation within 7 days from referral. 100% of cases on high risk pathway receive formal review within 15 days of referral. 100% of patients with anorexia nervosa or bulimia nervosa receive follow up treatments for up to 12 months following treatment on high risk pathway. 100% of patients receive treatment within 23 days on the ‘getting help’ managing routine cases pathway. 100% receive formal review at 4 weeks on the ‘getting help’ managing routine cases pathway.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>Indicative funding – £92,000</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>Improving access to effective support</td>
</tr>
<tr>
<td><strong>Priority 7</strong></td>
<td>Develop therapeutic pathways provision for victims of Child Sexual Exploitation.</td>
</tr>
<tr>
<td><strong>Case for change</strong></td>
<td>A CSE Team is now in place therefore pathways are clearer and the volume of referrals are growing. As a result of this more support is required to ensure young people who become victims of CSE are supported appropriately. Demand for improved CSE approaches is recognised both locally and nationally.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>The objective is to ensure we have clear pathways and appropriate interventions that prevent, reduce and support young people around CSE.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>By April 2020 we will:- understand the CSE picture in Dudley; develop a clear training package of support for all professionals raise awareness within the community all professionals who work with children and young people will be able to spot the signs of CSE.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>KPIs</strong></td>
<td>To be determined.</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>Care for the most vulnerable</td>
</tr>
</tbody>
</table>
The following table details the aims and objectives of each of the key themes that were non-recurrently funded in **2015-16** to improve access and equality to services and build capacity and capability in the system to deliver the required sustainable transformational change by 2020.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Improving Access and Equality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>Addressing Specialist CAMHS waiting times</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Unacceptable waiting times across range of services (see Appendix x)</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>To provide access and support to children and young people at times to suit them. To reduce waiting times to contract values.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>£180,000</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>Improving access to effective support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Additional Therapeutic intervention for CSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>Currently partners are working hard to implement the new pathways and access relevant training and supporting documentation. If funding were available we would be able to commission the Phase Trust to work with the existing CSE Team to develop pathways which would support these vulnerable children.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Pathways to be developed.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>£12,000</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>Care for the Most Vulnerable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Community Eating Disorder Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>The current provision is supported through professionals within the Specialist CAMHS Service, with limited resource to meet the current demand and needs of our local population.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>To commission the new service from 1st January 2016.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Review service by 31st March 2016 to inform the future model of service provision.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>£10,000</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>Improving access to effective support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Early Attachment Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>Currently partners are working hard to implement the new pathways and access relevant training and supporting documentation. If funding were</td>
</tr>
</tbody>
</table>
available we would be able to ensure that training was offered to all partners (not just Health Visitors) which would support our current integration model and further improve experiences and outcomes for families.

We would also be able to target fathers more effectively and also offer some bespoke service for BME communities.

In addition we would be able to commission a pilot from a local charity (Home Start) to do some focused work with families who are not engaging with the Health Visiting Service (possibly the families most in need of early intervention) with two aims, firstly to support them to access mainstream services but also, where appropriate, work directly with the family.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Increase the number and skill mix of front line professionals accessing the following training:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baby Massage</td>
</tr>
<tr>
<td></td>
<td>2 day Dudley breastfeeding management</td>
</tr>
<tr>
<td></td>
<td>Solihull Approach</td>
</tr>
<tr>
<td></td>
<td>Perinatal Mental Health Training</td>
</tr>
<tr>
<td></td>
<td>Signs of Safety Promotional Guide training</td>
</tr>
<tr>
<td></td>
<td>Responsive parenting / feeding</td>
</tr>
<tr>
<td></td>
<td>Holding and Reassurance (Peter Walker)</td>
</tr>
<tr>
<td></td>
<td>Offer bespoke sessions for fathers / BME communities.</td>
</tr>
</tbody>
</table>

| Outcomes | More front line professionals, with a varied skill mix offering a first class service to Dudley Families. |
|          | Further engagement from targeted groups (fathers/BME).                                      |
|          | An increase in the number of families accessing the Health Visitor Service.                   |

| Resources Required | £50,000 |

| Future in Mind Theme | Promoting, resilience, prevention and early intervention |

| Priority | Evaluate Emotional Health and Wellbeing provision for LAC |

| Case for change | Looked after children represent one of the boroughs most vulnerable groups and the evidence highlights that they are disproportionately represented within higher tiered provisions. It will be important for services to ensure specific resources are allocated to this group to provide targeted early intervention to mitigate the impact of difficult contributory life experiences. It is recognised that the routine screening and assessment of children at presentation to care is inconsistent and would benefit from a clear evaluation to consider better ways of partnership working. |

| Objectives | Looked after children receive early support and interventions to address emerging emotional health and wellbeing issues. |

| Outcomes | Services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people. Reduced waiting times to access services and beyond. Identifying, reaching out to and prioritising vulnerable group e.g., children on the edge of care, leaving care, homeless, complex needs, substance misuse, domestic violence and sexual exploitation. |
Commissioning is informed by robust data, information and outcomes reporting to enable effective and consistent service provision across all partners.

<table>
<thead>
<tr>
<th>Resources Required</th>
<th>Future in Mind Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>£40,000</td>
<td>Care for the Most Vulnerable</td>
</tr>
</tbody>
</table>

**Priority**  
KOOTH increase in referrals

**Case for change**  
Increase in demand for service.

**Objectives**  
Commission more capacity in 2015-16 to meet demand.

**Outcomes**  
20% more clients supported by the service.

<table>
<thead>
<tr>
<th>Resources Required</th>
<th>Future in Mind Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>£14,000</td>
<td>Improving access to effective support</td>
</tr>
</tbody>
</table>

**Priority**  
Additional capacity for EHCPs

**Case for change**  
Existing statements need to be transferred into EHCPs in response to the SEND Reforms.

**Objectives**  
To increase educational psychology and therapeutic capacity to undertake assessments to inform EHCP plans.

**Outcomes**  
All existing statements to be transferred to an EHCP by March 2016.

<table>
<thead>
<tr>
<th>Resources Required</th>
<th>Future in Mind Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>£35,000</td>
<td>Care for the Most Vulnerable</td>
</tr>
</tbody>
</table>

**Building Capacity and Capability in the System**

**Priority**  
Educational Settings and Training Plan

**Case for change**  
Currently there is inequitable delivery of the emotional health and wellbeing agenda across settings; the approach is fragmented and we recognise the need to join up services and have a training plan and provision in place signed up by all key partners.

16 schools are already signed up to the Whole School Approach (WSA) to Emotional Health and Wellbeing (EHWB) with 27 having expressed an interest. We would ideally like to extend this to all schools (all schools in Dudley are already signed up to the healthy schools programme) however staff capacity and the non-statutory nature of this area of work in an already stretched curriculum make this difficult. With a level of funding to enable suitably skilled professionals to help staff to understand and deliver the whole school approach and evaluate the impact more schools may buy in.

There is an Emotional Health and Training Programme available for all primary, secondary and special school staff. However, the programme is currently heavily focused on the emotional development elements and in particular attachment and nurture with a universal, targeted and specialist model of delivery. There remains a need for the Mental Health elements to
be included and despite previous delivery from CAMHS, Primary Mental Health Workers and an external provider to pilot Mental Health First Aid Youth there has not been a sustained Mental Health element.

If funding were available it would be beneficial to extend the emotional development elements of the training to enable more schools and colleges to understand the links between emotional health, physical health and learning and to explore a suitable programme of mental health training at the right level for school staff.

The PSHE association have recently produced guidance for teachers and a programme of mental health awareness training for school staff to deliver. This would benefit from a supported delivery model again utilising appropriately skilled professionals.

All of these elements would benefit from a funding boost to support their integration and with the right level of evaluation highlight the impact that good EHWB support has on overall health and learning potential.

The sustainability would be achieved through the integration of the approach through the Early Years, schools and Colleges group, the new tier 2 emotional health and wellbeing team and ‘CAMHS’ link approach.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Increased number of schools signed up to Whole School Approach (WSA) to Emotional Health and Wellbeing (EHWB). Audit current training and gaps in training provision in the educational setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>By April 2016 we will have a training plan developed in consultation with all key stakeholders. Commission delivery of nurture training. Commission and deliver/pilot training where we know there are gaps.</td>
</tr>
<tr>
<td>Resources Required</td>
<td>Schools based audit to include consultation with staff / schools /colleges and development of an evidence training based plan -£5,000 Nurture group training universal, targeted and specialist cost of £3,000 per 20 delegates. £6,000 requested for 40 staff.</td>
</tr>
<tr>
<td>Future in Mind Theme</td>
<td>Developing the Workforce</td>
</tr>
</tbody>
</table>

**Priority**  Commissioning Support

**Case for change**  The scale of transformational change attached to this plan is significant and evidences the need for additional Commissioner capacity to support and implement effective change. Increased requirements around care and treatment reviews further this need.

**Objectives**  To extend our integrated commissioning approach by broadening the scope of our section 75 agreement around learning disability commissioning to become all age. So to provide specific capacity to support 0-18 emotional health and wellbeing.

