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

2015 – 2020

January 2020 Refresh
Version 9
(07.01.2020)
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1 Vision and Ambition

1.1 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.

Local and National Drivers

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

- NHS Long Term Plan.
- 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.
- Dudley All Age Autism Strategy 2018 – 2023
- Black Country STP Clinical Strategy.
- Review of children and young people’s mental health services: Phase one report (CQC, 2017).
- Are we listening? A review of children and young people’s mental health services (CQC, 2018).

1.3 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.

1.4 Our original Local Transformational Plan, submitted in 2015, set 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. It described how we will build on existing capacity within communities to children, young people and families to have good mental health and develop resilience.
1.5 It identified priorities, key areas for action and an outcomes and performance framework to monitor the impact we are having. This will be underpinned by the development of detailed action plans for each priority, which are closely monitored by the Dudley Children and Young People’s Alliance Board who will provide challenge and scrutiny across all agencies.

1.6 Dudley children and young people’s Emotional Health and Wellbeing Strategy is about how we will make Dudley a place that:

“Promotes, supports and improves children and young people’s emotional health and wellbeing.”

This is important because we know that:

Good social and emotional skills and mental health are critical for healthy child development, for school attainment and for living a fulfilling and productive adult life.

Children’s mental health is everyone’s business. From the first spark of life, all those in contact with children and their families can influence and strengthen a child and young person’s emotional health.

Some children and families may need help to build strong mental health, to preserve their wellbeing and to help manage poor mental health in a timely way.

We want all children and young people in Dudley to enjoy a happy, confident childhood. We want to help families develop strong social and emotional skills in their children - right from the first spark of life. We want to help all children grow into resilient young people who know how to promote their own wellbeing and cope with the challenges of daily life - supported where necessary by those around them.

1.7 Therefore our vision by 2020:-

- All children and young people will enjoy a happy and fulfilling childhood.
- All children and young people will be resilient and manage their emotional health and wellbeing in their family, school and community.
- That 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 ensuring the voice of the child is incorporated into all service developments.

**Ambition of our CAMHS Transformation Plan**

1.8 What will make things better?

We have consulted with our communities and professionals and the following diagram encapsulates their views.

We have identified the following aims and objectives across Dudley, informed by national principles and local consultation 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.

1.9 Our communities and professionals have told us that this is what good will look like.

There will be more integrated activity from the first spark of life to promote and support children’s and families’ mental health and wellbeing and to reduce adverse childhood experiences.

All of the services that work with children and families in Dudley will work in partnership to achieve the aims of this strategy. Health services, children’s services, early years services, parenting providers, adult services, schools and the voluntary sector will come together to improve children’s mental health in the borough.

Young people aged 16 to 24 years with diagnosable difficulties will get better access to the help they need.

Help offered in Dudley will have the best chance of improving children and young people’s mental health.

More young people will have good mental health including those in vulnerable groups - such as children looked after, children subject to child protection plans, children with learning disabilities, LGBTQ, children from some Black, Asian and Minority Ethnic (BAME) communities, children at risk of or victims of child sexual exploitation and young offenders.

More young people will have access to the right help in the right place to help build resilience, prevent the escalation of poor emotional health and to maximise chances of recovery when in poor mental health.

Those routinely in contact with children and young people in Dudley (including parents and carers) will feel more confident promoting and supporting children and young people’s mental health. They will also feel confident in identifying when children need more help and will know how to navigate to good quality services.
1.10 Principles of a good emotional health and wellbeing

We also know from speaking to a wide range of communities, parents, children and young people and professionals that we need to commit to the following principles if we are to achieve our vision.

- **Be child, young person, family and / carer friendly - providing ‘the right help at the right time in the right place’**
- **Prevent problems, helps children get back on track or facilitates early help**
- **Recognises the important role that maternity services, primary care and early years support plays in building strong family mental health and emotional wellbeing**
- **Minimises the chances of children falling between the gaps of systems of care, particularly during teenage years.**
- **Draws together the activity of a confident and skilled workforce, including staff in schools and colleges, voluntary sector organisations, the NHS and children’s services**
- **Have strengths and needs of children and young people and families at the heart of what we do**
- **Recognises the important role that schools play in supporting children and young people’s social, emotional, 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 costs**
- **Provides a clear gateway with trouble-free access to an easy to understand offer of help for children, young people, carers and families who need it**
- **Recognises the important role that maternity services, primary care and early years support plays in building strong family mental health and emotional wellbeing**
- **Builds capacity in parents, carers, children and young people themselves so that they can strengthen and preserve wellbeing and so they know how to help themselves or where to go if they need extra help**
- **Works together to achieve best outcomes for all children, regardless of gender, sexuality, ethnicity, religion, class and disability, while recognising that some face greater adversity and need more help**
- **Ensures that mental and physical health are equally important**
1.11 Based on this feedback and 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 that were identified in 2015 at the start of our transformational journey. These were:-

- Ensuring that the “voice of the child” is incorporated into all children service developments.
- Reducing health inequalities and promote equality
- Investing in prevention and early intervention.
- Expanding the existing school based Emotional Health and Wellbeing Team.
- Increase access by ensure that a systematic and consistent application of Children and Young People’s Improving Access to Psychological Therapies programme (CY IAPT) principles
- Increase access by developing a CAMHS Tier 3+ service as part of our home treatment service.
- Increase access by commissioning a 0-18 year old Children and Young People’s Community Eating Disorder Service in partnership with Walsall CCG. Increase access by investing services to meet the needs of vulnerable children and young people. Increase access by expanding our service offer for children with ASD and or/ADHD.

1.12 Therefore our vision by 2020:-

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

1.13 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 and promote equality.
- Developing the workforce.
Plan outline

1.14 Section Two outlines the Dudley Context within which we have transformed and continue to transform emotional health and wellbeing the service offer and outcomes of our children and young people.

1.15 It describes what our communities, partners and practitioners told us, how we will deliver our vision and how we will know when we have got there.

1.16 Our Transparency and Governance structure, including our Collaborative Commissioning arrangements, alignment with the Black Country Sustainability and Transformation Plan and our "placed –based" Integrated Care System is also outlined in this section.

1.17 Our local needs analysis, across the age ranges are described, together with the implications from the needs assessment for future planning and the prevalence and scale of need are covered in Section Three.

1.18 This section also contains how we will reduce health inequalities and promote equity.

1.19 Our Local Transformational Pan Ambition and developments are outlined in Section Four.

1.20 Workforce development and our workforce plans are described in Section Five.

1.21 Data – Access and outcomes are covered in Section Six.

1.22 The update on transformational developments and plans for the future are detailed in Section 7.

1.23 Finally our Financial Profile for all the developments included in the plan is presented in Section Eight.
2.0 Dudley Context

How we will deliver the vision

2.1 Emotional Health and Wellbeing is a priority for the Children and Young People’s Alliance Board. It is one of the seven transformational programmes that is aligned to the CYP Alliance’s Strategy.

The emotional health and wellbeing vision will be achieved by:

- Local CAMHS Transformation Plan
- Commissioning services informed by the outcome of the Mental Health Needs Assessment
- Delivery of 5 Ways to Wellbeing for CYP
- Schools Nurture Programme

The transformational programme area, led by a named responsible officer, will provide performance overview reports as required to the Alliance Board, with exception reporting at each meeting. Responsible officers will ensure that:

- a delivery plan is completed for that programme
- an annual report is presented to the Board on the outcomes of the programme
- reporting templates are completed and returned

Identified lead officers for each programme will be responsible for providing quarterly updates to the responsible officer to ensure an ongoing oversight of the progress in each area of activity.

The Alliance Board will monitor progress using a number of tools:

- Outcomes Framework
- Quarterly Progress Reports
- Standards outlined in the ‘Your Welcome’ framework (Department of Health)
- Dudley Deal for Children and Young People

This monitoring will include evidence that children and young people have contributed to the process, in line with the principles outlined in the Children and Young People’s Engagement Strategy.

How will we know we have got there?

2.2 The following high level outcomes will help us to measure progress towards achieving our vision.
## System wide Approach

2.3 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.

2.4 As described in October 2018 refresh 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 physical and mental health needs.

2.5 Many people and organisations in Dudley borough can influence children and young people’s mental health. Families are the most immediate influence on a child’s mental health and wellbeing. All of the people and organisations that come into contact with children, young people and families can have an impact on mental health and have a role to play in supporting wellbeing.

<table>
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<th>Population outcomes</th>
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<th>The quality of services and support</th>
<th>Investment in line with priorities</th>
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<td>Mental health status of children and young people (school survey) Reduce Emergency Hospital Admissions for Intentional Self-Harm among children &amp; young people aged 0-14 and 15-25</td>
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The following diagram depicts who supports mental health and wellbeing in Dudley

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

**What our communities, partners and practitioners told us**

2.6 We spoke with 195 people, including service providers, practitioners, parents, carers and young people about children and young people’s mental health in Dudley.

We identified insufficient early help for children’s mental health and wellbeing linked to schools and colleges. People seeking help found it difficult to find out about all the help available and referral systems were complicated and help did not always feel well integrated.

This is what people involved in the consultation told us.
Nine out of ten people consulted in Dudley said there was not enough focus on promoting children and young people’s resilience and mental health as they grow. Workers felt that there was not enough attention and coordinated action to address adverse childhood experiences and family-based risk factors for poor mental health.

Getting help was frustrating for everyone in Dudley. There are not enough therapeutic services for children with common mental health problems. This leads to long delays for help and children drifting into crisis.

When you get to CAMHS you are not at a healthy stage, you’re already in crisis, your child’s unwell and the waiting times make it worse…you are at the end of your tether and if you don’t get help, things get even worse…” (Parent/carer).

Referrals systems for specialist help are confusing and frustrating for parents, young people, GPs and schools.

Young people wanted trusted, open access, help that doesn’t categorise them or hurry them, places their views and wishes centre-stage and helps them quickly get back on track when their resilience or mental health was tested.

Parents/carers say they want help that listens to their views, is compassionate, that provides practical advice and that works collaboratively to support the wellbeing of their children.

There was not enough support for young people’s mental health and wellbeing from 16 year onwards. Furthermore, transitional care for those with poor mental health was highly variable.

People in Dudley felt that schools and colleges had important opportunities to promote children and young people’s mental health and wellbeing and to signpost children and young people to the help they needed; but schools often struggled to know what to do and where to children the help they needed.

Young people in Dudley said they often turned to parents/carers when they had mental health difficulties. They felt parents/carers could be better assisted to help young people.

Practitioners felt concerned about fragmented service responses and a lack of integrated working.

2.7 As described above 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.

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

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

2.10 Specifically children and young people said:-
2.11 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.
2.12 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.

2.13 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.

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

2.15 To ensure that we are able to measure new outcomes, including metrics such as reduced social isolation, educational attainment etc., we have continued to 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.

Governance and Accountability

2.16 We are committed to transparent and accountable delivery of this plan.

Formulation and Approval of the Plan

2.49 The LTP will be refreshed by the deadline of 7th January 2020 and will be accessible on the Dudley CCG’s website following sign-off by the Policy and Commissioning Committee on the 15th January 2020.
2.52 Version 8 of the plan was approved by the Health and Wellbeing Board at its meeting on the 5th December 2019. The CCG will issue a statement on its website indicating when the final plan has been approved by the Health and Wellbeing Board on the 19th March 2020.

2.53 It will be available on all of our partner’s websites, including Dudley and Walsall Mental Health Foundation Trust, Black Country Partnership NHS Trust, Dudley Metropolitan Council, Dudley Group NHS Trust and our voluntary sector services that have contributed to the plan. It will also be available in accessible formats for CYP, parents, carers and those with a disability.

2.54 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. 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 1.

2.55 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.
2.56 We have continued to strengthen 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.

2.57 The 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
- Service Manager for Children and Young People, 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

2.58 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.

2.59 Safeguarding arrangements and Local Safeguarding Boards
The Dudley Children’s Safeguarding Board provides information to the commissioners relating to safeguarding needs of the CYP in the borough with particular emphasis on the vulnerable groups to ensure that their needs are being met. They are also responsible for identifying needs that are not met as well as challenging services to ensure they meet the needs.

2.60 Specialised Commissioning

Specialised commissioning are involved in supporting development of the New Care Models which is now called Establishing Steady State Commissioning (ESSC) and the favoured provider for community provision as part of the Provider Collaborative. D&WPT’s involvement has been through the clinical pathways development groups for both CAMHS and ED and at Board level for CAMHS and at a strategic level for both developments.

Key Leads in the Local Authority

2.61 The Head of SEND and the lead Educational Psychologist are involved as Key Education leads in Dudley as part of the SEND agenda, Transforming Care Agenda and also the Mental Health Support Teams in Schools (MHSTs). They have been actively involved in the development of the Emotional Mental Health and Wellbeing strategy which will support the MHST in schools. They also ensure that the risk register has active participation from relevant education leads and that the model for the transforming care programme cohort actively involves education. The Director of Public Health has supported the development of the refresh of the CAMHS transformation plan by identifying staff who can support the strategic direction for the city as well as ensuring that it is integrated with other areas of work.

Collaborative Commissioning

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

2.62 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;
- working with Black Country’s Sustainability and Transformation Programme;
- 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.
Health and Justice Commissioners

2.63 Specialist commissioning have also been involved in the Youth and Justice pathway to ensure that all commissioners are aware of the Liaison and Diversion team and how it dovetails into current services commissioned by CCG. They have provided funding for specialist pilot services to support those young people who may or have come in contact with the health and justice system.