**Outcomes**  By April 2016 we will sufficient commissioning capacity to deliver this change programme.

**Resources Required**  £48,000

**Future in Mind Theme**  All
<table>
<thead>
<tr>
<th><strong>Priority</strong></th>
<th>CYP Engagement Event and Development of Communication Strategy for CAMHS transformation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>There has been a considerable amount of engagement activity with children and young people between April 2013 and September 2015, carried out by a range of partnership organisations across the borough. Appendix 1 details the engagement activities carried out with Children and Young People to date to inform this transformation plan but we have not yet asked the views of our children about the contents of the plan and how we should implement the plan.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>We have started working with a group of young people who are putting plans together for a celebration event to be held in January 2015. We will also be bringing together a group of local professionals to support the young people with planning, organising, delivering and evaluating this event and the idea is that we will work collectively to do this. This funding will be used to commission additional capacity support the event and develop</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Children, young people and their families actively engaged in the implementation of this plan and developing the workforce. A better understanding of issues regarding CYP. Prioritise key areas which require further engagement / research. Recommendations that will inform the transformation agenda. A process developed that will continue to support engagement.</td>
</tr>
<tr>
<td><strong>Resources Required</strong></td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>Future in Mind Theme</strong></td>
<td>All</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Priority</strong></th>
<th>Consultation Event with BME population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>We know from research that: -</td>
</tr>
<tr>
<td></td>
<td>• black and minority ethnic (BME) parents with mental health problems are likely to experience poverty, unemployment, and homelessness;</td>
</tr>
<tr>
<td></td>
<td>• some common family structures, such as lone parenting, can increase the risks arising from isolation and lack of support for both parents and their children. People from BME communities are poorly served by mental health services. BME parents with mental health problems are often reluctant to use existing services because these are often not culturally sensitive to their needs;</td>
</tr>
<tr>
<td></td>
<td>• reluctance to access services may result in mental health problems becoming more severe before diagnosis, treatment and support is obtained;</td>
</tr>
<tr>
<td></td>
<td>• mental health problems among BME parents, compounded by lack of treatment and support, can have enduring effects upon their children and contribute to their over-representation in the child care system;</td>
</tr>
<tr>
<td></td>
<td>• though it is possible to generalise from the greater body of research into mental health problems in BME communities we need to understand what this means for children and young people in Dudley;</td>
</tr>
<tr>
<td></td>
<td>• we know from service reviews, consultation with BME communities</td>
</tr>
</tbody>
</table>
and some of the work we have started that there are areas and needs of the BME population we can do with understanding better.

| Objectives | Scope an appropriate methodology to undertake social research with BME communities that involves participation and engagement with BME communities on possibly the four areas where we recognise issues exist; maternal health (0-5), culture/religion and intergenerational issues (i.e. are our younger generation experiences different to older generation) gender inequalities, stigma.

| Outcomes | A better understanding of the issues regarding CYP from BME communities. Prioritise key areas which require further engagement/research. Recommendations that will inform the transformation agenda. A process developed that will continue to support engagement from the BME community.

| Resources Required | £26,000
| Future in Mind Theme | Care for the most vulnerable

| Priority | Skills audit of staff
| Case for change | It is recognised that there remains duplication across the system in terms of the supporting provision for children with emerging emotional health and wellbeing issues. It will be important as we work towards the integration agenda to gain a clearer understanding of the skills across the partnership to consider the opportunities for cross skilling staff and rationalising the workforce across the delivery of tier 2 work.

| Objectives | By April 2016 we will have:
- a clear partnership workforce strategy
- a learning and development framework

| Outcomes | Services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people.

| Resources Required | £25,000
| Future in Mind Theme | Developing the Workforce

| Priority | Deep Dive Needs Assessment
| Case for change | We recognise that needs assessment is the foundation of the commissioning process and will form the basis from which outcomes are identified, services are planned, resources committed and progress measured.

The Dudley JSNA brings together, in a single, continuous iterative process, all the information on the health and wellbeing needs of Dudley's population. It examines current and predicted health and social care needs, as well as the other main things that affect people's life-chances, quality of life and health and wellbeing. By identifying the major issues that need to be addressed regarding people's health and wellbeing it provides the evidence base needed to develop Dudley's Joint Health and Well-being Strategy (JHWBS).
Although the JSNA takes a life-course approach and has chapters on children and young people, the focus is more on physical health and not on emotional health and wellbeing and mental health. We recognise that this is an area we need to focus on to help shape and inform our CAMHS services.

### Objectives

By April 2016 we will have a needs assessment that will:

- describe the levels of need within the Dudley Population;
- describe what children and young people, professionals and other stakeholders say;
- describe the provision / activity data on child and adolescent mental health in tiers 1 to 4;
- review the evidence base of good practice;
- assess unmet need to inform commissioning and service model development, including inequalities in service provision and access;
- make recommendations to inform service provision and the transformation plan;
- inform the Health and Wellbeing Strategy.

### Outcomes

A better understanding of inequalities in mental health outcomes. A understanding of where there is inequitable distribution/provision of services. An evidence based approach to shaping and delivering the transformation agenda.

### Resources Required

<table>
<thead>
<tr>
<th>Future in Mind Theme</th>
<th>£50,000</th>
</tr>
</thead>
</table>

### Priority

| Autism audit and developing pathways |

### Case for change

The number of referrals to the ASD Clinic and the Neurodevelopment Delay service has increased in 2015 to date. We need to understand why this is the case and what are the presenting conditions.

### Objectives

To undertake an assertive case review of all referrals. To further develop the pathway between the ASD Clinic, the Neurodevelopment Delay Clinic and Autism Out Reach Service.

### Outcomes

Provide effective, timely and accessible services for children and young people on the autistic spectrum. Seamless service for children and young people. Improved patient experience for children, young people and their families.

### Resources Required

| Improving access to effective support |

### Priority

| Evaluating the response to E-safety |

### Case for change

Issues relating to E-safety and cyber bullying is a rapidly emerging area of concern for young people the impact of which has a profound impact on the emotional wellbeing of those increasing numbers affected. It is recognised that intelligence relating to this area remains undeveloped. In planning for resource allocation as part of the transformation programme it will be necessary to commission an evaluation to look at the issues surrounding digital and social media. The work will consider pathways for children and young people who experience bullying, harassment and threats of violence along with best practice and evidenced based
approaches to support those that have fallen victim.

### Objectives

Services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people.

Use of evidenced based practice informs all that we do.

Commissioning is informed by robust data, information and outcomes reporting to enable effective and consistent service provision across all partners.

### Outcomes

Development of targeted services to support children who have experienced harm through digital technologies.

### Resources Required

£25,000 to commission evaluation.

### Future in Mind Theme

Care for the most vulnerable

The Table below outline the addition recurrent funding and non recurrent funding workstreams funded from our **2016-17 allocation**.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>£ (R)</th>
<th>£ (N/R)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enhancing the Integrated Tier 2/Vulnerable EHWT to incorporate the universal element of the EHWT.</td>
<td>30,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fund the Phase Trust to provide a personalised programme of 1-2-1 or/and group support for those children and young people, with less complex difficulties, who need intervention support to help them cope with their mental health and well-being challenges</td>
<td>15,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fund a Clinical Psychologist to provide therapeutic support to our high risk, threshold level 4 cases of those at risk of / involved in Child Sexual Exploitation (CSE). This post will be part of the Integrated Tier 2/Vulnerable EHWT.</td>
<td>45,799</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part fund Family Therapist for ED service.</td>
<td>20,201</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake a skills audit of the workforce that support children and young people that may have a SEMH need.</td>
<td>39,700</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of the Universal offer (primarily in educational settings).</td>
<td>20,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review the existing Parenting Programme support services</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial support to the children and young people's engagement for the ME FESTIVAL.</td>
<td>2,650</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fund a PSIAMS Pilot to offer children, families and practitioners an opportunity to co-ordinate plans, personal information and the wishes and feelings of the child in question through a range of media which offers an alternative to print.</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake an audit of the existing CAMHS service delivery model.</td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide additional therapeutic support to CAMHS/ LAC.</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total funding</strong></td>
<td></td>
<td><strong>111,000</strong></td>
<td><strong>232,350</strong></td>
</tr>
</tbody>
</table>
The following table details the aims and objectives and of each of the work steams funded recurrently from unallocated 2016-17 funding.

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Family Therapist for Dudley CAMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case for change</td>
<td>At present in Dudley CAMHS we do not have a commissioned Family Therapist, input is currently due to a locum arrangement that we are funding through slippage monies.</td>
</tr>
<tr>
<td></td>
<td>NICE guidelines state that all eating disorder cases should include family interventions including work with siblings as part of the treatment plan, this is due to the effects on other family members and the need for them to be able to support each other.</td>
</tr>
<tr>
<td></td>
<td>Anorexia nervosa presentation in adolescents would particularly benefit from family interventions focused explicitly on eating disorders. In patients where there is deterioration or no significant improvement, combined individual and family work should be offered and a move from just individual therapy.</td>
</tr>
<tr>
<td></td>
<td>There is also emerging evidence of the need to tailor treatment to the characteristics of each patient and their family hence family therapy is more electric as it is integrated into a variety of interventions. Family therapy has shifted from a deficit based (normalising pathology) to a resource-based approach to render family resources available to challenge eating disorder and other mental health conditions. The richness of the family approach is contingent on the therapist’s ability to take into account the specifics and idiosyncrasies of each particular family and construct interventions accordingly to unique need.</td>
</tr>
<tr>
<td></td>
<td>Systemic family therapists offer a unique skill base that incorporates the above principals not just for eating disorder cases but for a range of mental health issues where family beliefs and patterns may impact a child/young person’s recovery. Fully qualified family therapists are dual qualified therefore they bring the advantage of a complimentary model/discipline.</td>
</tr>
<tr>
<td>Objectives</td>
<td>A dedicated post holder would be able to offer the following on a more consistent basis:</td>
</tr>
<tr>
<td></td>
<td>- To offer a flexible and timely service for families referred as research/guidelines suggests earlier intervention has better outcomes. Days and times for appointments are agreed with the patient and family to allow flexibility.</td>
</tr>
<tr>
<td></td>
<td>- Consultations to colleagues and where appropriate other agencies including LAAC to assess the suitability for family therapy intervention).</td>
</tr>
<tr>
<td></td>
<td>- An apprentice model of learning for trainees on long term placement e.g. Psychologists, Medics</td>
</tr>
<tr>
<td></td>
<td>- Introduce a range of tasks, games, experiments to enable family members to present their own unique resources and learn to function independently of CAMHS in the future</td>
</tr>
<tr>
<td></td>
<td>- To offer a combination of choices to families as to who to invite to sessions this can include siblings, extended family members, friends, foster carers and professionals if required both within and outside of CAMHS.</td>
</tr>
</tbody>
</table>
To offer a more holistic service for eating disorder cases by working with all the family and professional systems with a view to preventing further deterioration and prioritising inpatients that are discharged into the community.
- To offer team reflections in front of the family in a transparent and curious yet non-judgemental manner.
- To be able to contribute to generic choice/partnership assessments and therefore embed themselves further within the wider professional system and offer joint working and management responsibilities from a systemic lens.

**Outcomes**
- Families that have accessed family therapy state that their recovery has been helped by the flexibility in the approach offered by seeing the whole family system.
- Family therapists use playful techniques to suit different age groups and needs
- Family therapists are collaborative in setting goals and care plans that allow families to understand that they have the solutions to many of their problems, therefore the therapists are there to help facilitate this process.

**KPIs**
- Currently there are seventeen families waiting for family therapy intervention, the reduction of this waiting list would be priority.
- To strengthen the family’s ability to support each other and the young person concerned by involving them in the treatment plan particularly in the case of children and young people with an eating disorder.

**Resources Required**

| £20,201 |

**Future in Mind Theme**

**Proposal**

**Development of the universal element of the EHWT Team (tier 2) service model.**

**Case for change**

The CAMHS Transformational Plan is about delivering the vision for Dudley to be a place where children and young people thrive and have the capacity to develop both physical and emotional resilience and driving change to improve outcomes. Part of that vision is that children and young people will be resilient and manage their emotional health and wellbeing in their family, school and community.