Alignment of LTP with other key strategic reforms and plans for CYP overall, as well as CYP with MH

Mental Health Sustainability and Transformation Plan

2.64 This plan is embedded and aligned within the Black Country’s Sustainability and Transformation Plan (BCSTP) as part of the Mental Health work stream. This is being led by Wolverhampton CCG.

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

2.66 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- skilling.

2.67 The Improving Mental Health and Services for Learning Disabilities chapter of The Black Country Sustainability and Transformation Plan 2016-2021 Specialist Commissioning – NHS England demonstrates the role of the STP which is reflected in place-based commissioning plans i.e. aligning services specifications across different CAMH services. The STP has monthly meetings called ‘One Commissioner’ where any workstream meetings that have been taking place are discussed and any decisions required are passed over to either executives or the clinical reference group. The current issue is regarding age limits of services for CAMHS across the Black Country and it has been agreed that this decision will be made by the clinical reference group.

2.68 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.

2.69 This work has involved a different children’s commissioner in the Black Country CCGs taking responsibility for each of these service specifications and working with the providers to align the service specifications so each area is working in the same way. Once a draft has been developed the specification is shared with all of the other commissioners to ensure they are happy to agree the specification developed.

2.70 The STP has also developed a Black Country and West Birmingham Clinical Strategy. The strategy sets out what the clinical leaders consider to matter most to improve care and outcomes for the people of the Black Country and West Birmingham (BCWB). Our work builds on the strong partnerships already in place, recognising the significance of ‘local place’ as determined by our four place-based arrangements across the Black Country but also embracing the strength in delivering integrated strategic approaches to clinical care. Taking account of the operating context, this strategy combines the public health indicators that point to the wider determinants challenges locally and the ambitions set out in the Sustainability and Transformation Plan 2016-21 (STP Plan) to identify a ‘long-list’ of priority areas for clinical transformation or standardisation.

2.71 The starting point for the strategy development lies in the NHSE Five Year Forward View and the 2018/9 Planning Guidance that set out national ambitions for transformation in six vital clinical priorities.

2.72 In line with our priorities, of these, 3 are pertinent to transforming children and young people’s emotional health and wellbeing i.e.

- Improving access for children and young people, IAPT, crisis care, dementia, suicide prevention, integrating mental/physical health.
- Transforming the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.
- Ensuring that the Black Country is a place where children and young people thrive: that all children in the Black Country get a good start in life and are healthy; that all families are supported to be independent, responsible and successful; where the most vulnerable children are protected; and where our children are supported to become function and productive members of our communities. We want to move the Marmot curve for our CYP population.

Transforming Care Programme

2.73 One of the underlying aims of the original Local Transformation Plan and which will further support work which has already been progressing in this area was the drive to bring care closer to home and prevent hospital admissions. The pre-admission Care, Education and Treatment Reviews
(CETRs) for Children and Young People with diagnoses of Autism Spectrum Disorder and/or Learning Disabilities support the process of reducing hospital admissions as it allows individual commissioning to be undertaken to support a child/young person to remain at home with more intensive support than is commissioned as part of the universal offer.

2.74 The Black Country Transforming Care Partnership (TCP) was established in April 2016 to transform health and care services for people with learning disabilities and/or autism. The programme aims to reduce the number of people with learning disabilities and/or autism residing in hospital so that more people can live in the community, with the right support, close to their home. Dudley CCG and Dudley MBC are part of a Black Country and West Birmingham Transforming Care Partnership (TCP) which is responsible for meeting the needs of a diverse group of Children and Young People with a learning disability, autism or both who display, or are at risk of developing behaviour that challenges, including those with Mental Health conditions. Representatives for the CCG and DMBC are active members of the TCP CYP subgroup and attend all regional workshops.

2.75 The pathways for Children and Young People with ASD/LD are evident in the use of the pre-admission CETR (Care, Education and Treatment Review process which involves all relevant agencies in the local area. For those under 18 years, by integrating the provisions of both the CETR process and the Access Assessment for an inpatient bed, it ensures that consideration is given to the whole care pathway and will help to strengthen the range of treatment modalities available and wider support for the adult or child, young person and their family. It will also ensure that all other alternatives have been considered before secure provision is agreed as the appropriate placement option. Specialist commissioning from NHS England are also part of this process as well as commissioner from the CCG, specialist CAMHS, child/young person and/or parents/carers, social care and education from the Local Authority as well as a patient by experience and Independent clinician. Any pre-admission CETRs that have taken place in Wolverhampton over the past 12 months have had a specialist commissioner from NHS England present to support the process. These meetings are routinely organised when an admission is requested to ensure that all services involved with the Child/Young Person are providing the appropriate level of support whilst in the community and if not, this support can be arranged/commissioned as a matter of urgency to prevent admission.

**Dudley’s Integrated Care System**

2.76 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.

2.77 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.

2.78. 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.

2.79. 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.

2.80. 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.

2.81. This programme will include:-

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

Tracking and improving progress in activity outcomes and experience of care

2.82 Performance monitoring of all NHS CYP EY&WB commissioned service is undertaken in Contract Review Meetings. The D&WMHPT occurs monthly and all activity is tracked to ensure that services are meeting targets set as well as what outcomes are being achieved for the CYP.

Tracking system is available to demonstrate that the CYP are in receipt of appropriate support.

2.83 Our providers now use outcome measures to measure the service the children and young people are in receipt of, it ensures that the children and young people are in receipt of appropriate support.
2.84 Paired outcome scores are used to demonstrate improvement.

2.85 The Local Transformation Plan refresh is also aligned to the Transforming Care agenda with work being undertaken to ensure that CYP in crisis are better supported by staff who have skills in managing CYP with LD and/or ASD and prevent hospital admission. As part of this agenda, the development of the risk register supports this group of young people and also those who are at risk of entering the criminal justice system with work being undertaken with the Liaison and Diversion team to further enhance the offer to the group of young people who have ASD and/or LD. This work is being undertaken in conjunction with the Youth Justice Commissioner. Work is continuing with the local SEND commissioning team to ensure that any work undertaken as part of the LTP is aligned with SEND needs including meeting CQC/Ofsted inspection framework.

**Innovation that can be shared as ‘best practice’**

**GP Liaison Specialist Team**

2.86 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. The GP Liaison service is currently being piloted with up to 20 GP Surgeries in the Dudley borough.

2.87 This involves the GP Liaison team going out to GP practices once a month and offering a triage service. They meet with young people and their families at the GP practice, as requested by the GP, and discuss the needs of the young person. Together with the young person and family they then offer advice and decide on the best support for the young person, whether this is CAMHS, or other services available such as counselling or educational psychology etc. The GP Liaison is also available for GPs to call or email should they want any advice regarding a young person.

2.88 The GP Liaison service is currently going out to 17 GP Practices. There are also discussions ongoing with further GP practices about setting up the service in their practices.

2.89 During the first twelve months of the GP Liaison service being operational there have been a total of 376 referrals received from GP practices as shown in the table below.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>J</th>
<th>F</th>
<th>M</th>
<th>A</th>
<th>M</th>
<th>J</th>
<th>A</th>
<th>S</th>
<th>O</th>
<th>N</th>
<th>D</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keelinge H</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Ridgeway</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>Coseley</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>The Greens</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.90 The above data clearly demonstrates that the service is being consistently accessed by the surgeries and due to the demonstration of success three surgeries later opted in during October 2018 (High Oak, Bath Street and Wychbury).

2.91 The presenting problems to the service are illustrated below

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lapal</td>
<td>33</td>
</tr>
<tr>
<td>Three Villages</td>
<td>31</td>
</tr>
<tr>
<td>Rangeways</td>
<td>31</td>
</tr>
<tr>
<td>Quarry Bank</td>
<td>30</td>
</tr>
<tr>
<td>Wordsley</td>
<td>28</td>
</tr>
<tr>
<td>Stourside</td>
<td>27</td>
</tr>
<tr>
<td>Bean Road</td>
<td>15</td>
</tr>
<tr>
<td>AW Surgeries</td>
<td>11</td>
</tr>
<tr>
<td>Clement Rd</td>
<td>7</td>
</tr>
<tr>
<td>High Oak</td>
<td>7</td>
</tr>
<tr>
<td>Northway</td>
<td>2</td>
</tr>
<tr>
<td>Bath Street</td>
<td>1</td>
</tr>
<tr>
<td>Wychbury</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376</strong></td>
</tr>
</tbody>
</table>

2.92 Five very clear presenting problems were apparent upon analysis of the referrals as shown within the pie chart (left). 23% have been identified as neurodevelopmental however within this category are those young people who are query ASD/ADHD. 11% of all referrals were for as mixture of presenting problems such as:

- Self-harm
- Bereavement
- Self Esteem
- Effects of Abuse
2.93 From the 376 young people who have been referred into the GP Liaison service, 37% have been assessed as suitable for CAMHS intervention. There are very clear trends around presenting problems for this cohort with query neurodevelopmental, behaviour, low mood and anxiety being the most predominant.

2.94 61% of all young people referred to the GP Liaison service during the determined time period were signposted to other lower level services.

2.95 Post assessment onward referral were as follows.

2.96 10% of all young people signposted were of infant age. There are clear trends within this age group around behaviour and query neurodevelopmental and the paediatrician was the highest sign posted to service.

2.97 16% of the young people signposted were aged between 5yrs and 7yrs and whilst the trend around behaviour and neurodevelopmental remains apparent, anxiety is identified as emerging as a trend.

2.98 8-10 years olds make up 17% of those signposted to other services as trends remained consistent with the 5-7yrs age group in that behaviour, neurodevelopmental and anxiety remain the highest presenting problem, it is however apparent that anger issues are starting to emerge within this age group.

2.99 28% of all young people signposted were early age secondary school children. This age group demonstrates an expansion around referrals levels for anger with a high proportion accessing The What? Centre and school support. Anxiety and behaviour remain a common trend however neurodevelopmental has now become less demanding on services.

2.100 Through analysis of the 25% young people who are within the 14-16yrs category it is clear to identify that 75% are presenting with low mood or anxiety and that the requirement of services such as Dudley Talking Therapies and in particular The What? Centre is very high. This age group also demonstrates need for anger management support from Phase Trust.

2.101 17 and 18 year olds who were assessed by the GP Liaison Team demonstrated presenting problems with anger, anxiety and low mood. Although this cohort was only 9% of the total young people seen by the service the trends are still apparent.

2.102 This service is an excellent example of how our service delivery pathways have been developed across the tiers of provision.
3.0 Understanding Local need

Local Needs Analysis

3.1 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.

3.2 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).

3.3 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.

3.4 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.

3.5 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.

3.6 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.
3.7 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.

Social, emotional and mental health needs assessment.

3.8 The 2015 CAMHS LTP included 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.

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.

3.9 Previous methodologies for assessing mental health need have generally focused only on those with diagnosable level or subthreshold clinical need. However, the whole system approach advocated by Future in Mind requires a step change in the way we conceptualise and think about promoting children’s mental health and responding to need. We need a formula that helps us assess what everyone needs to develop or maintain good mental health. We also need a way of identifying emerging need (usually described as sub threshold clinical need) or those needing extra help to build resilience because they belong to a vulnerable group whose wellbeing is more likely to escalate. Of course, some children, when they begin to struggle emotionally and socially, will bounce back or find a resolution on their own or with minimal support. Others’ difficulties, if left, will escalate into crisis and worsen causing damage and distress to children and resulting in unnecessary costs for society.

3.10 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.

3.11 In 1996, Kurtz developed a formula based on evidence of sub threshold and clinical need. She used this formula to estimate how many children would need responses to support their mental health across the tiered system. The formula assesses around 10% of children having diagnosable level difficulties. It also sub divides children with diagnosable level needs into those with common mental health needs (e.g. those with conduct problems and anxiety and depression)\(^1\) and those with more serious mental illnesses (e.g. psychosis, high risk and complex presentations).

3.12 This methodology is based on the Tiered model and sees the 10% of diagnosable need for children aged 5-10 falling across the 4 Tier model in the following proportions as demonstrated below.

3.13 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.

3.14 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

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\(^1\) Kurtz
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.

3.15 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 mid-point of around 20% for the prevalence of these more severe social, emotional or mental health difficulties during early
years. The 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>
</thead>
<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>
</tr>
</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.

3.16 **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.

Around 3400 more children will also have sub threshold needs or face risk factors undermining their resilience requiring early multi sector targeted help.

<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>Total number of 5-10 year olds in Dudley with a diagnosable level need</td>
<td>1,734</td>
<td>1,717</td>
</tr>
</tbody>
</table>

3.17 **Young people aged 11-16 years**

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

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

Likely prevalence of diagnosable conditions among Dudley’s 11-16 year old school population. Numbers based on current population projections and numbers based on 2020 population projection (1%).

<table>
<thead>
<tr>
<th>Condition</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.

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).

### 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).

| Likely numbers of 16-24 year olds in Dudley with diagnosable level and sub threshold mental health difficulties based on 2016 population estimates. |
|-------------------------------------------------|-------------------------------------------------|
| Likely diagnosable rates (2016 population estimate) | Estimate of lower level difficulties /symptoms who may need some support (based on 2016 population estimate) |
| Common mental health difficulties e.g. anxiety and depression) | 3,023 | 1,289 |
| PTSD – current positive screen | 1,561 | NA |
3.19 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.

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

3.20 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.

As described on page 8 we therefore identified our key strategic priorities for service development these are 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 skills audit.

<table>
<thead>
<tr>
<th>Eating disorders</th>
<th>1,163</th>
<th>4,352</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>365</td>
<td>4,584</td>
</tr>
<tr>
<td>Psychosis</td>
<td>66</td>
<td>NA</td>
</tr>
<tr>
<td>Anti-social personality disorder</td>
<td>266</td>
<td>NA</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>100</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,544</strong></td>
<td><strong>10,225</strong></td>
</tr>
</tbody>
</table>
Prevalence and scale of need

3.21 Although 10% of children and young people will have a diagnosable difficulty, specialist CAMHS are only commissioned to engage with around 2% of those who are unwell. This means that the broader system of mental health support (including school, community and digital counselling, primary mental health workers, school nursing, youth workers, well-implemented parenting support etc.) will be attempting to support the remaining 8% of children and young people who are unwell.

Furthermore, the World Health Organisation identifies that another 20 to 30% of children will be struggling in terms of their emotional and mental health needing some early low frequency support to help build resilience, coping skills and de-escalate risk of children becoming unwell. Finally, all families will need support to give their child the best start in terms of their mental health and wellbeing, to promote good parental mental health and to foster parental strategies that we know have the best chance of building and sustaining good child mental health. All children also need social and emotional skills built through school curriculum PSHE work. These skills can strengthen a child’s ability to cope with tolerable adversity and can prevent later poor mental health – particularly for those at risk.

This prevalence and scale of need is depicted below:

![Prevalence and scale of need diagram](image)

### 100% of children in Dudley

<table>
<thead>
<tr>
<th>Service/Support</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives and health visitors</td>
<td>20%</td>
</tr>
<tr>
<td>Family Centres</td>
<td>10%</td>
</tr>
<tr>
<td>Schools universal SEL PSHE and targeted lessons/groups</td>
<td>8%</td>
</tr>
<tr>
<td>Parents/carers</td>
<td>2%</td>
</tr>
<tr>
<td>CYP self-care</td>
<td>Sp. LAC LD CAMHS;</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Eating Disorder services</td>
</tr>
<tr>
<td>Online counselling</td>
<td>Crisis teams</td>
</tr>
<tr>
<td>School counselling</td>
<td>Inpatient</td>
</tr>
<tr>
<td>School or universal drop ins</td>
<td></td>
</tr>
<tr>
<td>Graduated SEND</td>
<td></td>
</tr>
<tr>
<td>Signposting</td>
<td></td>
</tr>
<tr>
<td>Youth work and SM help</td>
<td></td>
</tr>
<tr>
<td>Early help</td>
<td></td>
</tr>
<tr>
<td>School Counselling</td>
<td></td>
</tr>
<tr>
<td>Voluntary sector &amp; online counselling</td>
<td></td>
</tr>
<tr>
<td>ECHP delivery</td>
<td></td>
</tr>
<tr>
<td>Paediatricians</td>
<td></td>
</tr>
<tr>
<td>Parenting interventions</td>
<td></td>
</tr>
<tr>
<td>Youth work and SM help</td>
<td></td>
</tr>
</tbody>
</table>

Reach unknown – particularly important gap is school social and emotional learning provision

Reach unknown

Reach unknown

Met less than half of projected need

Reaches just over projected need
Addressing local needs of the most vulnerable children and young people

3.22 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.

3.23 The following services have been commissioned to support children and young people who may be considered at more risk of developing mental health and emotional health and wellbeing needs.

Adverse child experiences (ACEs)

3.24 ACEs have become an increasing local and national concern. ACEs arise from abuse and neglect of children and growing up in households where they are exposed to issues such as domestic violence or individuals with alcohol and substance misuse. ACEs not only have an adverse effect on health but affected individuals are more likely to perform poorly in school, more likely be involved in crime and ultimately less likely to be a productive member of society.

3.25 People who experience ACEs as children often end up trying to raise their own children in households where ACEs are more common. Such a cycle of childhood adversity can lock successive generations of families into poor health, abusive and anti-social behaviour for generations.

3.26 Preventing ACEs can improve outcomes across the whole life course, enhancing individuals’ well-being and productivity while reducing pressures and costs on public sector services. Outcomes can also be improved by developing resilience and protective factors in children and young people. Research shows that resilience helps reduce the effect of ACEs.
3.27 Programmes that encourage attachment, healthy relationships, promoting and protecting mental health are key to preventing ACEs. The evidence base for reduction of ACE’s supports investment in the early years including; Home visiting programmes, Health visiting and Family Nurse Partnership, parenting programmes, maternal mental health, child-parent psychotherapy.

3.28 In November 2017 a multiagency partnership workshop focusing on Adverse Child Experiences (ACEs) was delivered in Dudley. This workshop gave participants the opportunity to explore the impact of A.C.Es, their effect on children and adults and reflect on their own organisations systems and procedures to see where and how this might be embedded into practice to improve outcomes for all. Over 80 professionals attended the event. The key messages from the event;

- Highlighted varying understanding of ACEs, so although the majority of practitioners were aware of the impact of adversity on child development they had not appreciated the strong evidence behind the dosage effect.
- The workshop was welcomed as an opportunity for practitioners to share good practice in and outside of Dudley.
- There was awareness that the most vulnerable children; including those engaging in YOS, FNP and troubled families were likely to have higher levels of ACEs.
- It was felt that services needed to do more to prevent ACEs from occurring in the first place but resourcing, capacity, barriers to partnership working sometimes hindered this.
- The Police, Early Help services, some voluntary organisations were already engaged in building ACEs into their targeted approaches.

Child Sexual Exploitation and Missing Person’s Service

3.29 Exploitation can affect any child, young person or family, yet we know that children living in chaotic households and children affected by adverse childhood experiences (ACE’ s) are more likely to be exploited and be susceptible to coercion, corruption, grooming, engaging in harmful sexual behaviour and exploitation.

3.30 Child sex offences recorded by police forces across the UK have hit an all time high, prompting campaigners to urge that more needs to be done. The number of alleged sex offences against children in 2016 was up by nearly a fifth on the previous year, climbing to 55,507 or one child sex offence every ten minutes, according to figures obtained by the National Society for the Prevention of Cruelty to Children (NSPCC).

3.31 Children in Dudley are being sexually assaulted, forced to commit crime and moved to unsafe environments around the country for the sexual or financial benefit of their exploiters. Like all areas across the country the partnership and wider communities do not have the answers to competing with the speed, manipulation and fear that perpetrators impose up on them. It is therefore
essential to mobilise quickly using new and innovate approaches to prevent children from being groomed and protect children affected by exploitation.

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

3.33 CSE referrals in Dudley remain steady at 2 – 3 per week. There are currently 109 children open to the CSE team across all three risk levels which are At Risk (a child is at risk of being groomed for sexual exploitation) Significant Risk a child who is targeted for abuse through the exchange of sex for affection, drugs, accommodation and goods etc. and Serious Risk (a child who is entrenched in sexual exploitation, but often does not recognise or self denies the nature of their abuse and where coercion / control is implicit.

3.34 In 2017/18 The CAMHS Transformation fund was used to commission interventions from two charities Barnardo’s and Phase Trust who provide evidence based support to children at risk and affected by CSE. Due to the success in 2017/18 the funding was repeated via the LTP in 2018/19 with a view to enhancing the services and outcomes achieved in the first year.

3.35 Barnardo’s receive referrals for children deemed to be high significant and at serious risk, the benefit of this intervention is that it is not time limited. The CSE worker can work with up to 15 children at any one time. She is currently working with 9 children the majority of whom are now stepped down from MASE (Multi Agency Sexual Exploitation) meetings to At Risk.

3.36 Whilst referrals are low conversations between the CSE team and Barnardo’s have been taking place to explore how the CSE worker might undertake a preliminary MASE visit to help the child and family understand what they can expect and ascertain from the child/ parents details of the situation highlighted in the screening tool and National Working Group (NWG) risk assessment submitted to the CSE Team. The aim is to prepare them for the initial MASE meeting and ensure the appropriate referrals can be made more quickly and appropriately.

3.37 Phase Trust receive referrals for children who do not meet threshold for statutory intervention but who are deemed to be at risk and who require education and support to enable them to make informed decisions about engaging in future positive relationships and the consequence and dangers that challenge their online activity.

3.38 The CSE team have recently revised and enhanced the dataset and are now confident that they can provide a comprehensive Dudley CSE profile report. As a direct result of this in September 2018 we agreed plans for a Phase Trust worker, Safeguarding Lead for education and the CSE Co-ordinator to visit the schools attended by CSE victims and potential victims with a package of support from Phase Trust for those at risk and Educational Psychology service to support staff to better meet the needs of these children and avoid where possible fixed term / permanent exclusions and managed school moves.
3.39 This is especially important as children at risk and not in education are more likely to be exploited and have this go unnoticed. MASE activity and other interventions will be provided alongside this support from a range of providers for those who do meet the threshold for statutory intervention.

3.40 The interventions from both providers are having a positive impact and Barnardo’s, Phase Trust and the CSE Team are now working together to analyse what has made the difference, we are also working on a set of outcome/impact measurements that can be used to report the success of this project to a range of stakeholders including the DSCB CSE/Missing and Vulnerabilities sub group.

3.41 As a result of success of the provision funded through the CAMHS transformation/LTP fund Phase Trust and Barnardo’s have attracted further investment enabling them to enhance the services they provide and increase their services to support children who are being criminally exploited, trafficked and forced into modern day slavery.

3.42 In 2018/2019 CAMHS received funding to employ a dedicated CSE child Psychologist. Agencies that provide emotional health and wellbeing services are working together with CAMHS to agree a CSE emotional health and wellbeing pathway, the team are confident this will be completed shortly. In the meantime staff at CAMHS are developing their internal referral arrangements and again we are confident that they will be in a position to receive referrals shortly.

Services to support Looked After and Adopted Children

3.43 An Emotional Health and Well-being Modernisation Group was 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.

3.44 This group developed a newly structured team that will focus on stabilising placements for children and young people who are adopted, fostered, on special guardianship orders or children living with connected cares. This service was jointly funded service between the Local Authority and CCG and will benefit from CAMHS practitioners working alongside Local Authority staff to offer a complete service to this vulnerable cohort. This service, Lighthouse Links, was launched in July 2019.

Services to support challenging behaviour and learning difficulties

3.45 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.

3.46 We have enhanced the 0-5 specialist CAMHS Service to include a diagnostic clinic. 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.

3.47 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 Service. Twelve CYP have been referred from the CAS 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.

Special Educational needs and Disability (SEND)

3.48 SEND (Special Educational Needs and Disability) reforms were introduced under the Children’s & Families Act (2014) resulting in Dudley CCG commissioning services jointly for Children and Young People (up to age 25) with SEND, including those with Education Health and Care (EHC) plans. As part of this process, there are many Children and Young People who access CAMHS (core CAMHS) and the specialist Learning Disability CAMH service and now have these needs addressed as part of their EHC plans with clear focus on health outcomes as well as education and social care which will make a real difference to how a Child or Young Person lives their life. With regards to SEND processes and commissioning for health needs of the Children and Young People who have an EHC plan, this is discussed at a regular EHC panel.

3.49 We also have a High Needs Panel that agrees additional funding that is required for specialist input for Young People who are post 16 and are in external colleges that are located out of borough.

Children and young people that identify as LGBTQ+

3.51 Our needs assessment also identified the community BAME and LGBTQ as being at risk of poor emotional health and wellbeing.
3.52 A piece of research has been undertaken to better understand the needs of BAME CYP. The report ‘Thankyou for listening’ captures the voices of CYP and their experiences in relation to mental wellbeing.

3.53 We now need to share these ‘voices’ and stories and translate these into action.

3.54 We know from national reports and more recently a local consultation with CYP that the LGBTQ group is likely to be at higher risk of being bullied, has higher levels of suicide ideation compared to heterosexual groups and higher rates of suicide attempts.

3.55 Following feedback from local CYP the following areas of concerns were identified:

- Schools need to be better educated on LGBT issues and support they provide for ‘LGBT and questioning’ individuals including therapeutic support, anti bullying approaches and general settings/schools approach to accepting difference.
- The view was that CAMHS specialist services on the whole didn’t quite ‘get them’ either – hi-lighting the need to raise the awareness of staff on understanding how being LGBTQ can impact on mental health and emotional wellbeing.
- Being LGBT doesn’t necessarily correlate with having MH issues.
- The way parents, schools, professionals behave and treat this group is an additional strain.
- Parental support was very varied and therefore information, signposting for parents is required.

3.56 In response to this feedback two Dudley voluntary organisations, The What Centre and The Phase Trust have been successful in securing funding from the national Health and Wellbeing Fund.

3.57 The Dudley VCSE project aims to:

- expand provision of current work with LGBTQ+ YP aged 13-25 and their families;
- increase capacity, reach to BAME community not accessing traditional mental-health provision;
- build on the work with CYP around their experience with loss.

**Addressing local needs**

3.58 Our specific local needs analysis and prevalence of scale of need informed the gaps in service provision and what services we have commissioned in the plan.
Expansion Plan

3.62 Over the last four years of the CAMHS Transformation Plan we have continued to increase our workforce by investing in the services in the table below.