Dudley is a diverse and changing borough with some specific challenges. The demand for services is increasing and therefore a greater focus upon preventative interventions and work around resilience and universal services and programmes to support wellbeing are essential.

The commissioned Needs Assessment (Centre for Mental Health, 2016) recommendations included that commissioners prioritise early intervention and prevention and create emotional health and wellbeing teams linked to schools/colleges/GPs/Early Help Hubs, create a local system for supporting whole system mental health literacy and good quality interventions, and support development of School-based universal programmes for CYP (audit).

A tier 2 service to support children, young people and their families is a key component of Dudley’s Transformational Plan and the intention has always been for the tier 2 team to have a link to the universal provision with regard to training and support at a universal/tier 1 level.
There would be distinct advantages to having an appropriately skilled staff member to help facilitate not only the universal/tier 1 & tier 2 pathway and provision e.g. Whole school Approaches to EHWWB and Nurture provision but to work in close partnership with appropriate partners to ensure that commissioned services are provided based on need and in response to data/intelligence held and the recent needs assessment referred to above.

**Objectives**

- Improvement in availability of universal good quality school SEL programmes supporting children’s social, emotional and mental health skills.
- Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.
- Provide an interface between those working in and attending educational settings, parents and carers and the professionals providing services e.g. Educational Psychology, School Nurses and Tier 2 team.
- Liaise at a strategic level with partners in the CCG, OPH, DCVS and commissioned providers e.g. DWMH.
- Identify and work in partnership to develop relationships and pathways between a wide range of commissioned services well placed to provide support at a universal level e.g. Young Carers Support and Safe and Sound Partnership.

**Outcomes**

**Access**

Support the recommendation to improve access to information, help, advice and support.

**Co-ordination**

Support and facilitate Work with partners, CYP and parents/carers to develop clear set of integrated and understandable whole system pathways linked to schools, Early Help Hubs and Vanguard developments Communication;

Facilitate and maintain systems to improve communication between commissioners and providers ensuring that the views of CYP, parents and carers are reflected.

**KPIs**

Number of children who have received a whole school intervention to develop social and emotional skills in Dudley

Proxies for the effectiveness of such interventions might include:

- percentage reduction in secondary school exclusion rates
- improved well-being (measured through biennial HBSCS)
- reduced bullying (measured through biennial HBSCS)

Requires an audit to create a baseline (separate request for non-recurrent funding required) This will then allow measurement of improvement going forward

Number of schools signed up and delivering whole school/ evidence based approaches to promote mental health and wellbeing.

**Resources Required**

The current allocation from CAMHS transformation monies towards the Tier 2 team developments is £140,000 & £35,000.

The additional funding required to develop the team into a tier less service
encompassing the universal elements will require an additional £30,000 recurrently

For 2016/17 £15,000

<table>
<thead>
<tr>
<th>Future in Mind Theme</th>
<th>Promoting resilience, prevention and early intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposal</td>
<td>Provide a personalised programme of 1-2-1 or/and group support for those children and young people, with less complex difficulties, who need intervention support to help them cope with their mental health and well-being challenges.</td>
</tr>
</tbody>
</table>

| Case for change | This support supports the recommendation in the recent Dudley Needs assessment report relating to early intervention and prevention. The report highlighted the following concerns which were shared by young people, parents and practitioners across the borough |

- Young people felt resilience was deteriorating due to poor awareness, coping skills and knowledge of where to get help.
- Most young people approach parents for help in Dudley, Who supports parental awareness?
- Accessing help promptly was a considerable concern.
- Young people wanted open access help to get quickly back on track.
- They hated being: categorised and assessed.
- Insufficient early intervention and prevention Parenting support for children with early conduct disorder reaches only around 14% of local need.
- Few good quality universal school based SEL programmes mentioned – young people say they lack info and skills.
- Support for children with less complex diagnosable difficulties is only meeting around half of need = log jam.
- Mental health needs of Children in Care and children affected by Child Sexual Exploitation are considerably underserved.
- Children with Learning Disability needs or lower level SEN are likely to be underserved.
- Young adults have poor access to mental health support – need better information and audit.
- Better whole system and outcome data required reflecting priorities – with monitoring. |

During the needs assessment feedback presentation Phase Trust were credited for their early help social model of intervention. It was a verbal recommendation that further development and widening of this support be commissioned.

| Objectives | - Provide young people with coping skills for their barriers, specifically relating to high anxiety, low-level autism, depression etc.  
- Increase awareness and belief that their specific challenges do not need to be a barrier to life opportunities.  
- For individuals to recognise the signs of moving from coping to struggling and be able to address them at the earliest possibility.  
- To identify need early, to help avoid crisis and a future long term intervention.  
- To signpost to appropriate additional support networks.  
- To support any therapeutic services currently involved in care. |
| **Outcomes** | - Increased resilience in young people.  
- Continued or re-engagement in education, employment or training.  
- Young people move from struggling to coping, from coping to well.  
- Reduce isolation and build potential community/positive social connection.  
- Embedded behaviours that support an individual’s mental health and well-being. |
| **KPIs** | - Progress made by the individual during programme cycle toward set objectives (varies according to targets created by each participant).  
- Completion of support programme.  
- Evaluation by individuals regarding satisfaction of programme. |
| **Resources Required** | £15,000 |
| **Future in Mind Theme** | Promoting resilience, prevention and early intervention. |
| **Proposal for 2016-17 recurrent funding** | Funding for a Band 7, Clinical Psychotherapist post to specifically focussed on offering therapeutic support to our high risk, threshold level 4 cases of those at risk of / involved in Child Sexual Exploitation (CSE). |
| **Case for change** | The CSE offer in Dudley is currently under review to ensure that we have a robust, consistent and enduring strategy in place. The pathways for dealing with CSE need to become more prescriptive and must be a priority for every professional working with children and young people, not something dealt with in silo by one specific team.  

One area that is lacking within our current offer is therapeutic input that will provide on-going, long lasting support to those seriously affected by CSE. The purpose of this proposal is to identify funding that would provide a post dedicated to dealing with these high level cases. Any level 4 cases we currently receive are managed through the CSE team. For the higher level 4 cases our current arrangements are not sustainable will be spot purchased from Barnardos.  

This funding will link in with the Children’s Services Improvement Plan in terms of CSE improvement. It will also form a key part of the wider CSE strategy. Improvement plan actions (Phase 1) need to be undertaken now, with the (Phase 2) wider strategy being an on-going piece of work. Regular reviews of the strategy will take place at least every 12 months. The current CSE Strategy runs from 2015-2018. |
| **Objectives** | In regards to how the offer will look, the proposal is as follows:  
- Referrals come in via SPA and any specific concerns being matched against the CSE screening Tool.  
- More serious concerns will be passed to the Multi Agency Safeguarding Hub (MASH) and may then go through to Social Care assessment (Social Care undertake the NWG Risk Assessment).  
- The referral then comes back to Police and the CSE coordinator, who will make a decision as to whether the referral will go on to a Multi Agency Sexual Exploitation (MASE) meeting.  
- The case will then be given a significant or serious risk category and the best intervention is then decided upon. Medium/High-Level |
case will receive Early Help support but high level / serious cases will be referred for Therapeutic input.

The aim of early intervention work is in part to identify risk and to intervene before things get too entrenched.

Clinical Psychologists are trained with highly specialist skills which are pertinent to working with this vulnerable group of children and young people. These include skills of very close observation; skills of thinking about what is under the surface that might be causing the presenting difficulty which makes the child or young person vulnerable to sexual exploitation; an ability to talk about difficult and sensitive issues, which are often embarrassing, in a way that the young person is able to hear. They are particularly able to work with groups of young people who are difficult to reach and who don’t respond to other interventions. The post holder will be part of the Integrated “Tier 2” service.

The post holder will make a range of contributions to the work of the team:

- They can offer direct work with children and young people;
- They can offer thinking to the CSE team about some of the dynamics that can get acted out around this vulnerable client group;
- They can offer thinking to staff in schools and Children’s Services who need support with managing the complex emotions which get raised when young people are at risk of sexual exploitation.

Direct work with young people could take the form of one off sessions or short term therapeutic interventions, or more sustained help and support. The will be able to identify where more specialist or longer term work in CAMHS is needed and link with the CAMHS team to enable effective care planning.

The post would enhance the current robust mental health provision for children and young people as it would be a dedicated post. It would allow for robust partnership working by providing the child or young person with a timely seamless access to CAMHS if specialist mental health intervention was required, this would benefit them as they would only have to tell their story once.

**Outcomes**

The aim of this work is to reduce sexual exploitation of young people. Bringing the hidden into the open and finding a way to talk about it gives it less power and allows professionals the chance to work with young people to keep them safe. By the very nature of sexual exploitation, the emotions and reactions associated with this can be very powerful - areas which are considered private can be embarrassing to talk about. Therefore work with young people who are vulnerable to sexual exploitation has to be approached carefully and sensitively. This work may have a number of aims.

It will raise the young person’s awareness of the risk they put themselves in, it could be to bring to light some of the hidden motivations which might be attracting or driving the young person towards behaviour which might be sexually exploitative.

This work can increase the young person’s awareness of the risks and
what might be leading them to this kind of behaviour. This awareness can give the young person important information which essential for them to be able to make conscious decisions about what they are doing. The aim of this would be to try to break the cycle of exploitation by working on a change of pattern of thinking or behaviour before it becomes entrenched.

This means that with sustained support young people can find ways of relating in a different way, which is not based on exploitation but on a sense and confidence within the young person that they can form more meaningful and equal relationships where they have an active say in how they want to engage with others.

The young people that this support will focus on will require on-going, long-term support to get out of the cycle of exploitation. Therapeutic support will help victims of CSE right from the point of when disclosures are made. The pathway will also mean that there are robust and comprehensive step up and step down processes in place so that anybody dealing with CSE cases are clear about the process they need to follow.

**KPIs**

- Improve children’s early access to therapeutic support.
- Reduce number of children exposed to CSE.
- Strengthen the family’s ability to support each other and the young person who is at risk of CSE.
- Reduce the number of children and young people that are victims of CSA.
- Raise awareness of CSE/CSA in schools.

**Resources Required**

£52,000

**Future in Mind Theme**

Care for the most Vulnerable

The following table details the aims and objectives and of each of the work steams funded from 2016-2017 slippage.

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Development of the Universal offer (primarily in educational settings)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case for change</strong></td>
<td>We need to value the importance of recognising and promoting good mental health and wellbeing in all people, not just focusing on mental illness and diagnosis. There is evidence that supporting families and carers, building resiliency through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course. Many schools are already developing whole school approaches to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do. Evidence shows that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes. The proposed named mental health lead for schools would also make an important contribution to leading and developing whole school approaches. An effective system supporting the mental health of children is one that amongst other things: -</td>
</tr>
<tr>
<td></td>
<td>• Builds capacity in parents, children and young people so that they can promote and preserve wellbeing and also know how to</td>
</tr>
</tbody>
</table>
- Recognises the important role that whole-school approaches play in supporting children and young people’s mental health and attainment.
- Commits to an ‘invest to save’ approach: recognising that inadequate early investment stores up problems for all sectors later on, damaging children’s outcomes, reducing quality of life and building up later crisis costs (Knapp, et al., 2011).
- Provides a clear gateway with trouble-free access to an easy to understand offer of help for all children, young people and families. The offer should be developed in collaboration with parents, children and young people and backed up by a single gateway to get help.

**Objectives**

To support the recommendations made in the emerging Dudley Needs Assessment.

To support/ undertake an audit of universal provision in Educational settings for CYP.

To review current training offer and design a more comprehensive universal training programme in consultation with children and young people, parents and carers, school staff and support agencies which has the capacity to be delivered in a variety of formats e.g. centre based, team based(e.g. in schools) and on-line in order to maximise uptake and accessibility.

To develop a comprehensive evidence based resource collection to be used in training, group work and 1:1 support.

To support the development of nurture groups in educational settings.

To support the development of SEMH website script and signposting (to be aligned with the CYP website being developed in Dudley).

**Outcomes**

Audit of Universal services - will identify gaps in service provision.

A clear and comprehensive programme of training with improved accessibility and capacity

A clear and comprehensive offer of evidence based initiatives to support universal wellbeing (alignment to tier 2 team).

Highly skilled team with adequate resources to support training, group interventions and individual support to professionals, children, young people and their families.

**KPIs**

Improvement in availability of universal good quality school SEL programmes supporting children’s social, emotional and mental health skills (as recommended in needs assessment (audit required to create a baseline. This will then allow measurement of improvement going forward).

Improve children’s early access to SEMH help.

Number of children who have received a whole school intervention to
develop social and emotional skills in Dudley.

Proxies for the effectiveness of such interventions might include:

- percentage reduction in primary and secondary school exclusion rates;
- improved well-being (measured through biennial HBSCS);
- reduced bullying (measured through biennial HBSCS);
- Improved attendance.

**Resources Required**

£20,000

**Future in Mind Theme**

Promoting resilience, prevention and early intervention

**Proposal**

Review of Parenting Programme

**Case for change**

There is strong evidence of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. These are benefits to the individual child and family, as well as producing significant cost saving to the system as a whole. Such programmes should remain a priority for local authorities and better links developed with specialist services to work jointly on cases where families have difficulty engaging in groups or need intensive individual support before they are ready to join a group.

There are around 19,652 infants and children aged 0 to 5 in Dudley based on recent population estimates. During routine contact with universal primary care, maternity services and the Healthy Child Programme, families benefit from help that focuses both on the physical and emotional wellbeing of their child. This can include the role played in an infant’s development by positive attunement, which ‘jump starts’ infant’s cognitive and emotional health, sensitive and positive parenting and of attachment which helps children to self soothe and regulate emotions and behaviour over time.

The Dudley Needs assessment identifies that we are not investing enough resource into parenting programmes. It estimates that Triple P Parenting support only currently reaches about 14% of the families who could benefit from this evidence-based intervention which provides proven strategies for settling children’s behaviour. Severe behavioural problems are the most common childhood mental health problem.

It is advised that Dudley’s commissioners should double the number of children with early starting severe behavioural difficulties aged 2-10 years whose parents are reached by Triple P and other NICE guidance compliant parenting interventions. This should result in reaching 200 more children and young people thereby contributing to half of annual NHS England goals to improve access.

**Objectives**

To support the recommendations made in the emerging Dudley Needs Assessment and Future In Mind.

To review the current parenting programmes and help develop more robust evidence based targeted approaches to parenting.

To identify future funding options and strategies to double the number of
parents (of children with early starting severe behavioural difficulties aged 2-10 years) supported by parenting programmes.

To reduce waiting times for parenting programmes.

**Outcomes**

Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour. With additional funding, this would be delivered by enhancing existing maternal, perinatal and early years health services and parenting programmes.

**KPIs**

Review undertaken – identifies current service provision and opportunities to redesign /increase evidence based parenting support programmes.

Numbers of additional families accessing parenting programmes (reduction in waiting list).

**Resources Required**

£10,000 (with a view that future recurrent funding maybe allocated to support implementation)

**Future in Mind Theme Proposal**

Promoting resilience, prevention and early intervention

**Case for change**

The theme this year is Emotional Health and Wellbeing. 40 primary schools within the Dudley borough have signed up. Me Festival is an informal but fun, interactive and educational day on November 24th at Himley Hall. A number of structured workshops which deliver work around Emotional health and wellbeing will take place in the rooms within the Hall and fit into the five ways to wellbeing:

- **Be active**
- **Connect**
- **Take Notice**
- **Give**
- **Keep Learning**

A ‘VIP area’ allows a number of support agencies to offer information as well as an interactive activity in an informal, busy area. A marquee at the front of Himley Hall will offer physical activities for the students to engage with in between workshops and to try out new activities which can be accessed in their local park.

**Objectives**

- To bring primary schools together in a fun and interactive environment
- To help young people to develop to grow skills and confidence around emotional health and wellbeing.
- Creating an environment to raise awareness of health and wellbeing.
- Building relationships with schools to identify barriers and gaps to see what support could be offered or available.

**Outcomes**

- Groups to inform the school of their experience at Me Festival
- Schools to take learning back into the school environment
- Workshops supporting schools with ideas and activities to take back into the school environment to promote positive change
### KPIs
To be determined.

<table>
<thead>
<tr>
<th>Resources required</th>
<th>Loudmouth £950</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Loudmouth's theatre in education programme on bullying, four sessions through the day. Consists of scenes of drama and an interactive workshop.</td>
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<table>
<thead>
<tr>
<th>Resources required</th>
<th>Vamos Theatre £450 (plus travel £20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gives students an insight into how to create full mask characters and develop clarity in communication. Through focused games and exercises participants will explore how non-verbal communication affects how we come across to others, and ways we can use it positively. It explores the impact of eye-contact, touch, and gesture in four sessions through the day.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Resources required</th>
<th>Fast Aid Workshop (donation of £500)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Teaching basic CPR, Recovery position and tour of ambulance, sessions through the day to ensure as many schools as possible access this session.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Resources required</th>
<th>Barnados session £250</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive affirmation stones – to promote positive thinking and empowerment, 4 sessions through the day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources required</th>
<th>What’s Up Doc Session £300</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Actor supplied by Creative Health exploring current health issues with one of Dudley CCG’s GP’s, four sessions through the day.</td>
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</table>

<table>
<thead>
<tr>
<th>Resources required</th>
<th>Forestry school £180</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>‘Natural Scavenger Hunt’ taking groups out into the grounds of Himley Hall, supporting the ‘walk a mile’ initiative, number of sessions through the day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future in Mind Theme</th>
<th>Promoting resilience, prevention and early intervention</th>
</tr>
</thead>
</table>

| TOTAL: | £2,650 |

**Future in Mind Theme**
Promoting resilience, prevention and early intervention
Appendix 9 CAMHS Team Structure

DUDLEY CORE CAMHS TEAM
Clinical Nurse Specialist x 0.5 (7)
Senior Mental Health Nurse x 2 (6)
Consultant Psychotherapist x 1 (BC)
Psychotherapist x 2 (7)
CSE Lead Practitioner x 1 (7)
Trainee Psychotherapist x 4
Family Therapist x 0.3 (8A)
Consultant Psychologist x 0.8 (8D)
Clinical Psychologist x 0.8 (8B)
Clinical Psychologist x 2 (7)
Senior Occupational Therapist x 1.52 (7)
Occupational Therapist x 1 (6)
Senior Social Worker x 1
Family Support Worker x 1.8 (4)
Project Coordinator x 0.5 (7)
Senior Administrator x 1 (4)
Team Administrator x 1 (3)
Administrator x 1.8 (2)
Receptionist x 1 (2)
Modern Apprentice x 2

LEARNING DISABILITIES TEAM
Consultant Psychologist x 0.8 (8C)
Clinical Psychologist x 0.6 (7)
Learning Disabilities Nurse x 1 (6)
Occupational Therapist x 0.5 (6)
Team Administrator x 0.5 (3)

ICAMHS TEAM
Clinical Nurse Specialist x 2 (7)
Senior Mental Health Nurse x 3 (6)
Team Administrator x 0.5 (3)

LAC SERVICE
Psychotherapist x 0.8 (7)

GP LIASION TEAM
GP Liaison Lead x 1 (7)
GP Liaison Practitioner x 1 (6)

PAN TRUST EATING DISORDERS TEAM
Lead Nurse x 1 (7)
Senior Mental Health Nurse x 1 (6) Walsall
Senior Mental Health Nurse x 0.5 (6) Dudley
Psychologist x 0.6 (7)
Family Therapist x 0.3 (8A)
Team Administrator x 0.5 (3)

CAMHS MEDICAL TEAM
Consultant Psychiatrist x 3.6
Staff Grade x 1
Medical Secretaries x 3.42 (4)

YOUTH OFFENDING TEAM
Clinical Nurse Specialist x 0.5 (7)

POSITIVE STEPS
Lead Practitioner x 2 (7)
Practitioners x 5 (6)
Team Administrator x 0.8 (3)

0-5 ASD LINKWORKERS
CAMHS Practitioners x 1.5 (7)
## Appendix 10 - CAMHS Dataset and Activity and Waiting Times