<table>
<thead>
<tr>
<th>Service</th>
<th>HEALTHY</th>
<th>COPING</th>
<th>STRUGGLING</th>
<th>UNWELL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Workforce</td>
<td>0</td>
<td>1</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>School Nursing</td>
<td></td>
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<tr>
<td>MHST Trailblazer</td>
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<tr>
<td>Positive Steps</td>
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<tr>
<td>Talking Therapies</td>
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<tr>
<td>Ed. Psychologists</td>
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<tr>
<td>School Counselling Team</td>
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<tr>
<td>KOOOTH</td>
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<td></td>
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<tr>
<td>Phase Trust</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>The What Centre</td>
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<td></td>
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<tr>
<td>Liaison &amp; Diversion</td>
<td></td>
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<tr>
<td>YOS</td>
<td></td>
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<tr>
<td>Switch/Brook</td>
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<tr>
<td>Lighthouse Links</td>
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<tr>
<td>IAPT/CBT</td>
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<td>Core CAMHS</td>
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<tr>
<td>CAMHS LD</td>
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<tr>
<td>T-CAMHS</td>
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</tbody>
</table>

3.63 Service details are described throughout the plan.

Reducing Health Inequalities and Promote Equity

3.64 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.

3.65 These inequalities are being addressed by identifying the specific groups who are affected and using proactive action between them and the whole children and young peoples’ population.

3.66 We will change how services are commissioned and delivered, using more evidence based approaches to target vulnerable families by delivering preventative interventions and connecting parents to support. The actions that are being undertaken include the following.

3.67 Dudley was chosen as one of five areas by the national charity -The Early Years Transformation Academy (EYTA), led by the Early Intervention Foundation (EIF). This is an exciting opportunity for Dudley to transform maternity and early year services and will be aligned to the Children’s (MCP) model.
3.68 As part of this programme we will ensure that every woman experiences a healthy pregnancy and is supported to give her child the best start in life by investing in the first 1000 critical days.

3.69 We will improve levels of school readiness for all Dudley children but with the greatest improvement in the most disadvantaged families with a specific focus on speech, language and communication needs. We commit to empowering families and hearing the child’s voice.

3.70 The programme also aims to reduce the impact that poverty has on the health, wellbeing and development of young children by having an early years offer (including a range of services in different /appropriate settings) that we know that work and meet the needs of our most vulnerable children and families.

3.71 The MHSTs will also support a reduction in health inequalities by helping to develop a confident and skilled school workforce supported by effective multi-agency information sharing and joint commissioning, which will impact on the whole service system. It is known that the workforce should be working at different stages of the life span and across sectors, including education, working to common outcomes and backed up by a clear shared understanding of roles and responsibilities which will again impact on how young people and their emotional mental health and wellbeing is managed. This program will support the workforce to develop competencies in understanding, promoting and preserving health, emotional wellbeing and behaviour.

3.72 We will also ensure that all services will audit the ethnicity of access to services.

3.73 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.
4.0 Local Transformation Plan Ambition 2018-2020

Our Journey so Far

4.1 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.

4.2 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. The detail is provided in Appendix 2 including which agencies funded the services.

4.3 Our Financial Profile summarises how Dudley, as an economy, has invested the CAMHS LTP allocations from 2016 – 2019/20 (Section 8) In year 1 non recurrent funding was used to undertake a range of generic initiatives, including a needs analysis and work force audit, engaging with our service users and providing education and training events, reviewing existing services and pump prime a number of new Emotional Health and Wellbeing service developments within our economy. These investments provided the foundation for the future allocation of subsequent funding across the spectrum of need from specialist to universal services.

4.4 The main focus in 2017/18 was to recurrently fund and extend the pumped primed services and additional specialist services to meet national directives and complement our core CAMHS offer. In addition, we started our investment programme is Child Sexual Exploitation and started to invest in strengthen the universal element of Emotional Health and Wellbeing services. We also began our development of CYP IAPT service with our acute provider and the voluntary sector. CAMHS LTP funding enabled us the opportunity to further develop the Emotional Health & Wellbeing Support Team (EHWT) based in schools and having a close relationship with both school nurses and CAMHS i.e. our Positive Steps Service.

4.5 In 2018/19 funding was targeted at lower level interventions and the IAPT service offer was further extended and additional support to primary care was delivered by our GP Liaison Service. However, the referral so our specialist services, although not rising, remained static and therefore we had to invest in our core CAMHs to reduce waiting times.

4.6 Our voluntary sector services were further supported in 2018-20 and parent/carers began to share the need for a way to tell their story once and celebrate all the great things their children and young people could do, their achievements and aspirations. They also wanted more connectivity with professionals and a way to regularly be updated on their child’s progress as well as being able to provide and share updates from home. Therefore LTP funding was used to pilot develop a tool that could do this and put local people in control to inform the development of services. We commissioned a local
social enterprise called PSIAMS to design and develop the tool and asked educational settings to volunteer to be involved. In September 2018, we also commissioned the Centre for Mental Health to complete a review of the model of Youth Offending Service (YOS) health provision in the borough.

4.7 Finally, in 2019/20 we increased the age range of our voluntary sector counselling provider so that children aged 9-12 can access the service and funding has been allocated to three of our voluntary to provide therapeutic support for CYP exhibiting harmful sexual behaviour. To complement these developments we have invested in a 0-8 early years intervention resilience worker. We also launched our Lighthouse Links Services our emotional health and wellbeing service for children looked after.

4.8 To summarise, based on our needs assessment and national directives we have apportioned our CAMHS LTP funding to a range of services to support our children, young people and families to prevent and early identify emotional health and wellbeing issues, more targeted services, either on an individual and/or population level and specialist services including crisis interventions. Funding has also been directed to support our most vulnerable CYP. We have commissioned services from a range of NHS and non NHS providers and developed pathways accordingly.

4.9 It is important to note that some of the services have been financed from other funding streams from the CCG, the LA, including the Office of Public Health. Our voluntary sectors have also been able to attract other investment e.g. National Lottery, charities to match fund and/or expand services that the CAMHS LTP funding has been allocated to.

4.10 Our development across the tiers of service delivery is represented in the table below.

4.11 Our journey so far is pictorially represented in below:
- Develop 0-25 year old service
- Develop Autism/ LD Community Service
- Embed iThrive operating model
- Increase access to crisis services
- Reduce waiting times for specialist services to 4 weeks
- Embed MHST in schools

2018/19
- CAPA Triage
- GP Liaison Service
- YOS Health review

2019/20
- Roll out of IAPT
- Expansion of CSE offer
- CAMHS Social Worker
- 9-12 counselling service
- Therapeutic support for CYP exhibiting HSB

2016/17
- Need analysis engagement
- Work force audit
- Pump – priming of new initiative

2017/18
- Positive steps (Tier 2)
- Community GP
- i-CAMHS
- IAPT
- CSE and Missing Person Service
- 0-5 Neurodevelopment Pathway
4.12 The Whole System Dudley Pathway is presented in the table below:

**Outcomes: improved emotional and social well-being, attainment and life chances for children**

1. Prevent, promote
2. Self-care, advice and signpost
3. Extended evidence based therapeutic support and step down
4. Multi-agency panels managing children with complex needs

**MH capacity building**
- Public Health
- Emotional Health and wellbeing coordinator
- Send and EHWB directory
- School nursing
- Phase Trust
- Other VSO and leisure providers
- Kooth online counselling
- MHFA - youth
- MindEd/Mentally Healthy schools, websites, National helplines

**MH promotion:**
- First 1000 days
- Youth Champions
- Pastoral networks
- Workforce development and wellbeing
- Whole school approaches
- PSHE
- Consultancy
- Graduated SEND

**Dudley needs a clear integrating front door for help**
- School counselling
- Nurture groups
- Kooth online counselling
- Positive Steps
- What Centre counselling and family work
- Triple P offer via Family Centres
- Phase Trust: social prescribing
- Young carers support?
- SEND activity Switch

**What is the process to refer and escalate up or step down between services?**
- Trauma-informed support
- Barnardo’s What Centre Specialist CAMHS
- LAC EHWB team
- Special & LD CAMHS
- Multi-agency assessment, planning and specialist support
- For CYP with high risks and severely unwell
- Eating Disorder iCAMHS
- LD CAMHS

**Crisis care:** de-escalates risk and also supports step down from inpatient and crisis care

**Workforce development**
- (including early years, social care, A&E, GPs, employers, VSO youth leisure, School staff etc)

**C&YP & Families, foster carers**

**Outcomes & Workforce Development**

**CYP IAPT Training**
4.13 The detail of the service developments are described in the following sections.

**Promoting resilience, prevention and early intervention**

4.14 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.

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

**Nurturing and Resilience**

4.16 We have a nurturing and resilience programme to support children and young people in Dudley to thrive and to building resilient children, young people, families and communities that collectively and individually are able to ‘bounce’ back from any form of adversity.

4.17 In April 2018 we developed a 3 year phased plan of universal, targeted and specialist interventions to support the resilience and emotional wellbeing of 0 - 19 population of Dudley was developed. A Nurture and Resilience partnership group set up to oversee this programme.

4.18 In Autumn 2018 schools began to develop nurture based provision.
4.19 In 2018 partners in Dudley secured West Midlands Violence Prevention Alliance funding to develop and test a trauma informed approach to addressing adversity in childhood.

4.20 We also, led by Barnados, had a workshop were partners contributed to shaping the priorities for the work plan of the ACES co-ordinators.

4.21 In March 2019 Dudley, alongside 4 other areas (Barking and Dagenham, Norfolk, Sandwell and Westminster/Kensington & Chelsea) were selected to partner the EIF Early Years Transformation Academy in a 12 month system transformation programme.

4.22 EIF Academy will work with key children’s leads in Dudley from across maternity, NHS, voluntary sector and Dudley council to develop a transformation plan to improve the early years and maternity system so that is meets the needs of the local population and improves outcomes. It will help local areas to focus on what families and communities do for themselves alongside a shared responsibility across health, social care and children services.

**Early Help and Targeted Services**

**Early Years**

4.23 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.

4.24 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. The service the age range has been expanded up to 5 years and has been integrated with the 0-5 psychological assessment service that currently sits within CAMHS.

4.25 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
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.

FAST and Parenting Assessment Service

Parenting is fundamental in children’s development and the most important influence on their future outcomes & successes. Dudley Public Health have acknowledged parenting as a priority and a public health issue, this has meant a continued commitment and funding for the parenting agenda.

Early Help

When considering its early offer of support for children and young people’s mental health, The Centre for Mental Health have recommended that we should consider Anna Freud Centre’s Thrive framework as a reference point for thinking through and planning their pathways - focusing on the following early functions and issues:

- **Prevention and promotion**: what range of services, provided by whom, seek to promote resilience and prevent emotional and mental health difficulties.
- **Signposting, self-management and one-off contact**: how are children and young people and families signposted, given advice, provided with self-management strategies and given brief support to help them re-stabilise?
- **Goals focused evidence-based intervention**: who provides time-limited goal orientated and evidence-based help?
4.29 Few local services are likely to sit just in one of these Thrive ‘segments’ of care; many will span a range. However, many services will prioritise some activities over and above others.

4.30 Any pathways that are developed will need to integrate with the broad range of preventative and promotional activity as well as with specialist CAMHS pathways. Specialist CAMHS pathways may need to be refined to ensure they support step-up and step-down support for children and young people.

4.31 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.

4.32 Early Help remains a partnership wide responsibility and in order to keep Early Help as a priority there are a number of key areas that have shown development over the past 12 months.

4.33 In 2016, Dudley Children and Young People’s Alliance Board endorsed Dudley’s Early Help Strategy. This document served to provide the overarching aim of Dudley’s Early Help operating model enabling effective, well-co-ordinated Early Help for those who need it and a seamless journey of support for children, young people and their families across all levels of need. The strategy has now been reviewed and was relaunched at a partnership wide event on 20th April 2018 alongside the revised Early Help Assessment and Threshold Guidance.

4.34 A key part of the Early Help operating model highlights cluster based working as the preferred method of delivery for Early Help Services across the Borough. Five clusters (Brierley Hill, Halesowen, Stourbridge, Dudley North and Dudley Central) offer services that can be accessed at the heart of the communities where they are needed most. This has created a more even distribution of families across the borough ensuring that no matter where families access services across the borough the service that they see and receive will be the same.

4.35 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.

4.36 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.
4.37 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.

4.38 To measure progress against these key desired outcomes, we have developed 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 is shared, at the Early Help Strategic Group, 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.

**Multiagency Safeguarding Hub**

4.39 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.

4.40 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 wellbeing needs the MASH will ensure that children and young people receive the right support at the right time.

**Evidence based routine care**

4.67 The CCG, D&WMHT and The What Centre joined the CYP IAPT Midlands Collaborative in 2017 and have established a CYP IAPT Strategy Group that is supported by the collaborative. Colleagues from DMBC have now joined the group.
4.68 The CYP IAPT Project Lead for the Dudley partnership holds regular meetings with The What Centre to ensure that the CYP IAPT principles are rolled out appropriately. There are also triangulated meetings held along with the Systemic Family Practice supervisor to ensure that trainees are supported in the best way possible. In addition to this there are four to six weekly meetings held within CAMHS to ensure that CYP IAPT principles are being achieved and that trainees are fully supported and pathways are being appropriately embedded into the service.

4.69 Details of the commitment to existing training is presented in the table below together with our plans for Well Being Practitioners.