**Dudley and Walsall Mental Health Partnership NHS Trust**

**CAMHS, Learning Disabilities, ICMHs and Eating Disorders Dataset 2017-18**

*(Dudley CCG patients)*

<table>
<thead>
<tr>
<th>Referree</th>
<th>Apr 17</th>
<th>May 17</th>
<th>Jun 17</th>
<th>Q1 17 18</th>
<th>Jul 17</th>
<th>Aug 17</th>
<th>Sep 17</th>
<th>Q2 17 18</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Dec 17</th>
<th>Q3 17 18</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
<th>Q4 17 18</th>
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</thead>
<tbody>
<tr>
<td>No of external referrals received</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
<td>I-CAMHS</td>
<td>Eating Disorders</td>
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<tr>
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<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
<td>I-CAMHS</td>
<td>Eating Disorders</td>
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<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
<td>I-CAMHS</td>
<td>Eating Disorders</td>
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<tr>
<td>Total number of ICD 10 Codes recorded for all CAMHS patients broken down by quarter (date recorded)</td>
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<tr>
<td>Total % of ICD 10 Codes recorded for all CAMHS patients broken down by quarter (date recorded)</td>
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<tr>
<td>Average waiting time from referral to 1st assessment (Choice)</td>
<td></td>
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<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
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<tr>
<td>Average waiting time from 1st assessment (Choice) to Partnership (Therapy)</td>
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<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
<td>I-CAMHS</td>
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<tr>
<td>Average waiting time from referral to Partnership (Therapy)</td>
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<tr>
<td>CAMHS Tier 3</td>
<td>Learning Disabilities</td>
<td>I-CAMHS</td>
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</tr>
<tr>
<td>LAC</td>
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<td></td>
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<tr>
<td>Total number of patients in all CAMHS</td>
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<td></td>
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<tr>
<td>Total number of patients discharged from CAMHS to Adult mental health Services</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total number of patients discharged to their GP</td>
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<td></td>
</tr>
</tbody>
</table>

124 | Page
Activity and Waiting Times

Data based on CAMHS and LD CAMHS - 1st April 2017 – 31st August 2017

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>F2F Contacts</td>
<td>4649</td>
</tr>
<tr>
<td>NF2F Contacts</td>
<td>1391</td>
</tr>
<tr>
<td>DNAs</td>
<td>9.9%</td>
</tr>
<tr>
<td>Referrals</td>
<td>852</td>
</tr>
<tr>
<td>Referrals accepted (after screening)</td>
<td>730 (86% acceptance rate)</td>
</tr>
<tr>
<td>Discharges</td>
<td>362</td>
</tr>
<tr>
<td>Caseloads</td>
<td>CAMHS Dudley - 1003</td>
</tr>
<tr>
<td></td>
<td>CAMHS LD Dudley – 171</td>
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<tr>
<td>Looked After Children currently in CAMHS</td>
<td>121</td>
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Referral Information

Ethnicities

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<tr>
<th>Ethnicity</th>
<th>Number</th>
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<tr>
<td>ANY OTHER GROUP</td>
<td>2</td>
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<tr>
<td>ASIAN-BRITISH ASIAN</td>
<td>1</td>
</tr>
<tr>
<td>ASIAN-BANGLADESH</td>
<td>1</td>
</tr>
<tr>
<td>ASIAN-BRITISH INDIAN</td>
<td>5</td>
</tr>
<tr>
<td>ASIAN-PAKISTANI OR BRITISH PAKISTANI</td>
<td>5</td>
</tr>
<tr>
<td>ASIAN – MIXED</td>
<td>1</td>
</tr>
<tr>
<td>ASIAN – OTHER ASIAN</td>
<td>8</td>
</tr>
<tr>
<td>ASIAN – PUNJABI</td>
<td>1</td>
</tr>
<tr>
<td>BLACK-AFRICAN</td>
<td>2</td>
</tr>
<tr>
<td>BLACK-CARIBBEAN</td>
<td>1</td>
</tr>
<tr>
<td>BLACK - MIXED</td>
<td>1</td>
</tr>
<tr>
<td>MIXED-OTHER</td>
<td>1</td>
</tr>
<tr>
<td>MIXED – WHITE AND ASIAN</td>
<td>3</td>
</tr>
<tr>
<td>MIXED-WHITE AND BLCK CARIBBEAN</td>
<td>1</td>
</tr>
<tr>
<td>NOT STATED</td>
<td>17</td>
</tr>
<tr>
<td>WHITE-BRITISH</td>
<td>679</td>
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<tr>
<td>TOTAL</td>
<td>730</td>
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</table>

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>292</td>
</tr>
<tr>
<td>Male</td>
<td>438</td>
</tr>
<tr>
<td>Grand Total</td>
<td>730</td>
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</table>

Referral Sources inc internal referrals

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY CHILD AND ADOLESCENT MENTAL HEALTH</td>
<td>107</td>
</tr>
<tr>
<td>COMMUNITY-BASED PAEDIATRICS</td>
<td>5</td>
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<tr>
<td>CONSULTANT</td>
<td>29</td>
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<tr>
<td>------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>GENERAL PRACTITIONER</td>
<td>473</td>
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<tr>
<td>HOSPITAL-BASED PAEDIATRICS</td>
<td>90</td>
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<tr>
<td>OTHER INDEPENDENT SECTOR MENTAL HEALTH SERVICES</td>
<td>10</td>
</tr>
<tr>
<td>OTHER PRIMARY HEALTH CARE</td>
<td>2</td>
</tr>
<tr>
<td>OTHER SECONDARY CARE SPECIALTY</td>
<td>1</td>
</tr>
<tr>
<td>POLICE</td>
<td>1</td>
</tr>
<tr>
<td>SOCIAL SERVICES</td>
<td>11</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>730</td>
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Community Eating Disorder Service

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Referrals</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internally referred from CAMHS</td>
<td>23</td>
<td>21 Dudley</td>
</tr>
<tr>
<td>GP</td>
<td>15</td>
<td>15 x Dudley</td>
</tr>
<tr>
<td>Hospital Based Paediatrics</td>
<td>3</td>
<td>1 x Dudley; 1 x Wyre Forest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 x South East Staffordshire &amp; Seisdon</td>
</tr>
</tbody>
</table>

There has been 100% compliance with Eating Disorders performance indicators, one week to be seen for an urgent referral and four weeks for a routine referral.

I-CAMHS

| Referrals received and accepted in Dudley borough | 366 |

As anticipated all referrals were accepted by the ICAMHS service as they are assessed for their severity before being responded to by the service. The referral numbers also include the DSH referrals received.

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>241</th>
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<tbody>
<tr>
<td>Female</td>
<td>125</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>366</td>
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</table>
**Ethnicities**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER ASAIN UNSPECIFIED</td>
<td>2</td>
</tr>
<tr>
<td>ASIAN-BRITISH</td>
<td>1</td>
</tr>
<tr>
<td>ASIAN-BRITISH INDIAN</td>
<td>2</td>
</tr>
<tr>
<td>ASIAN-PAKISTANI OR BRITISH PAKISTANI</td>
<td>2</td>
</tr>
<tr>
<td>ASIAN – OTHER ASIAN</td>
<td>2</td>
</tr>
<tr>
<td>ASIAN – PUNJABI</td>
<td>2</td>
</tr>
<tr>
<td>BLACK-AFRICAN</td>
<td>2</td>
</tr>
<tr>
<td>MIXED-OTHER</td>
<td>1</td>
</tr>
<tr>
<td>MIXED-WHITE AND BLCK CARIBBEAN</td>
<td>4</td>
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<tr>
<td>NOT STATED</td>
<td>19</td>
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<tr>
<td>WHITE-BRITISH</td>
<td>329</td>
</tr>
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<td><strong>TOTAL</strong></td>
<td>366</td>
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**Referral Source**

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<tr>
<th>Source</th>
<th>Referrals</th>
<th>CCG</th>
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</thead>
<tbody>
<tr>
<td>Hospital Based Paediatrics</td>
<td>190</td>
<td></td>
</tr>
<tr>
<td>CAMHS (Internal from Tier 3 team)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>Community Based Paediatrics</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Out of Borough Agency</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Other Primary Health Care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other Secondary Care</td>
<td>3</td>
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</tr>
</tbody>
</table>

**Positive Steps**

The Positive Steps team have now been fully functional since September 1st 2017 however were seeing young people prior to this date. The below chart demonstrates the number of referrals received, the referral source and discharges to date:

<table>
<thead>
<tr>
<th>Source</th>
<th>Referrals received</th>
<th>GP</th>
<th>School Health Advisor</th>
<th>Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal CAMHS</td>
<td>32</td>
<td>12</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Discharges</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Waiting Times

Core CAMHS

<table>
<thead>
<tr>
<th>Waiting List</th>
<th>Waiting time in October 2015</th>
<th>Waiting time on March 15th 2016</th>
<th>Waiting time as of 30th September 2016</th>
<th>Waiting time as of 31st August 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice</td>
<td>8 weeks (priority 3.5wks)</td>
<td>7 weeks (priority 2wks)</td>
<td>8 weeks (priority 4 days)</td>
<td>9 weeks (priority 4 days)</td>
</tr>
<tr>
<td>Partnership</td>
<td>22 weeks</td>
<td>15 weeks</td>
<td>26 weeks</td>
<td>14 weeks</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>31 weeks</td>
<td>30 weeks</td>
<td>26 weeks</td>
<td>28 weeks</td>
</tr>
<tr>
<td>Psychology</td>
<td>31 weeks</td>
<td>22 weeks</td>
<td>10 weeks</td>
<td>10 weeks</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>23 weeks</td>
<td>31 weeks</td>
<td>32 weeks</td>
<td>28 weeks</td>
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<td>Occupational Therapy</td>
<td>52 weeks</td>
<td>36 weeks</td>
<td>26 weeks</td>
<td>26 weeks</td>
</tr>
<tr>
<td>ASD</td>
<td>12 weeks</td>
<td>10 weeks</td>
<td>30 weeks</td>
<td>16 weeks</td>
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<tr>
<td>ADHD</td>
<td>No wait</td>
<td>No wait</td>
<td>7 weeks</td>
<td>9 weeks</td>
</tr>
<tr>
<td>Medic</td>
<td>No wait</td>
<td>No wait</td>
<td>12 weeks Duty medic sees patients the same day</td>
<td>14 weeks Duty medic sees the patient the same day</td>
</tr>
</tbody>
</table>

Community Eating Disorder Service

There is currently no waiting list for Eating Disorder patients as they receive an appointment as soon as a patient is referred due to them being extremely high risk.

I-CAMHS

The I-CAMHS team meet the 4 hours and 7 days follow up national targets.

ASD Clinic update

There are currently 60 young people being assessed within the ASD clinic in Dudley CAMHS. The waiting time is presently 16 weeks from referral to first appointment. Once the young person is accepted into the clinic they will typically remain in that setting for approximately 9 months in order for school observations, developmental history, an ADOS and psychometric testing to all be completed prior to the panel meeting where a decision is made by a multi disciplinary team as to whether a diagnosis can be given.

ADHD Clinic update

There are currently 269 young people in the ADHD clinic in Dudley CAMHS. Some young people have been under the ADHD clinic for up to six years due to the requirement of medication which makes capacity difficult as discharge is not possible in many cases. There have been 38 new referrals received since April 2017.
Training

The increase in CAMHS LPT funding has enabled the following training for staff.

<table>
<thead>
<tr>
<th>Training</th>
<th>Dates</th>
<th>Staff</th>
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<tbody>
<tr>
<td>ADOS2</td>
<td>November 2015</td>
<td>7 staff (varying disciplines)</td>
</tr>
<tr>
<td>DBT</td>
<td>February 2016 (1 week)</td>
<td>9 staff (varying disciplines)</td>
</tr>
<tr>
<td></td>
<td>October 2016 (1 week)</td>
<td></td>
</tr>
<tr>
<td>RODBT</td>
<td>Variety of dates between September 2015 and April 2016</td>
<td>1 – Eating Disorders specialism</td>
</tr>
<tr>
<td>Eating Disorders Conference</td>
<td>March 2016</td>
<td>1 – Eating Disorders specialism</td>
</tr>
</tbody>
</table>

Technological advances

The increase in CAMHS LPT funding has supported the team to be provided with I pads. The devices have been set up with a suite of apps to be used in therapy sessions. The I pads are due to have the WISC assessment downloaded on to them for use in cognitive assessments and service user feedback forms will also be available for use with patients and families.
Appendix 12 – Deliberate Self Harm Audit

Self-harm is a common and possibly increasing (Gunnel et al, 2000) problem among young people in the UK, affecting 7-14% at some point in their life (Hawton & James, 2005). The NICE guidelines published on self-harm (2004 & 2011) provide a framework of the collaborative working aspects to assess and treat this group of patients. Suicide prevention is high on the mental health agenda (Preventing Suicide in England: a cross-government outcome strategy to save lives, 2012; Suicide in children and young people in England, University Manchester, 2016) and therefore the collation of local data is important.

The author re-evaluated the self-harm assessment referrals from the local paediatric hospital service (Russells Hall Hospital, Dudley) to Dudley CAMHS.

Self-harm Referral Review 2016 ( up to December)

Total of self-harm referral requests: 205 (31.12.16)

1) Monthly distribution of self-harm assessment requests:

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
<th>Apr 16</th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>8</td>
<td>15</td>
<td>20</td>
<td>18</td>
<td>10</td>
<td>12</td>
<td>21</td>
<td>26</td>
<td>20</td>
</tr>
</tbody>
</table>

2) Weekday distribution of self-harm assessment requests:

<table>
<thead>
<tr>
<th>Weekday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>53 (26%)</td>
<td>39</td>
<td>33</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

3) a) More than one self-harm assessment request on same day totalled 51 (25%) out 205 of requests and following weekday distribution was evident: ()=number of referrals

<table>
<thead>
<tr>
<th>Weekday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>8(2); 6(3); 2(4); 1(5)</td>
<td>5(2); 1(3)</td>
<td>9(2)</td>
<td>7(2); 1(5)</td>
<td>6(2); 5(3)</td>
</tr>
</tbody>
</table>

3) b) Weekly distribution of self-harm referral requests throughout 2016: up to week: 52; ( )= number of referrals

<table>
<thead>
<tr>
<th>Number/ week</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>&gt;4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>4(5); 5(6); 6(7); 1(8); 1(9); 1(11)</td>
</tr>
</tbody>
</table>

4) Gender distribution:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>164 (80%)</td>
</tr>
</tbody>
</table>
5) Age at point of referral:  
Mean age: 14.3 years

<table>
<thead>
<tr>
<th>Age in years</th>
<th>&lt;12</th>
<th>12 years</th>
<th>13 years</th>
<th>14 years</th>
<th>15 years</th>
<th>16 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1(9); 1(10); 4(11)</td>
<td>18</td>
<td>29</td>
<td>38 (19%)</td>
<td>79 (39%)</td>
<td>35 (17%)</td>
</tr>
</tbody>
</table>

6) Ethnicity:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>White British</th>
<th>Afro-Caribbean</th>
<th>Asian</th>
<th>Mixed</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>186 (91%)</td>
<td>1</td>
<td>11</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

7) Total Out-of-Area assessments:

<table>
<thead>
<tr>
<th>Out-of-Area</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>30 (15%)</td>
<td>174</td>
<td>1</td>
</tr>
</tbody>
</table>

8) Re-referral to CAMHS:

<table>
<thead>
<tr>
<th>Re-referral</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>127 (62%)</td>
<td>78</td>
</tr>
</tbody>
</table>

9) Current involvement with CAMHS:

<table>
<thead>
<tr>
<th>CAMHS involvement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>94 (46%)</td>
<td>111</td>
</tr>
</tbody>
</table>

10) Method of Self-Harm:

<table>
<thead>
<tr>
<th>Method</th>
<th>Over Dose(OD) (tablets)</th>
<th>Cutting</th>
<th>Threats of Self-harm</th>
<th>OD &amp; alcohol/ illicit drugs</th>
<th>OD &amp; Cutting &amp; alcohol</th>
<th>Other = see below</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>86 (42%)</td>
<td>39 (19%)</td>
<td>47 (23%)</td>
<td>2(alcohol), 1(ecstasy/alcohol)</td>
<td>2</td>
<td>25</td>
<td>3</td>
</tr>
</tbody>
</table>

4x hearing voices; drank bleach x4; not eating/drinking’ attempted to jump out of window x4; cord around neck; stabbed himself with a fork; 2xagression; bang to head; head butted wall; ingestion of nail varnish; attempt of hanging; attempt of drowning; eating issues; running in front of moving car; low mood; violent to others

11) YP with repeated self-harm behaviour:

<table>
<thead>
<tr>
<th>Repeated self-harm behaviour</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Person</td>
<td>79 (39%)</td>
<td>126</td>
</tr>
</tbody>
</table>

**CONCLUSION**

Suicide prevention is high on the mental health agenda (Preventing Suicide in England: a cross-government outcome strategy to save lives, 2012; Suicide in children and young people in England, University Manchester, 2016) and the NICE guidelines on self-harm (NICE, 2004 & 2011) and emphasises the importance of a mental health and risk assessment of the young person and their circumstances.
Dudley CAMHS serves a population of approx. 70,000 children in the Dudley borough. The service provides a weekday only self-harm assessment service to the paediatric ward at Russell Hall Hospital as part of a service level agreement. The self-harm assessment rota is staffed by several different CAMHS professionals.

The current evaluation findings provide insight into aspects of Dudley CAMHS crisis work. There was a significant increase (14 %) in the self-harm referrals compared to the previous year (total number for 2015: 180) which put strain on CAMHS resources to cover this type of work. The average weekly self-harm assessment referral rate to Dudley CAMHS was almost four (3.9) and in a quarter of all referrals (25%) more than one request for assessment was made to Dudley CAMHS.

The rate of referrals Dudley CAMHS has been particularly low in the months of April/May and August/ September. The assessment requests were highest on Mondays as there is no assessment service during the week end period/ Bank Holidays. The gender distribution was in the expected range with 80 % of young people who self-harmed being female. The mean age was just over 14 years which is middle adolescent and almost half (46%) of referrals were already engaged with Dudley CAMHS. The main method of self-harm was taking overdoses (42%), followed by threats of self-harm (23%) and cutting (19%). Out of the total of 205 patients who self-harmed almost 40% did it on more than one occasion. The out-of-borough referral rate was 15 % and involved close liaison with neighbouring CAMHS to secure the transfer of care of the Young People for adequate support.

Recommendations

1. Dudley administrative staff to record all self-harm assessment referral requests using the agreed XL spread sheet as some self-harm referrals were not captured.

2. Due to the high DSH referral assessment demands the DSH rota has been covered by different CAMHS professionals on a day by day basis and more recently the ICAMHS professionals have taken over this duty.

3. The high number of repeat self-harm patient’s needs to be looked at as this is the most vulnerable group to succeed with a completed suicide.

4. Review in 12 months and findings should feed into upcoming suicide prevention audit which has been planned for year 2017/18.
Self-harm Referral Review 2017 (up to October 2017)

Total of self-harm referral requests: 218 (standing 18.10.17)

1) Monthly/seasonal distribution of self-harm assessment requests:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>20</td>
<td>22</td>
<td>31</td>
<td>22</td>
<td>35</td>
<td>24</td>
<td>12</td>
<td>17</td>
<td>15</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Season</td>
<td>Winter</td>
<td>Spring</td>
<td>Summer</td>
<td>Autumn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) Weekday distribution of self-harm assessment requests:

<table>
<thead>
<tr>
<th>Weekday</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>44</td>
<td>52</td>
<td>21</td>
<td>33</td>
<td>30</td>
<td>21</td>
<td>17</td>
</tr>
</tbody>
</table>

3)a) More than one self-harm assessment request on same day totalled out 52 of 134 requests and following weekday distribution was evident: ()= number of referrals

<table>
<thead>
<tr>
<th>Weekday</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>8(2); 5(3)</td>
<td>7(2); 3(3); 3(4)</td>
<td>2(2)</td>
<td>7(2); 3(3)</td>
<td>5(2); 2(3)</td>
<td>2(2); 1(4)</td>
<td>3(2); 1(3)</td>
</tr>
</tbody>
</table>

3)b) Weekly distribution of self-harm referral requests throughout 2017: up to week 41. ( )= number of assessments

<table>
<thead>
<tr>
<th>Number/ week</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>&gt;4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>6(5); 9(6); 1(7); 3(8); 3(9); 1(12)</td>
</tr>
</tbody>
</table>

4) Gender distribution

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>162</td>
</tr>
</tbody>
</table>

5) Age at point of referral

<table>
<thead>
<tr>
<th>Age in years</th>
<th>&lt;12</th>
<th>12 years</th>
<th>13 years</th>
<th>14 years</th>
<th>15 years</th>
<th>16 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1(4); 2(7); 5(8); 1(9); 6(10); 12(11)</td>
<td>18</td>
<td>39</td>
<td>51</td>
<td>56</td>
<td>27</td>
</tr>
</tbody>
</table>

NB: 1x age not mentioned

6) Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>White</th>
<th>Afro-</th>
<th>Asian</th>
<th>Mixed</th>
<th>Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>Caribbean</td>
<td>recorded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>199</td>
<td>1</td>
<td>13</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

7) Total Out-of-Area assessments

<table>
<thead>
<tr>
<th>Out-of-Area</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>38</td>
<td>179</td>
<td>1</td>
</tr>
</tbody>
</table>

8) Re-referral to CAMHS

<table>
<thead>
<tr>
<th>CAMHS re-referral</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>125</td>
<td>81</td>
<td>12</td>
</tr>
</tbody>
</table>

9) Current involvement with CAMHS

<table>
<thead>
<tr>
<th>CAMHS involvement</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>99</td>
<td>107</td>
<td>12</td>
</tr>
</tbody>
</table>