<table>
<thead>
<tr>
<th>Course</th>
<th>Organisation</th>
<th>Role</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Transformation &amp; Leadership</td>
<td>DWMHT</td>
<td>CAMHS Project Manager</td>
<td>September 2018</td>
</tr>
<tr>
<td>SFP Supervisor</td>
<td>DWMHT</td>
<td>Consultant Family Therapist</td>
<td>June 2018</td>
</tr>
<tr>
<td>CBT Course</td>
<td>DWMHT</td>
<td>CAMHS Social Worker</td>
<td>November 2018</td>
</tr>
<tr>
<td>CBT Course</td>
<td>DWMHT</td>
<td>Recruit to Train (transfer to a permanent position in Positive Steps)</td>
<td>December 2019</td>
</tr>
<tr>
<td>SFP Course</td>
<td>DWMHT</td>
<td>Mental Health Practitioner (Positive Steps)</td>
<td>November 2018</td>
</tr>
<tr>
<td>SFP Course</td>
<td>DWMHT</td>
<td>Recruit to Train</td>
<td>December 2019</td>
</tr>
<tr>
<td>Wellbeing Practitioner</td>
<td>DWMHT</td>
<td>Recruit to Train (will be seconded into 0-19 model with school nursing)</td>
<td>December 2019</td>
</tr>
<tr>
<td>Wellbeing Practitioner</td>
<td>DWMHT</td>
<td>Recruit to Train (will be seconded into 0-19 model with school nursing)</td>
<td>December 2019</td>
</tr>
<tr>
<td>EEBP</td>
<td>DWMHT</td>
<td>Family Support Worker</td>
<td>November 2018</td>
</tr>
<tr>
<td>SFP Course</td>
<td>The What Centre</td>
<td>Counsellor</td>
<td>November 2018</td>
</tr>
<tr>
<td>SFP Course</td>
<td>The What Centre</td>
<td>Counsellor</td>
<td>November 2018</td>
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<tr>
<td>SFP Course</td>
<td>The What Centre</td>
<td>Counsellor</td>
<td>November 2018</td>
</tr>
</tbody>
</table>

4.70 The wellbeing practitioners will be trained in low mood, anxiety and mild behavioural difficulties. Once they finish their training they will remain with CAMHS for a further twelve months to gain experience and then they will return to their original workplaces to roll out their learning. They will continue to be supervised by CAMHS CYP IAPT CBT supervisors. The interventions they deliver will be ‘pre’ Positive Steps and therefore will work in tandem with that team.
4.71 From 2020 onwards the plan is for the additional wellbeing practitioners to be trained and that we hope to secure at least four places each year but we will need more supervision capacity.

4.72 In addition to the above we also have Recruit to Train places in CBT and Systemic Family Practice. The CBT is accredited and both are higher banded therefore the intention is to grow the CAMHS workforce. We have one place this year however we are not sure just yet whether we are going to be able to support this place this year as we are still trying to work through funding issues.

4.73 The CYP IAPT transformation project also remains as a standing item on the Emotional Health & Wellbeing Strategy meeting with the CCG and partners and this will become more predominant once partners are signed up to the new cohort of wellbeing practitioners in 2019. Unfortunately, due to a lack of funding from central government to ensure more colleagues can be trained with backfill etc. in place sustainability will be difficult but will be part of our future workforce planning.

Crisis care and intensive interventions

4.74 Our ambition is that children and young people in crisis can receive evidence-based interventions at home and do not need to either attend, or be admitted to the acute trust. The model of care has been altered to ensure that CAMHS crisis staff are available at the acute trust from 8.00 – 20.00 and can see CYP as they attend A and E. Once the child is out of crisis and further interventions are required they are transferred to an alternative service. Further detail is included in Section x.

New care models

4.75 Our Dudley & Walsall CAMHS is working closely on the “NHSE” new care models to ensure that the funding devolved down to the local region is used appropriately for the gaps identified to in crisis care and supporting the C&YP and their families during the most difficult times and prevent things from escalation.

4.76 If C&YP do go into Tier 4, there would be a plan to ensure that they return home as quickly as possible but also to ensure that they are place as locally as possible.

4.77 The ultimate aim is to transfer finances and move all specialised commissioning for Mental Health to this new way of working by 2021 and within the West Midlands the process of transferring commissioning to Provider collaborative has started with three areas; secure care, CAMHS Tier 4 and Adult Eating Disorders. The CAMHS Tier 4 model should also include an inpatient gate-keeping process.
4.78 Work has progressed to development of business cases being presented to the national teams and each programme being advised if they are progressing on the fast track or the developmental track. A full business case is now being prepared in the Midlands and collaborative and leads being identified. The lead for CAMHS Tier 4 has been identified as Birmingham Women and Children’s NHS Trust and the lead for Adult Eating Disorders is Midland Partnership NHS Foundation Trust. The function of the Lead provider will be to hold the main contract with NHSE and they will be responsible for planning for and sourcing partners and sub-contractors to enable the best provider-mix possible to attain equity of services and value for money. Both the full financial implications of implementing these models and the delivery require further clarification and the Trust will remain involved in the process at every level.

Reprofiling inpatient expenditure into community-based care as part of New Care Model

4.79 Specialised commissioning are involved in supporting development of the New Care Models which is now called Establishing Steady State Commissioning (ESSC) and the favoured provider for community provision as part of the Provider Collaborative. Currently no financial envelope has been agreed locally and no timeframe for when the transfer will occur but these discussions are taking place locally which local CCG commissioners have not been actively involved in as it has been provider led

Specialist Care e.g. CYP with learning disabilities and forensic CAMHS

4.80 Transforming Care Programme supports Children and young people with Learning Disabilities and/or ASD with pathways developed to support admission prevention as well as reduction in length of stays. The plan for the TCP this year is to increase the expertise in the crisis team to include staff with ASD and LD knowledge and experience to ensure young people with these conditions can be supported in their own home in an appropriate manner. It will also increase the knowledge of the use of the forensic team, Youth First, to ensure that the spectrum of support available is considered for each child who comes into the service.

Services provided directly by educational settings to support emotional wellbeing and Mental Health

4.81 Currently some of the local voluntary sector organisations are commissioned by educational settings directly to provide additional support to them. These services are also commissioned to provide the Emotional Mental Health and Wellbeing Service for CYP in the city. If the service supporting the educational settings find that the young person needs additional support they are able to refer into specialist CAMHS making it a more streamline system. The new Mental Health Support Teams in Schools will be able to ensure that there is an effective pathway available for children and young people in educational settings through to specialist CAMHS.
LTP demonstrates Thrive model framework which promote needs-based care

4.82 Using the THRIVE model, we can demonstrate how we undertake place based commissioning to ensure that we are using a person-centred model of care for young people’s Mental Health which helps young people to THRIVE. It enables Mental Health services to be delivered according to the needs and preferences of young people and their families. It uses an integrated, person-centred model of child and adolescent Mental Health care across the system.

Work underway with mental health services to link with liaison psychiatry or mental health teams

4.83 Currently although there is no gap in provision, work is required to identify clearly the activity undertaken with the 18–25 cohort. The liaison psychiatry service manages any adults who come into the acute trust in crises and for those CYP who are transitioning into adult hood there are clear pathways for transfer from CAMHS to AMHS.

How will needs of CYP going through transition be met

4.84 The initial transition CQUIN supported children and young people as they moved into adult services and ensured they are properly prepared. The ambition of services post 2020 is that young people will be fully aware of their plan going forward into adulthood and that services will be available to meet their needs. As part of their transition process, young people will have had contact with their new adult team and be aware of how they can receive support going forward. This has been built into service specifications as they are developed.

4.85 This has formed the discussions with AMHS commissioners as part of the ‘One commissioner’ across the STP.

4.86 It has also been recognised that Children and Young People who have received services from CAMHS over the years are often referred to Primary Care services and work has been undertaken with both CAMHS and Primary care to ensure that appropriate information is sent across with adequate notice so that GPs are fully aware of the needs of the young people and feel confident that they can meet their needs as adults.

Improvement in access figures

4.87 The service is modelled on the Choice and Partnership Approach (CAPA). CAPA is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management. In addition, the following work has been undertaken to increase activity:

- Commission new services as described in the plan.
- Waiting list initiative in undertaken to reduce waiting times.
• Electronic booking system.
• Group work as an alternative method of delivering interventions.
• Pathways & length of stay to be standardized across services that are similar
• Work with partner agencies to ensure that activity is possible to be integrated across the system and ensure it could be recorded on MHSDS appropriately.
• Roll out CYP IAPT principles.
• Mental health support teams in schools and their development and ensuring that the data can be included on the MHSDS.

Evidence that CYPMH commissioners and providers are beginning to consider with AMH colleagues and other system partners how to better meet the needs of 18 – 25 year olds

4.88 We have a Transitions out of CAMHS to AMHS Project Team which is in the process of identifying the baseline of current activity for 16 – 25 year olds in this financial year to support the gap in knowledge for this cohort.

4.89 The team updates on progress relating to transition and reports on the positives and negatives of a young person transitioning into adult services. Where possible there have been examples given of good practice but equally where difficulties or obstructions with pathways have been identified these too have been included to demonstrate that no two young people are the same and their journey in CAMHS is individualised requiring a tailored package of care.

4.90 The SEND agenda ensures that CYP are considered across the 0 – 25 age range ensuring necessary transition is in place with appropriate services in place.

4.91 Lighthouse links accepts care leavers up to the age of 25.

4.92 Young people also have access to the following services:-

• Out-patient clinics (all ages);
• 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).

Comprehensive 0 – 25 support offer in the STPs by 2023/24

4.93 The STP LTP Action Plan includes the following priorities for a comprehensive 0-25 offer:-
• Review BCWB transition processes
• Review and align where possible standard service offer for 0 to 25 across BCWB.
• Scope 18 to 25 pathways to identify potential opportunities for integrated pathways including submitting data for MHSDS
• Develop commissioning plan for 0 to 25 services
• Support change across providers for 0 to 25 services
• Develop data quality plans to improve reporting against MHSDS.
• Utilise principles from Sandwell and Wolverhampton demand and capacity modelling to support Walsall and Dudley access plans.
• Develop a crisis service specification for CYP across the Black Country which to offer 24/7 blended response.

CORE Specialist CAMHS

4.94 In the old model of service delivery, 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. Crucially there would be no exclusion criteria to CAMHS.

4.95 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);
- Eating Disorder Service (all ages);
- Criminal Justice Liaison (all ages);

Specialist Perinatal Community Psychiatric Team (SPCPT)

4.96 Following three perinatal community mental health pilot schemes this year, the Black Country and West Birmingham Sustainability and Transformation Partnership (STP) has been awarded £1,253,727 as part of the Perinatal Mental Health Community Services Development Fund Wave 2 to develop7 Pilot perinatal mental health liaison clinics were set up in Russell’s Hall Hospital in Dudley, Walsall Manor Hospital and New Cross Hospital in Wolverhampton (in addition to an existing clinic is available at City Hospital, Sandwell). The aim of the clinics has been to provide better, more timely support and treatment for pregnant women and new mums. Depression and anxiety are two of the most common mental health problems women experience during pregnancy and the continuation of these services will improve their health and wellbeing.

4.97 Midwives can refer women with moderate to severe mental health difficulties related to preconception, pregnancy and the first post-partum year to a liaison
clinic. There they receive high quality care from a consultant perinatal psychiatrist, community psychiatric nurses and local midwives who work together to provide specialist evidence-based treatment. It is anticipated that an additional 240 women will benefit from the extra funding which will enable a new Specialist Perinatal Community Mental Health Service to operate as a single service across the Black Country.
5.0 Workforce

5.1 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.

5.2 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.

5.3 As part of local transformation activity we have commissioned the Centre for Mental Health has completed a skills workforce audit to help us 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. The recommendations from this audit are presented in Appendix 3.

5.4 Part of our approach we also sought 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 have also engaged with the professionals and ask them to audit their skills, competencies and practice against their ambitions. We held a 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.

5.5 The methodology was developed 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.
Workforce Plan

5.6 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.

Mental Health Promotion and Prevention

5.7 Further progress has been made in expanding our universal service to develop the universal Emotional Health co-ordinator role which has supported the following areas of development to date.

5.8 The development of an ever evolving training offer designed for the universal children's workforce (predominantly education and school health but currently being expanded to include the wider workforce) to increase their knowledge, skills and strategies that help support children and young people’s mental health. The training offer has been developed in partnership with local multi agency partners and is delivered by both local and national providers and the universal.

5.9 Mental Health First Aid Youth training is being made available to the multi-agency children and young people’s workforce (including schools and colleges) and local provider colleagues have now been MHFAY instructor trained to ensure that there is a sustainable programme of training with knowledge of local pathways and support. Young people reported that their school was not an environment in which they felt safe to be open about their mental health concerns.

5.10 5 ways to wellbeing (NEF 2008) informed resources have been developed locally and are being utilised to create a variety of visual health promotion resources appropriate for children and young people and are being rolled out for use and display across a number of settings including CAMHS provision, schools, colleges, family centres etc. The resources have also formed the basis for mental health promotion workshops.

5.11 A whole school approach to emotional health and wellbeing is available and being promoted for use by all schools/educational settings. 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.

5.12 Partnership working with public health and education has supported the provision of anti-bullying initiatives in schools including a locally developed accreditation, theatre in education programmes and Diana Award anti-bullying ambassador training. There are links in place between the local authority lead for e safety and the universal Early Help Co-ordinator.
5.13 The universal role has provided good links with schools and is key to ensure joined up approaches to universal mental health promotion and awareness. The role sits within and is managed by Dudley and Walsall Mental Health Partnership NHS Trust with support and direction from the Public Health Department Children and Young People’s team service lead. The post is co-located with the Educational Psychology service and works closely with them; the Positive Steps (tier 2 CAMHS service) and the School Nursing Service (See below).