10) Method of Self-Harm

<table>
<thead>
<tr>
<th>Method</th>
<th>Over Dose (OD) (tablets)</th>
<th>Cutting</th>
<th>Threats of Self-harm</th>
<th>OD &amp; alcohol/ illicit drugs</th>
<th>OD &amp; Cutting</th>
<th>Cutting &amp; alcohol</th>
<th>Other – see below for details</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>83</td>
<td>35</td>
<td>40</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>38</td>
<td>14</td>
</tr>
</tbody>
</table>

refusal to eat and drink after chocking event; climbing out of the window, abuse; 7x hearing voices; 8x attempted strangulation; epilepsy/low mood; inhaler misuse; 4x aggression to others; 2x feeling anxious; self-stabbing attempt; confused/vivid dreams; aggression & threat to jump out of a window; intoxicated & self-harm thoughts; 2 ED & physical issues; anxiety and tics; threat to kill mother and himself; low mood; injury to hand; fit taking cocaine and alcohol; collapsed & restricted eating; hearing voices not to eat; behavioural problems)

11) YP with repeated self-harm behaviour

<table>
<thead>
<tr>
<th>Repeat DSH</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>62</td>
<td>74</td>
<td>82</td>
</tr>
</tbody>
</table>
## Appendix 13 – CAMHS LTP Action Plan

### 1. Task & Finish Group 1 - Promoting resilience, prevention and early intervention

1.1 Developing the universal element of emotional health and wellbeing in schools

<table>
<thead>
<tr>
<th>Progress RAG</th>
<th>Action required</th>
<th>By When</th>
<th>Evidence of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in availability of universal good quality school SEL programmes supporting children’s social, emotional and mental health skills.</td>
<td>The development of tier 2 has been established within the Positive Steps Group, the group are working on the action plan. Pathways link with other task and finish groups. It was agreed that other tier 2 providers are engaged with.</td>
<td>31st March 2017</td>
<td>To be determined</td>
</tr>
<tr>
<td>Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide an interface between those working in and attending educational settings, parents and carers and the professionals providing services e.g. Educational Psychology, School Nurses and Tier 2 team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaise at a strategic level with partners in the CCG, OPH, DCVS and commissioned providers e.g. DWMH.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identify and work in partnership to develop relationships and pathways between a wide range of commissioned services well placed to provide support at a universal level e.g. Young Carers Support and Safe and Sound Partnership.

<table>
<thead>
<tr>
<th>1.2 Development of the Universal Offer in Educational Settings</th>
<th>Progress RAG</th>
<th>Action required</th>
<th>By When</th>
<th>Evidence of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support the recommendations made in the emerging Dudley Needs Assessment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To support/ undertake an audit of universal provision in Educational settings for CYP.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To review current training offer and design a more comprehensive universal training programme in consultation with children and young people, parents and carers, school staff and support agencies which has the capacity to be delivered in a variety of formats e.g. centre based, team based (e.g. in schools) and on-line in order to maximise uptake and accessibility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To develop a comprehensive evidence based resource collection to be used in training, group work and 1:1 support.</td>
<td></td>
<td></td>
<td></td>
<td>31\textsuperscript{st} March 2017</td>
</tr>
<tr>
<td>It was agreed that it is essential to have the right multidisciplinary team to sit on this group. Schools and the pupil voice are key to promote the 5 ways to well-being along with School heads and CAMHs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleges and pupils outside of mainstream provision are also to be invited to engage with this group. A new logo is being developed based on the 5-ways and will be circulated in due course. Workforce development will be used to engage with staff around the services available by various agencies to young people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of the number of children who have received a whole school intervention to develop social and emotional skills.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To support the development of nurture groups in educational settings.

To support the development of SEMH website script and signposting (to be aligned with the CYP website being developed in Dudley).

### 1.3 Review of Parenting Programme

<table>
<thead>
<tr>
<th>Progress RAG</th>
<th>Action required</th>
<th>By When</th>
<th>Evidence of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support the recommendations made in the emerging Dudley Needs Assessment and Future In Mind.</td>
<td>A parenting task &amp; finish group, made up of representatives from the council and partner services working with children, young people &amp; families, has been meeting to assess, scope and formulate a proposal for the parenting agenda in Dudley. <strong>Proposal</strong> The evidence based Triple P programme is to be the unifying programme across the board and utilised from universal to more intensive/focussed support. The offer will cover; the 0 – 11 years programme, the teen programme (12 – 17) and stepping stones (a programme to cover additional needs, like disabilities, ADHD etc.) A workforce is to be trained, 20 participants per 3 programmes outlined above.</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2017</td>
<td>Review undertaken – identifies current service provision and opportunities to redesign /increase evidence based parenting support programmes. Numbers of additional families accessing parenting programmes (reduction in waiting list).</td>
</tr>
<tr>
<td>To review the current parenting programmes and help develop more robust evidence based targeted approaches to parenting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To identify future funding options and strategies to double the number of parents (of children with early starting severe behavioural difficulties aged 2-10 years) supported by parenting programmes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To reduce waiting times for parenting programmes.</td>
<td></td>
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</tr>
</tbody>
</table>
Evaluation/measurement of impact/outcomes to be factored into the proposal.

Pathways for further support to be identified and shared, i.e. The Adolescent Response Team.

Communication across the council and wider 0 – 19 workforce is needed to clarify the approach, the process and how this fits within other professional roles and pathways.

Improved collaboration with children & young people staff/teams to avoid duplication and improve access to provision, reducing waiting times.

**Funding**

To train 20 people (60 in total) in each of the 3 programmes will cost £72,000.00.

£10k from CAMHS transformation. £50k from Public Health. £12k from Children’s Services. Training was commissioned in the financial year 2016/17.

<table>
<thead>
<tr>
<th>1.4</th>
<th>PSIAMS Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progress</strong></td>
<td><strong>Action required</strong></td>
</tr>
<tr>
<td>RAG</td>
<td></td>
</tr>
</tbody>
</table>
To offer 50 children and young people the opportunity to host and contribute to a personal person centred online tool with support of their families and support workers.

Enabling them to store information that is relative to their personal care planning and includes their wishes, feelings, hopes and dreams in a way that suits them.

Capture the evidence required to demonstrate how the child/ young person has influenced decisions made about them, about services and activities they access and policy and practice which affects them, their peers, their families and the wider community.

To empower the children/ young people to further develop skills and abilities to enable them to contribute to the implementation of the online tools, the use of their wiki’s and encourage and teach others how to use the tools efficiently safely and effectively.

| Pilot undertaken with SEND Families in January 2017. | 31st March 2017 | Children and young people who have been using these tools and their families have reported a significant increase in feelings of confidence, feeling in control, belonging as well as a greater attendance and contribution at annual reviews by the children and young people themselves. They are further empowered by being able to share the positive aspects of life and regularly seek family activities to attend that offer further opportunities to take pictures and video at the same time improving their health and wellbeing. |
| Work on the pilot has commenced 5 educational settings have been identified these being Bromley, Pensnett Specialist early years, Brockmoor Primary School. Holly Hall Secondary School, Dudley College and Pens Meadow Special School. Parents have and are still been nominated to take part in the pilot, two focus groups have already been conducted and work to build the Care and Share Web platforms has begun base on the feedback from the sessions. Further sessions are planned for February and March 2017. Pilot with 25 Children Looked After. A meeting with Independent reviewing officers, virtual school, Designated Nurse and the Care and Share team took place in November 2016, work is now being done with Foster Care Services to identify all 25 children looked after. The amount of time energy and work to involve so many partners was significantly underestimated. There is traction and movement now and although the pilot period will be extended all those are involved agree this is the correct approach. | | |

Parents have and are still been nominated to take part in the pilot, two focus groups have already been conducted and work to build the Care and Share Web platforms has begun base on the feedback from the sessions. Further sessions are planned for February and March 2017. Pilot with 25 Children Looked After. A meeting with Independent reviewing officers, virtual school, Designated Nurse and the Care and Share team took place in November 2016, work is now being done with Foster Care Services to identify all 25 children looked after. The amount of time energy and work to involve so many partners was significantly underestimated. There is traction and movement now and although the pilot period will be extended all those are involved agree this is the correct approach. | 31st March 2017 | Children and young people who have been using these tools and their families have reported a significant increase in feelings of confidence, feeling in control, belonging as well as a greater attendance and contribution at annual reviews by the children and young people themselves. They are further empowered by being able to share the positive aspects of life and regularly seek family activities to attend that offer further opportunities to take pictures and video at the same time improving their health and wellbeing. |

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There are a range
An evaluation event is being planned for the 2017 summer term.

It is proposed that specific KPI's would be agreed with practitioners involved in the pilot and aligned to those which will be used at the Children and Young People’s Alliance Board, Improvement Board, SEN Reform Board, Corporate parenting Board, Safeguarding Board and the Commissioning Sufficiency Strategic Group.
Provide young people with coping skills for their barriers, specifically relating to high anxiety, low-level autism, depression etc.

Increase awareness and belief that their specific challenges do not need to be a barrier to life opportunities:

For individuals to recognise the signs of moving from coping to struggling and be able to address them at the earliest possibility

To identify need early, to help avoid crisis and a future long term intervention
To signpost to appropriate additional support networks

To support any therapeutic services currently involved in care

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| In total, Phase Trust has worked with 75 different individuals across a wide range of personalised programmes around emotional health and wellbeing: ID Plus (Intentional Development): 14 participants aged 16-20, with a wide range of emotional needs (e.g. eating disorders, self-harming, high anxiety) were referred to the ID plus programme, running between 8-10 weeks. This is personalised support helping young people to embed strategies and coping mechanisms to deal with their own individual challenges, reduce isolation by helping them build community and social connections, and address barriers to handling change, transition to their next life goal (education/training/employment). It also helps to increase confidence, self-esteem and, most of all, resilience.

Out of the 14 participants, 2 did not complete the programme for varying reasons. However, for the 12 (86%) that completed, 6 started a further education college course, 3 started further training opportunities, 1 is exploring a university foundation degree, 1 has connected with Princes Trust, 1 is exploring further support through Black Country Impact. | 31st March 2017 | Progress made by the individual during programme cycle toward set objectives (varies according to targets created by each participant)
Completion of support programme Evaluation by individuals regarding satisfaction of programme |
A small focus group from these participants were also interviewed as part of the consultation process.

Step-Up Programme: focussed on helping those most vulnerable make the transition from school leaver to further education. Ran in July/August 2016. 33 young people aged 16-17 were referred to the programme and 100% enrolled on further education programmes.

Step-Up Plus: 7 participants aged 16 were referred from Autism Outreach/Dudley Psychology Service. Of the 7, 4 started the programme and completed successfully. This was a more focussed programme for those young people who had clear complex needs and most vulnerable to non-transition. The four who completed all had 100% progression success. One of the participants bought his lunch on his own for the first time in his life.
2. Task & Finish Group 2 – Early Help and Targeted Services

### 2.1 Developing an Integrated “Tier 2” Service – Positive Steps

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<tr>
<th>Progress RAG</th>
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<th>By When</th>
<th>Evidence of Impact</th>
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<tbody>
<tr>
<td></td>
<td>Team Recruitment</td>
<td>31st March 2017</td>
<td>Improve emotional, psychological and social wellbeing outcomes for children and young people via interventions delivered through schools. Improve the quality and accessibility of tier 2 services for children and young people in a timely manner; prevent inappropriate referrals into specialist CAMHS; have a strong involvement from CYP in shaping and monitoring our provision.</td>
</tr>
<tr>
<td></td>
<td>Recruitment was successful. Recruited one existing staff and 2 staff TUPED across. All band 6’s were in post by end February and beginning March 2017. Band 7 going through recruitment checks after accepting the post.</td>
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By April 2020 we will: -

- have a skilled team of professionals working at Tier 2 level that will improve emotional, psychological and social wellbeing outcomes for children and young people via interventions delivered through a range of settings including schools;
- improve the quality and accessibility of tier 2 services for children and young people in a timely manner;
- prevent inappropriate referrals into specialist CAMHS;
- have a strong involvement from CYP in shaping and monitoring our provision.

### 2.2 CYP IAPT

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<th>Progress</th>
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3. Task & Finish Group 3 – Improving access to effective support

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<tr>
<td>By 2020 our local offer will: - &lt;br&gt;have age appropriate services and support to children and young people; &lt;br&gt;have a range of health care professionals trained and delivering CYP IAPT; &lt;br&gt;developed pathways between all our providers of “talking therapy” services.</td>
<td>Dudley CCG are working with Walsall CCG to ensure that we are part of the CYP IAPT by 2018 but are planning be part to of the West Midlands Collaborative by May 2017</td>
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**3.1 Integrating 0-5 CAMHS Clinic with the Child Assessment Service**

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<th>Progress RAG</th>
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<th>By When</th>
<th>Evidence of Impact</th>
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<tr>
<td>By 2020 our local offer will: &lt;br&gt;Ensure services are responsive to meet current and future demand and need, resourced appropriately and delivered by a skilled workforce. &lt;br&gt;Improved access and waiting times for children and young people requiring ASD</td>
<td>Meetings have taken place with BCPFT. Pathways have been agreed and staff have been recruited for the 0-5’s service in CAU and should be operational by September 2017. A wider group is need for ADHD. It was agreed to scope out what the task is and agree a lead for the ADHD.</td>
<td>31 March 2016</td>
<td>To be determined</td>
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</table>
assessments.
Enables the redesigned service to operate more effectively, with less historical backlog of assessments and waits.
Have an integrated community service.

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<tr>
<th>Diagnostic training –</th>
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<tr>
<td>I hope we will be able to organise some ADOS training for key staff and I have some budget allocated for this. New member of staff is now working for our team and for Shropshire (both 0.5 WTE). We plan to share training costs with Shropshire and is looking into DISCO training.</td>
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<tr>
<td>Staff working together on the referral form before it come to CAMHS and are working together to develop appropriate pathways etc.</td>
</tr>
<tr>
<td>A very small percentage, of children from ASD clinic go to CAMHS. There was a backlog of children waiting. This is largely sorted now and I would anticipate the workload being very manageable going forward.</td>
</tr>
<tr>
<td>The Physical and Sensory Pathway very unlikely to include input from the new member of staff. We anticipate it running discretely from the ASD pathway.</td>
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5. Task & Finish Group 5- Care for the most vulnerable children

<p>| 5.1 | Additional therapeutic support to support victims of CSE |</p>
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<th>Progress RAG</th>
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<th>Evidence of Impact</th>
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<tbody>
<tr>
<td>Services work seamlessly and in collaboration to respond flexibly and creatively to meet the needs and desired outcomes of local children and young people.</td>
<td>1-2-1 work with identified CSE victims and those at risk of CSE. 18 individual girls were seen on a regular weekly basis concerning prevention of involvement or reducing involvement (from serious to low risk) of Child Sexual Exploitation. These girls were referred directly through either the Child Sexual Exploitation team or from local schools. Work included keep safe, internet safety, sexting, production of indecent images, sexual health, self-esteem and healthy life choices. MASE meeting and child protection meetings were attended as necessary. Using the NWG assessment tool, we were able to monitor the risk levels and see them reduce. <strong>Presence in local schools in high priority CSE areas</strong> Staff had a weekly presence in three local secondary schools (Castle High Monday all day &amp; Tuesday am, Earls High school Wednesday pm and Coseley High School Thursday am) to help identify early trigger factors, forward intelligence to the CSE team and provide those most vulnerable with early help. This is becoming one of the most effective ways of providing the earliest possible support. N.B. Coseley work ceased</td>
<td>31st March 2016</td>
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at the end of the Summer term 2016. We began working weekly on a Tuesday am in Sycamore from September 2016.

From this work:

20 girls were worked with of which 12 saw their risk levels significantly reduce. These girls were either in the step down process of CSE or at risk of being referred to the YPSE (Young people at risk of exploitation) panel.

28 girls were worked with regarding prevention and keeping safe work of which 90% were not referred for higher risk action. This work involved inappropriate images/sexting, aftercare following reassessment of risk factors for CSE and very early identification of behaviours and intervention.

Access to qualified solicitor

12 young people at risk of or involved in CSE were able to access the advice and support of our volunteer qualified solicitor (two days per week term time). This provided much need support and helped to reduce anxiety and trauma around police intervention and potential court visits. She was also able to speak to young people whose actions, if not addressed, may ultimately have resulted in them being seen as a perpetrator, should behaviours escalate.
**Group work**

A 6 week programme was delivered to 7 girls at Dudley College who were thought to be at risk of current involvement in CSE. Following the programme, participants were able to articulate risk factors in their own lives, and look at strategies for changes in their behaviour. The programme also included keep safe work, social media and the law governing CSE and indecent images.

A similar programme was delivered to 5 girls at Cherry Tree Learning Centre, focusing on understanding the risks connected with child sexual exploitation.

**Prevention & Awareness Raising**

Days of awareness raising were delivered to:

- 125 year 9 students at Wordsley High School
- 100 year 8 students at Pedmore Technical College
- 55 16-19 year olds at Dudley College
- 3 separate days to Leasowes to 208 students
- 3 separate days to Dudley College to 125 16-19 year olds.
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<td></td>
<td>From December 2015 to March 2016, 18 individual girls were seen on a regular weekly basis concerning prevention of involvement or reducing involvement (from high to low) of Children of CSE. These girls were referred directly through either the CSE team or from local schools. Work included keep safe, internet safety, sexting, production of indecent images, sexual health, self-esteem and healthy life choices. MASE meetings and Child Protection meetings were attended as necessary using the NWG risk assessment tool, we were able to monitor the risk levels and see them reduce. <strong>Presence in local Schools in high CSE areas</strong> Staff had a weekly presence in two local secondary schools (Castle High Monday all day &amp; Tuesday am &amp; Coseley Thursday) to help identify early trigger factors, forward intelligence to the CSE team and provide those most vulnerable with early help. The success of this work has led to a further school (Earls High) allowing a weekly presence on a Wednesday afternoon from April 2016. This is one of the most effective ways of providing the earliest possible support. <strong>From this work</strong> 13 girls were worked with of which 6 did not then need to be referred on to the YPSE</td>
<td>31st March 2016</td>
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Access to qualified Solicitor

16 young people at risk of or involved in CSE were able to access the advice and support of our qualified solicitor two days per week (Thursday and Fridays term time) for the period. This provided much needed specialist support and guidance for those concerned. This helped to reduce anxiety and trauma around potential court visits and police intervention. Our solicitor was also able to speak to young people whose actions may ultimately have resulted in them seen as a perpetrator, should behaviour continue and escalate.

Group Work

A six week programme was delivered to 10 girls at Dudley College who were known to have previous involvement or be at high risk of current involvement of CSE. Following completion of the programme, the girls were able to articulate risk factors on their own lives, and look at strategies for changes in behaviour. The programme also included focused keep safe work, social media and
the law concerning CSE and indecent images.

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<th>5.4</th>
<th>Supporting the Emotional Health and Well-being for LAC</th>
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<td><strong>Progress RAG</strong></td>
<td><strong>Action required</strong></td>
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<tr>
<td>Looked after children receive early support and interventions to address emerging emotional health and wellbeing issues.</td>
<td>A review of the Flipside Service including CCG Contribution. A review of the CAMHS offer to children looked after A review of CCG/CAMHS offer to external placements A review of spot purchase therapeutic provision for all children looked after and adopted A visit to FLASH in Walsall has taken place to understand and delivery A review of outcome measures. Revisit of the referral pathway between CAMHS and CLA Clinical Psychology service <strong>Next Steps</strong> Define Aims, Objectives and Outcomes for the new service model. Evaluate the most appropriate body to</td>
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deliver a therapeutic service
Agree contractual /operating arrangements with the chosen body.

**Proposed Purpose of New Model**
- Meet child’s emotional health and wellbeing
- Increase placement stability
- Reduce risk of mental illness, therefore reduce referrals to CAMHS
- Ability to respond (early identification)

Skilling others up to respond to the needs of children and young people (training, consultations, awareness raising of professionals, carers, children’s homes)

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<th>5.5</th>
<th>Supporting the Emotional Health and Well-being of the BME Community</th>
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<td><strong>Progress RAG</strong></td>
<td><strong>Action required</strong></td>
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<tr>
<td>Scope an appropriate methodology to undertake social research with BME communities that involves participation and engagement with BME communities on possibly the four areas where we recognise issues exist; maternal health (0-5); culture/religion and intergenerational issues (i.e. are our younger generation experiences different to older generation)</td>
<td>Women &amp; Theatre have been commissioned to carry out qualitative research to explore and gain insight into the emotional and mental health and wellbeing needs of children and young people from black and minority ethnic groups in Dudley Borough. Particularly to better understand how the experiences, views and cultures of first and second generations impact on young people’s ability to deal with their worries and concerns in a positive way. This needs assessment will inform the development of a local CAMHS strategy to ensure that</td>
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gender inequalities
stigma
culturally diverse needs are considered in service access and provision integrally.