5.14 As described in Section 4 our workforce will be expanded by commissioning the Mental Health Support teams in schools.

**CYP IAPT**

5.15 Details of the commitment to expand our workforce by joining the CYY IAPT Collaborative have is presented in the Table on page 52 above.

5.16 The current CBT trainee will be recruited into a vacancy to be able to provide ongoing CBT support to the high referral rate for anxiety treatment.

5.17 The current wellbeing practitioners will hopefully be seconded from CAMHS into the 0-19 offer for Dudley young people.

5.18 Supervision training will be provided to two existing CAMHS CBT trained members of staff to be able to provide ongoing support to existing and newly trained staff.

**CORE CAMHS and Specialist Services**

5.19 Generic CAMHS staff have been employed to help us meet our access rates.

5.20 We have plans to expand the community disorder team to include a dietician and commission an ADHD Lead and an additional member of staff will be joining our GP liaison team.

5.21 We also plan to commission behaviour management practitioners to prevent admission into Tier 4 or C&YP who have a diagnosis of ASD/LD. These will enable us to provide training to be delivered to school staff around neurodisability and learning disabilities to ensure that individual care plans are tailored to the needs of the C&YP.

5.22 Plus training to support the school to support pupils with other needs, e.g. self-harm, confidence building.

5.23 The current CAMHS Team Structure is attached in Appendix 4. The posts that are in red represent the additional workforce that has been funded by CAMHS transformational monies. 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”.
6.0 Data – Access and Outcomes

6.1 The waiting list initiative that began in October 2016 enabled the trust to employ temporary staff to reduce the waiting time considerably. However, this has not been sustainable. The table below demonstrates that in many of the specialist areas there have been reductions in waiting time. The waiting time for a medic has risen by four weeks and ADHD clinic by 3 weeks. The partnership waiting time has increased by four weeks since August 2017. The team regularly carry out caseload reviews and undertake process mapping to ensure that they are working as efficiently as possible however demand continues to increase is now creating difficulties with waits. Additional resource is was allocated this year and we are part of the 4 weeks Waiting Times pilot.

<table>
<thead>
<tr>
<th>Waiting List</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>
<th>Waiting time as of 31st May 2018</th>
<th>Waiting times as of 24th April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice</td>
<td>7 weeks (priority 2wks)</td>
<td>8 weeks (priority 4 days)</td>
<td>9 weeks (priority 4 days)</td>
<td>10 weeks (priority 4 days)</td>
<td>6 weeks (priority 4 days)</td>
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<td>Partnership</td>
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<td>26 weeks</td>
<td>14 weeks</td>
<td>18 weeks</td>
<td>24 weeks</td>
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<td>Psychotherapy</td>
<td>30 weeks</td>
<td>26 weeks</td>
<td>28 weeks</td>
<td>18 weeks</td>
<td>ND</td>
</tr>
<tr>
<td>Psychology</td>
<td>22 weeks</td>
<td>10 weeks</td>
<td>10 weeks</td>
<td>10 weeks</td>
<td>24 weeks</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>31 weeks</td>
<td>32 weeks</td>
<td>28 weeks</td>
<td>23 weeks</td>
<td>10 weeks</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>36 weeks</td>
<td>26 weeks</td>
<td>26 weeks</td>
<td>18 weeks</td>
<td>ND</td>
</tr>
<tr>
<td>ASD</td>
<td>10 weeks</td>
<td>30 weeks</td>
<td>16 weeks</td>
<td>12 weeks</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Medic</td>
<td>No wait</td>
<td>Duty medic sees patients the same day</td>
<td>Duty medic sees patients the same day</td>
<td>Duty medic sees patients the same day</td>
<td>Duty medic sees patients the same day</td>
</tr>
<tr>
<td>ADHD</td>
<td>No wait</td>
<td>7 weeks</td>
<td>9 weeks</td>
<td>12 weeks</td>
<td>15 weeks</td>
</tr>
</tbody>
</table>

Mental Health Minimum Data Set (MHMDS)

6.2 The MHSDS is a patient level, output based, secondary uses data set which delivers robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health Services. As a secondary uses data set it intends to re-use clinical and operational data for purposes other than direct patient care.
6.3 The MHSDS is unique in its coverage, because it covers not only services provided in hospitals, but also in outpatient clinics and in the community, where the majority of people in contact with these services are treated. MHSDS brings together key information from Adult and Children's mental health, learning disabilities or autism spectrum disorder, CYP-IAPT and early intervention care pathway that has been captured on clinical systems as part of patient care.

6.4 The providers of CCG commissioned relevant services are all submitting, on a monthly basis, into the NHS digital MHSDS.

6.5 Dudley CCG’s Performance Manager collates the monthly Improve Access Rate to CYPMH Monitoring Table performance updates, on behalf of the STP CGs, to the Task and Finish Group Meetings.

6.6 Our latest access figures are tabulated below demonstrating that we are meeting our target:

<table>
<thead>
<tr>
<th>CCG</th>
<th>NHS DUDLEY CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (Annual)</td>
<td>32%</td>
</tr>
<tr>
<td>Prevelance (Based on plan)</td>
<td>6718</td>
</tr>
<tr>
<td>18/19 Estimate (Based on plan)</td>
<td>2500</td>
</tr>
</tbody>
</table>

6.7 Details of providers contribution to the access targets is presented below.

<table>
<thead>
<tr>
<th>CYP Receiving 2nd Contact With Services</th>
<th>2018/19</th>
<th>Predicted 2019/20</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley and Walsall NHS MHT</td>
<td>1210</td>
<td>1260</td>
<td>Taken straight from MHSDS (rounded up to nearest 5). 2019/20 estimated on 3.85% contract uplift.</td>
</tr>
<tr>
<td>Other NHS MHTs</td>
<td>165</td>
<td>175</td>
<td>Taken straight from MHSDS (rounded up to nearest 5). 2019/20 estimated on 3.85% contract uplift.</td>
</tr>
<tr>
<td>Kooth</td>
<td>305</td>
<td>305</td>
<td>Number of unique CYP logging in with 84% returning.</td>
</tr>
<tr>
<td>The Phase Trust</td>
<td>872</td>
<td>872</td>
<td>1st January to 31st December 2018 actual data</td>
</tr>
<tr>
<td>The What Centre</td>
<td>605</td>
<td>785</td>
<td>Nov to March actual data extrapolated for FYE.2019/20 estimated to reflect increase in contract and expanded age range (30%).</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3157</td>
<td>3397</td>
<td></td>
</tr>
</tbody>
</table>

6.8 The latest CAMHS Performance Dashboard date is tabulated below.
<table>
<thead>
<tr>
<th>Referrals</th>
<th>No of external referrals received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>117</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>10</td>
</tr>
<tr>
<td>I-CAMHS</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No of External Referrals accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
<tr>
<td>I-CAMHS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number on current caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
<tr>
<td>I-CAMHS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD10</th>
<th>Total number of ICD 10 Codes recorded for all CAMHS patients broken down by quarter (date recorded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-18</td>
<td>143</td>
</tr>
<tr>
<td>May-18</td>
<td>35.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average waiting time from referral to 1st assessment (Choice)</th>
<th>Working Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>52.88</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>53.45</td>
</tr>
<tr>
<td>I-CAMHS</td>
<td>38.22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average waiting time from referral to Partnership (I Therapy)</th>
<th>Working Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>83.60</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>116.58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average waiting time from referral to referral priority based</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>3.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average waiting time from referral to referral priority based</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>2.20</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>NA</td>
<td>132</td>
<td>150</td>
<td>155</td>
<td>12</td>
<td>139</td>
<td>173</td>
<td>163</td>
<td>146</td>
<td>193</td>
<td>151</td>
<td>166</td>
<td></td>
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</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>NA</td>
<td>92</td>
<td>77</td>
<td>163</td>
<td>110</td>
<td>136</td>
<td>81</td>
<td>158</td>
<td>119</td>
<td>125</td>
<td>110</td>
<td>81</td>
<td>88</td>
</tr>
</tbody>
</table>
6.9 Dudley and Walsall MHT’s NHS CAMHS Benchmarking Network 2018-19 report is attached in Appendix 6. This data included performance measure for a wider range of KPIs for our commissioned services.

6.10 The table below demonstrates Dudley CGG’s position compared to England’s average and best and worst performing CCGs. The data is based upon the Mental Health Services Data Set (MHSDS). MHSDS data is known to be incomplete due to underreporting by some providers. The numbers presented here need to be considered within that context. For more on MHSDS data and the corresponding data quality issues, please refer to http://digital.nhs.uk/mhldsreports.

6.11 CCG overall score on five CYP MH indicators was calculated by summing the quintile scores for each of the five indicators: Percent of CCG budget spent on CYP Mental Health, MH spend per child, Percent of CYP in contact with MH services, Average wait time for MH services, Percent of MH referrals Closed Before Treatment.

6.12 The overall score for both Dudley and Walsall CCGs, who commission CAMHS from Dudley and Walsall Mental Health Trust is 22 compared with 25 for the best performer and 6 for the worst.

6.13 Dudley compares well on mental health spend per CYP but the % in contact with mental health services is below the national average. 

6.16 Dudley has the lowest average waiting times (18 days).

6.17 The definition of the average waiting time (in days) is between referral and second contact for CYPs accessing mental health services between April 2017 and March 2018 (excluding learning disabilities and autism services). Note that this number only includes people who have had two contacts. Data were provided by the NHS as part of a bespoke request.

6.18 Following the recent CQC inspection the Trust has also retained an overall rating of ‘Good’ and also received ‘Outstanding’ under the caring domain in our Child and Adolescent Mental Health Services.
### Mental Health Services Spending and Waiting Times for Children and Young People in Dudley CCG between April 2017 and March 2018

<table>
<thead>
<tr>
<th>Clinical Commissioning Group (CCG)</th>
<th>% CCG budget spent on CYP MH</th>
<th>MH Spend per CYP</th>
<th>MH Spend up (↑) or down (↓) from 16/17</th>
<th>% of CYP in contact with MH services</th>
<th>Average wait time for MH services (days)</th>
<th>% CYP whose referral closed before Treatment</th>
<th>% CYP referred and seen within 6 weeks</th>
<th>% CYP referred and seen after 6 weeks</th>
<th>% CYP referred and still waiting</th>
<th>CCG overall score on five CYP MH indicators (5 = bottom 20% on all five indicators; 25 = top 20% on all five indicators)</th>
<th>CCG MH CYP total score quintiles</th>
<th>Number of times in bottom 20% (0 to 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.87</td>
<td>£54</td>
<td>↑</td>
<td>2.85</td>
<td>57</td>
<td>37%</td>
<td>16%</td>
<td>15%</td>
<td>32%</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudley CCG</td>
<td>1.11</td>
<td>£70</td>
<td>↑</td>
<td>2.26</td>
<td>18</td>
<td>21%</td>
<td>12%</td>
<td>2%</td>
<td>65%</td>
<td>*</td>
<td>22.00</td>
<td>5</td>
</tr>
<tr>
<td>Walsall CCG</td>
<td>0.99</td>
<td>£57</td>
<td>↑</td>
<td>2.59</td>
<td>36</td>
<td>30%</td>
<td>6%</td>
<td>2%</td>
<td>62%</td>
<td>*</td>
<td>20.00</td>
<td>5</td>
</tr>
<tr>
<td>Ealing CCG (Worse performer)</td>
<td>0.58</td>
<td>£35</td>
<td>↑</td>
<td>2.02</td>
<td>89</td>
<td>59%</td>
<td>8%</td>
<td>10%</td>
<td>29%</td>
<td>94%</td>
<td>6.00</td>
<td>1</td>
</tr>
<tr>
<td>South Tees CCG (Best performer)</td>
<td>1.29</td>
<td>£93</td>
<td>↑</td>
<td>5.46</td>
<td>23</td>
<td>23%</td>
<td>54%</td>
<td>12%</td>
<td>11%</td>
<td>*</td>
<td>25.00</td>
<td>5</td>
</tr>
</tbody>
</table>
7.0 Health and Justice

7.1 NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities for children and young people, police and court Liaison and Diversion services and immigration removal centres. It is important that there is full pathway consideration for CYP in contact with the directly commissioned services with local CYP Mental Health Services. This cohort may include children and young people (up to the age of 18) who are accommodated in a Young Offender Institution, a Secure Training Centre or a Secure Children’s Home. They may be held either because they have been sentenced or remanded to custody (i.e. on youth justice grounds), or for the protection of themselves or others (known as a welfare placement). Together, these three types of institution are known as the Children and Young People’s Secure Estate (CYPSE).

7.2 Usually Children and young people who are accommodated in a Secure Children’s Home will have had to have met strict criteria and be at significant risk to themselves or others. For these young people who are in the secure care home estate, it is likely that they are in receipt of therapeutic interventions already and their allocated social worker co-ordinates intervention needed when the young person is re-settled ensuring that if anything additional is required, a request is made to the children’s commissioner to spot purchase as necessary CYP transitioning within secure estate are monitored by a Case worker from the Youth Offending Team. The Community Health Assessment Tool (CHAT) is completed by CPN in the community to identify emotional and mental health needs and a similar form is completed in secure estate. All young people returning from secure estate to the community are offered and encouraged to attend an appointment within 5 working days of release to ensure needs are addressed, i.e. medication CAMHS appointments.

7.3 The Regional Forensic Service based at Ardenleigh has relaunched their service earlier this year to offer services to CYP in the community with High Risk issues. Referral is via Community CAMHS. They also offer consultation on high risk and complex cases.

7.4 Forensic CAMHS for the Black Country is available through Youth First, a service available from Birmingham and Solihull Mental Health Trust. It is a specialist community child and adolescent mental health service for high risk young people with complex needs in the West Midlands region, providing an advisory, consultation, assessment and intervention model of care. Referrals are made by any professional working with those under 18 who are giving cause for concern and about whom there are questions regarding his/her mental health or neurodevelopmental difficulties including learning disability and autism who:

- present high risk of harm towards others and about whom there is major family or professional concern, and/or
- are in contact with the youth justice system, or
• about whom advice about the suitability of an appropriate secure setting is being sought because of complexity of presentation and severe, recurrent self-harm and/or challenging behaviour which cannot be managed elsewhere.

7.5 This service can work with existing services to support the young people by providing a consultation approach as well as face to face assessment and intervention as necessary. Usually referrals are made to this service for CYP who are at risk of entering the youth justice system, or have already entered it and are in custody. The pathway ensures that the children's commissioner is aware of these cases for any additional funding that may be required for intervention purposes. The Risk register meeting held as part of the Transforming Care Programme has supported referrals to this pathway to support CYP who are at risk of entry to the criminal justice system who have diagnoses of either ASD and/or Learning Disabilities.

7.6 Liaison and Diversion (L&D) work specifically with all Children and Young People, who have been arrested and are in the Custody suite aged 18 years and under to assess if they have any emotional Mental Health issues as part of their health and wellbeing assessments. They also see those who are issued with Court Resolution Orders although there can be a time lag between the issue of the order and the first visit from the L & D team. This can impact on the Child and Young Person and their families from engaging in the process as they feel the issue has already passed. If the L & D team identify Mental Health needs, they refer to the local mental health team as they are not commissioned to provide interventions. They can signpost to any point in the local emotional mental health and wellbeing service which will include the new Mental Health Support teams in schools when they are up and running as well as the Forensic CAMHS (Youth First) service.

7.7 The Sexual Assault Referral Centre is now known as the West Midlands Paediatric Sexual Assault Service (PSAS). Specialist counsellors are available who are trained in talking to and supporting children and young people who have been sexually abused and understand how difficult it can be to talk about it. The service works with children and young people aged 5 – 17 years old and also parents and carers of children aged below 5 years old. 6-10 sessions of psychological therapy are offered to survivors, after which time the expectation is that the patient is referred onto other local services if ongoing support is required, although consideration is being given to extending the PSAS offer up to 15 sessions but the Health and Justice Commissioning Team. The survivor has to have been through the PSAS to access this either as a historic or acute case and this pathway is open for 1 month post assault/ attendance at the PSAS. However, pathways available state that if the child or young person is at risk of self-harm or have suicidal thoughts then they should be urgently referred to the local CAMHS crisis team for these issues to be addressed as a matter of urgency. Once intervention is complete and if ongoing counselling is required as a result of their assault the child/young person can be referred back to those services that specialise in this area.
7.8 If a child or young person is in crisis and is in police custody (Oldbury or Wolverhampton custody suite) they are seen by the generic CPNs who are part of the Liaison and Diversion team within custody who will make an urgent referral through to either the local CAMHS crisis team or to Youth First (FCAMHS) if that is more appropriate. Youth First will offer support depending on which part of the model of care is appropriate whilst the CAMHS crisis team will assess and offer intervention as needed. It may be that a tier 4 placement is required as a matter of urgency and the local crisis teams will make that referral if appropriate. If the young person has a diagnosis of ASD and/or Learning Disabilities then a Care, Education and Treatment Review will have to be considered.

7.9 The Transforming Care Program for CYP has been working on developing services across the Black Country for CYP with autism and/or Learning Disabilities area. This has included development of a risk register meeting involving multiple agencies to discuss CYP who are at risk of admission to either a tier 4 mental health unit or the criminal justice system. These risk register meetings have included staff from our local special schools, Pupil Referral units, YOTs, Educational Psychology service, Crisis teams, police, social care, commissioners from LA and CCG and the TCP CYP case manager. It has allowed us to offer a wide ranging response to our most vulnerable young people as they display more challenging behaviours that raise concerns to ensure that their needs can be met locally and prevent them becoming involved in the criminal justice system. We have also agreed to support the Liaison and Diversion team to become engaged with the TCP to ensure that any CYP going into custody with a potential diagnosis of ASD and/or LD will have access to the necessary systems and support that have been developed to prevent their admission to the criminal justice system if possible.

7.10 For children and young people in care, a framework has been developed using the ‘National protocol on reducing criminalisation of looked-after children’ for local agencies to co-develop local arrangements to reduce the unnecessary criminalisation of looked-after children and care leavers. Appropriately identified Children and Young People in Care (CYPC) under the age of 18 years old who are eligible for any Out Of Court Disposals (OOCD), including Community Resolutions, will be referred to the OOCD panel. On receiving this notification at the YOT, lateral checks will be completed and contact will be made with the allocated Social Worker for the young person to confirm the date of the panel and who should attend to ensure that this panel is bespoke to the needs of the child and supports the Child First, Offender Second Principle. Where appropriate and available, victim information will also be considered. The mental health team, if appropriate, may be involved in this process if the young person is known to them.

Health needs of children in contact with the YOS

7.11 National reviews of the needs of children and young people in contact with YOS suggest an under reached population with multiple, severe, complex health and social needs and vulnerabilities. Many are noted to be reluctant to
seek help with health concerns or have fewer resources available to navigate complex systems of support.

7.12 Nationally, there has been a significant reduction in the numbers of children and young people entering the youth justice system in the last decade. This has reduced the caseload for YOS. But those who do enter the system are considered to have higher and more complex needs and risks. And there has been a rise in the number of offences involving the possession of a knife or offensive weapon. And young men from Black, Asian and minority ethnic communities are increasingly over-represented in the youth justice system.

7.13 Less than 1% of children in Dudley have contact with the police. But those who do come into contact with YOS tend to enter the system earlier than average, and there is some evidence of organised and postcode-related crime in the area linked to forced labour, drug dealing and child sexual exploitation.

7.14 Children and young people in Dudley YOS have very high levels of multiple health problems. More than 80% have emotional or mental health needs. Almost 90% have speech and language difficulties, nearly 70% have substance misuse problems and 65% have physical health problems. For about half of these children there are concerns about parents’ ability to care for and supervise them.

**Best practice approaches**

7.15 We are working on developing a ‘foot in, foot out’ approach in which they have a strong and regular physical presence in YOS balanced with delivery that is robustly embedded in the wider landscape of local support for all children and young people. It also means that YOS health workers have systematic links with other workers carrying out similar roles in other settings working with vulnerable children and young people. Workers with high visibility in YOS become the bridge to support outside creating strong links with other local services and benefitting the children and young people they are supporting.

7.16 YOS health practitioner activity should also integrate seamlessly with national liaison and diversion work and other preventative support for children and young people on the edges of and in the wider health and justice pathway.

7.17 Finally, based on evidence that our approach to preventing violence and gang involvement start from pregnancy onwards, we ensure that there is access to effective parenting programmes and whole school-based curricula promoting social and emotional skills.

7.18 Risk factors for conduct problems among children in Dudley, that are higher than the national average, include maternal smoking during pregnancy, living in poverty, being looked after and being excluded from school. Ensuring these
children and their families get access to effective support should be a foundation stone for any strategy to prevent crime or youth violence.

**Commissioning of health and justice support for children on the edges of and in YOS**

7.19 Commissioning of the health youth justice pathway is highly complex, often involving national, regional and local commissioners and providers. This complicates seamless planning and working and requires a collaborative approach and robust governance.

7.20 Youth Justice Board Draft Standards for children in the Justice System require a ‘child first, offender second’ approach, consistency of contact with workers and a developmentally informed approach that helps children lead a safe and crime free life. NHS England’s current strategy also emphasises a ‘care not custody’ approach, including early multi agency action to improve health among children and young people most at risk of offending and continuity of care and a whole system pathway of support for children on the edges of, in contact with and stepping down from the justice system.

7.21 National policy further reinforces the need for a ‘public health approach’ to youth violence with strong partnerships between schools, families, communities and public services supporting effective youth violence prevention. This approach has been most comprehensively adopted in Scotland. The implications of this approach for Dudley include the need for active community involvement in responding to youth violence, for a long-term as well as short-term approach to reducing violence, for the adoption of shared violence reduction outcomes across commissioning and providers, for the use of sound data and evidence of what works in determining what interventions are used, and for an understanding of the interplay between inequality and crime.

**Current service provision**

7.22 Dudley’s YOS health provision includes:

- An in-house general health nurse (0.6 whole time equivalent (WtE))
- Two in-house speech and language practitioners (0.4 WtE)
- An in-house CAMHS practitioner (0.5 WtE)
- A newly developed pathway with Switch CYP substance misuse services in Dudley

7.23 The contribution of Dudley health commissioners and providers in YOS health work is at least 8.5% of total staff costs.

7.24 A new CAMHS Youth Offending Service Nursing post role is due to go out to advert regarding a liaison post to further strengthen this. This will be across Dudley and Walsall with the aim of ensuring CYP returning to community access a service if required.
7.25 Currently Dudley YOS receives support from Liaison and Diversion Service. CYP at early intervention stage are offered appointments with a Land D CPN who would do short pieces of work or refer into Tier 3 CAMHS if required.

7.26 There is very good communication between Liaison and Diversion and CAMHS and Adult Services for those young people seen in the Super block Custody Suite at Oldbury. A further post has been advertised for a Court Liaison officer by DWMH with some expectation this will include support for CYP.

7.27 CAMHS do see CYP both as victim and perpetrators of sexual assault. Referrals are made to Sandwell Women’s Aid in regards victims where appropriate.

7.28 Liaison and diversion service also covers crisis needs regarding CYP in police Custody. They will contact clinicians if a case is open to Dudley and Walsall or make appropriate referrals once seen if not known to servicers. CYP should then be able to access services in mental health. For example if a CYP was actively Psychotic would be seen in cells assessed initially then referred to DWMH. A Medic would be asked to see them and Approved Mental Health Practitioner would be contacted if the MHA was required. If released into community on bail YOS CPN would see them within 5 working Days.

8.0 Community Eating Disorder Service

8.1 The current provisions differ in age across the Black Country. Within Dudley and Walsall, there are dedicated services served within local CAMHS teams for young people up to the age of 18. Dudley and Walsall have clear pathways and transition protocol in place for those young people needed to access services post 18. Within Sandwell and Wolverhampton, there is an all age model for eating disorder services to ensure smooth and robust care continued. Work has continued to align these services and reduce health inequalities across the STP.

8.2 Black Country all age eating disorder specification has been co-produced with input from commissioners, providers and service users. Continued monitoring and assurance on delivering the access and waiting time standard is clearly outlined within the specification to ensure that services will continue to deliver throughout 2020/2021. This Community Eating Disorder service (CEDS) outlined in this specification, will be in line with the model recommended in NHS England’s commissioning guidance and hopes to be in position to be offering self-referral over the coming the year.

8.3 Alongside developments to be fully complaint with the recommended model, all CEDS are working towards being members of National Quality Improvement Programme. Following becoming a member of the National Quality Improvement Programme, Dudley and Walsall CAMHS specialist community eating disorder service has just undergone its first formal peer
review. The outcome of the review was positive and highlighted the high standard of care being provided. The membership of the network will be funded through continued investment from the CCG and monitored regularly through contract meetings with the provider.

8.4 As discussed in last year’s update, the four local CCGs Walsall, Wolverhampton, Sandwell and West Birmingham and Dudley CCG have partnered up in the Eating Disorder Cluster to collaboratively work together and continue to commission dedicated CEDS. The providers of the service in these CCGs are working more collaboratively and this will support the cluster work and ensure that the service provided is consistent across the areas. In line with the Long Term Plan, the Black Country STP are committed to continue to ensure that the 95% CYP Eating Disorder referral to treatment time standards are achieved and will be maintained. Commissioners will continue to monitor through contract meetings and the benchmarking tool. CCGs will challenge providers on breaches and report on this information.

8.5 The majority of clinicians involved in the treatment of young people with Eating Disorders attended the national NHSE training programme over 2017/18. This included family therapists, nurses and clinicians from our ICAMHS team who often support ED young people who are at risk of admission.

8.6 In Dudley the service has been fully operational since January 2017. Our ED pathway is currently under review, to ensure that it reflects the updated NICE quality standards for Eating Disorders. We offer Family Therapy as a primary intervention as recommended by NICE guidelines. We can access 1:1 psychological therapy also, and we have recently started running a group body image intervention for our young people.

8.7 The majority of clinicians involved in the treatment of young people with Eating Disorders attended the national NHSE training programme over 2017/18. This included family therapists, nurses and clinicians from our ICAMHS team who often support ED young people who are at risk of admission. The clinician and the nurse specialist for ED based in Walsall have attended a specialist dietetics training day, and we have also attended training provided by the West Midlands ED network and staff attend quarterly meetings.

8.8 The team is building links with our local paediatric teams and have developed a training session on Eating Disorders which we are planning to deliver to Paediatric ward staff (we are just waiting for paediatric team in Dudley to agree a date for this.) We are also planning a similar session in Walsall. The team is currently in the process of joining QNCC – Eating Disorder for the next cycle.

9.0 Urgent & Emergency (Crisis) Mental Health Care for CYP

Crisis Intervention
9.1 An initial priority in Dudley was to address pressing gaps in early intervention to prevent children’s escalation into crisis.

9.2 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. This work is now being taken forward on the BCSTP footprint.

I-CAMHS (Increased CAMHS)

9.3 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.

9.4 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.

9.5 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.

9.6 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.

9.7 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.

9.8 A service specification has been developed to provide a CAMH Crisis and Intensive Community Support Service which will align the service available for children and young people across the Black Country. This will ensure that the CYP model is now more in line with the offer for adult mental health crisis team which is available for the 18 – 25 cohort. This will provide a blended
model response to crisis and is to be signed off and written into the relevant contracts for 2019 – 20. This service specification for the CAMHS service will provide the following components:

- Crisis and Home intervention service
- CAMHS Crisis In-reach Service within an acute trust with emphasis on seeing Children and Young People whose behaviours are indicative of severe mental health difficulties in A and E rather than as an admission via PAU. Preferably CYP should be seen outside of hospital environments if they do not require medical intervention.
- Gatekeeping tier 4 patients – Participating in Care Programme Approaches and Care, Education and Treatment Reviews etc. including finding appropriate hospital beds.
- Work is to be undertaken to ensure there is dedicated medical input to the team and access to medical assessment in complex and high risk cases. This includes patients presenting with more severe psychiatric symptoms and risks and/or reduced engagement with community treatment.

9.9 It is using a blended model approach with CAMHS offering support from 08.00 - 20.00 with access to a CAMHS psychiatrist on call outside of these hours to support any children or young people who are in crisis in an acute hospital setting. A mental health assessment can also be arranged with an AMHP at any time of the day as the CAMHS crisis team have an on call rota to attend such an assessment.

9.10 There is a Place of Safety (136 suite) in Wolverhampton which is staffed by members of their Crisis, Intervention and Home Treatment Team when it is required which is on an ad hoc basis. This is used by Children and Young People from across the region.

9.11 The increase in funding for the I-CAMHS Team will further promote the model which supports crisis presentations at Dudley Group NHS Trust and within the community and accepts the out of hours care for children and young people who are attending and in need of specialist core CAMHS. The team also provides home treatment for those presenting with greatest risk or who are unable to attend other services. Home treatment is also provided to young people who present with Eating Disorders and support for any young person requiring Mental Health act assessment in a place of safety. These provisions ensure that there is a swift and comprehensive assessment of the nature of the crisis.

**Appropriate urgent and emergency (crisis) mental health care for disabled children and young people particularly those with LD, Autism and /or ADHD**

9.12 As part of the Transforming Care Programme, it has been agreed to enhance the I-CAMHS by employing staff with Learning Disability qualifications as well
as CYP MH nurses with experience within an ASD service to support those Children and Young People with these co-morbid conditions as well as ADHD. This has helped the I-CAMHS Team to better support this cohort of young people and prevent admissions to hospital as staff have competencies to support managing this cohort. With the enhancement in funding streams, it is seen that the children and young people who require urgent and emergency crisis mental health who have additional needs e.g. disabilities, autism, ADHD or learning disabilities could be seen within a familiar environment e.g. home or school rather than having to attend the A and E department. Care, Education and Treatment Reviews are used when children and young people with Learning Disabilities and/or Learning Disabilities are in crisis to ensure that seeking a bed in a mental health unit is the right place for the young person or for additional support to be commissioned for support in their home environment if this is considered to be more clinically appropriate.

Support in place for CYP beyond their crisis presentation

9.13 When a young person’s presentation means that they no longer require Crisis or Home Treatment interventions, the young person is usually signposted to another service which could be the Core CAMH service for ongoing specialist work or the Targeted and Early Help service for other less specialist interventions. The young person could be referred back to their GP also for ongoing support.

9.14 When the young person is aged 18 – 25, they will initially receive support from the Adult Crisis and Home treatment team or the Mental Health Liaision team but then be signposted to other services e.g. Early Intervention in Psychosis, Healthy Minds, a range of third sector organisations or more specialist services that may be required to support their needs e.g. inpatient bed. It may also be appropriate for the young adult to be referred back to primary care for ongoing intervention and review.

9.15 In Dudley 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 Russell’s Hall Paediatric ward has to be responded to within four hours of receipt. The ICAMHS service operates 8am-8pm 7days per week, 365 days per year, it does not currently have a 24/7 urgent and crisis response beyond these times as a recent audit did not provide the required need for anything in addition to what is currently being provided. If a young person did present in crisis outside of operating hours then the adult psychiatric liaison team would respond and ensure safety until ICAMHS can attend, however this rarely happens. There is 100% compliance with the four hours response target to the ward and non-urgent cases are always seen within one week from referral.

9.16 The deliberate self-harm referral rate has increased by 37% since 2017. As a service the emphasis is now put on promoting the priority slot available with the ICAMHS team every day in order for children and young people not to be sent to A&E at Russell’s Hall Hospital but straight to the team. It is hoped that this new pathway will eventually demonstrate a reduction in A&E admissions.
but also enables the young person to access support more quickly. Obviously, if a young person has taken an overdose, severely self-harmed where stitching is required or is outside of the ICAMHS working hours, an A&E admission would still be required.

9.17 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 Russell’s Hall Hospital.

9.18 Over the first 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.

9.20 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>
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</tr>
<tr>
<td>2019</td>
<td>1</td>
<td>Awaiting discharge</td>
</tr>
</tbody>
</table>

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

The escalation process is attached in Appendix 5.

9.21 The I-CAMHS audit is currently being repeated.

10 Early Intervention in Psychosis (EIP) – an all age service including Children and Young People

10.1 The Early Intervention Service (EIP) is a specialist community Mental Health team which works with Young People aged between 14 and 65 years in the three years following a first episode of psychosis or those who are deemed to be at risk of developing psychosis (At Risk Mental State). The Service adopts an assertive outreach approach and provides individualised, comprehensive, evidence based interventions to optimise recovery, prevent relapse and help young people and their families to cope with their experiences. All referrals to
Child and Adolescent Mental Health Services (CAMHS) where psychosis or At Risk Mental State may be indicated will be passed to Early Intervention as soon as possible to ascertain if assessment is appropriate. The service in Dudley and Walsall Mental Health Trust is working towards achieving 60% access targets and they are currently achieving the target of over 50% which they have been set on a regular basis.

10.2 If the individual is allocated a care coordinator within the Early Intervention Service, medical responsibility will be held in the Early Intervention Service. However, liaison will continue with professionals in CAMHS as appropriate. This will ensure that the holistic needs of the individual and family are met. Crisis and out of hours support will be requested from the CAMHS crisis service as needed. In order to ensure continuity of care, all outpatient appointment letters, care plans and risk assessments will be routinely forwarded to the appropriate CAMHS Consultant so that information regarding treatment and risk can be accessed as needed.

10.3 The Early Intervention in Psychosis service aims to complete referral to treatment within 10 working days in line with Early Intervention access and waiting standards.

10.4 Children and Young People who are accepted to this service are more likely to be transitioned from EIP into adult community Mental Health services when the three year period of work EIP delivers with each individual is over. Currently monitoring of the CYP access to the EIP service is around having crisis and relapse plans as well as 95% of all non-urgent EIP referrals receive initial assessment within 10 working days.

10.5 DWMHT is adhering to the national specification for EIP in Dudley and Walsall as the age range has been increased to 65 and the service accepts referrals from ARMS. NICE recommended treatments are being offered in line with the waiting time standards but only achieved at level 2 in the last NCAP audit. The overall score on this audit was level 2 with a level 4 on team set up and timely access but level 1 on recording outcome measures resulting in the lower score. DWMHT are currently working on these areas to improve performance and work towards increasing the level in the next NCAP audit.

10.6 In summary this refreshed CAMHS LTP clearly demonstrates that the landscape of activity promoting and supporting children’s, young people’s and family mental health in Dudley Metropolitan Borough Council (MBC) is complex and risks being experienced by families, children and those seeking to refer as fragmented, potentially confusing and possibly threaded with duplication.
11 CYP Mental Health Services working with Educational Settings

11.1 We recognised that one of our weakest areas of support for children and young people was the number of and access to Tier 2 level services as they were not universally available. We also recognised the frustration schools faced 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.

11.2 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. We wanted the future service to be dynamic, forward thinking and to be 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.

11.3 CAMHS LTP funding enabled us the opportunity to further develop the Emotional Health & Wellbeing Support Team (EHWT) based in schools and having a close relationship with both school nurses and 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.

11.4 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.

11.5 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.

11.6 The service has been named ‘’ with the help of children and young people through a number of workshops, the branding and logo also designed with them.

The service is 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.

Positive Steps

11.17 This 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.

11.18 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.

11.19 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 is 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.

11.20 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.

11.21 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.

11.22 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.

11.23 Current pathway development includes timely targeted interventions for our most vulnerable CYP including SEN, CiN, LAC and CSE. The Early Help multi agency allocation meetings (MAAM) are set up to support the allocation of Early Help assessments. School nurses are responsible for assessing and referrals into the Positive Steps team for children and young people who are subject to an Early Help assessment.

11.24 The Positive Steps delivery model is depicted below.

11.25 The flow chart above demonstrates the process which a child or young person will follow during the time in Positive Steps. There is opportunity for the young person to receive up to twelve sessions as part of the core offer from Positive Steps however should the need arise for CBT or Systemic Family Practice work then there are internal referral pathways to allow for this input. There are also three opportunities for the case to be ‘stepped up’ to CAMHS should more intensive work be required, if this is needed an internal referral is made and a streamlined pathway is available to ensure that the young person is not disadvantaged and there is a continuous treatment plan.
11.26 The total number of referral from 1st April to 31st August 2019 was 433. Of these 119 were direct referral to the service and the remaining 214 from school nurse advisors.

11.27 The presenting problems to the service are illustrated below.

![Pie chart showing presenting problems]

### Mental Health Support Teams

11.28 Mental Health support teams (MHSTs) will be rolled out in the Black Country over the next 5 years and NHS Wolverhampton CCG has joined with the other CCGs that make up the Black Country and West Birmingham STP to apply for the Mental Health Support Teams in school programme for which work has already begun.

11.29 As part of the MHSTs in Schools, the model below illustrates a dynamic relationship across commissioned service providers offering emotional wellbeing and mental health support to education and CYPF. It capitalises on the strengths of each sector (education, health and the voluntary community) and where CYPF will be initially supported within MHSTs.
Evidence of MHST resource being targeted at areas of greatest needs

11.30 Education settings that have engaged in the process across our MHST footprint have been selected by;

- Existing feeder arrangements.
- Local groupings.
- Local intelligence and activation of schools.

11.31 Local intelligence for school selection has been used including organisations perceived and actual data identifying highest referral rates into mental health services. A variety of education settings with ratings from ‘requires improvement’ through to ‘Outstanding’ have been selected to be part of the Black Country and West Birmingham Trailblazers. Further work is required to ensure that MHST are established in education settings which would benefit the greatest as the programme rolls out.

11.32 Should additional or ongoing support be required, CYPF will be streamed to the most appropriate service, ensuring a jointly delivered integrated referral and advice system that prioritises CYP accessing appropriate help as quickly as possible. It is expected that the MHST will channel CYPF to access the right levels of support at the right time, in order that CYPF can thrive and achieve the best outcomes for their assessed need. Referral will be received via the Single Point of Access to ensure that the referral is signposted to the correct service i.e. MHSTs, specialist CAMHS or the emotional mental health and wellbeing service. This will ensure that no time is wasted allocating it to the correct service.

Joint assessment of need in the education setting

11.33 Our joint assessment of need in the education setting, carried out in conjunction with school/college leadership will direct how we target our engagement with schools and education settings. This assessment will identify the need in the education setting with the planned work of the MHSTs commensurate to the training and resources of the setting. We have opportunities to explore how MHST can reduce the impact of risk factors associated with poor mental health e.g. holistic family based support which can be provided to Children in Need, those who have been impacted by adverse childhood experiences (ACES) etc. In addition, we will work with CYP from vulnerable groups to identify what are the best ways to engage with them to increase access and reduce health inequalities. As part of the MHST we will triangulate and analyse data across the system to ensure that we increase access to the most vulnerable groups. The virtual MHST provides opportunities to share best practice in order to encourage access for those who are systematically under/over represented in current services in other group settings such as pupils known to the criminal justice system and connections with PRU/alternative education provision. The virtual team will provide the opportunity to address border issues and ensure continuity and consistent approaches across the Black Country and West Birmingham.
NHS CYP mental health services integrated into MHSTs

11.34 The MHST's will be a joint model between CAMHS and Educational Psychology and as a result NHS CYP mental health services will be integrated with MHSTs. There is also an understanding that school nursing services will also be able to receive support via the MHSTs. This enables a combined knowledge base of mental health and educational need which will enable young people identified as requiring support to be provided with a seamless service. Joint supervision can also be offered to the MHST which will enable staff to feel contained and supported.

MHSTs demonstration of fidelity to the nationally prescribed core functions

11.35 The MHSTs in the Black Country and West Birmingham STP will demonstrate fidelity of all of the following nationally prescribed core functions.

11.36 Delivering evidence based interventions for mild to moderate mental health issues. The new teams will carry out interventions alongside established provision such as counselling, educational psychologists, and school nurses building on the menu of support already available and not replacing it. We envisage a key role of the EMHP to promote emotional wellbeing and mental health through:

- Behaviour support programmes for mild conduct problems;
- Cognitive behaviour approaches for low mood, emotional distress and self-regulation;
- Problem focussed group sessions
- Parenting group sessions (stand alone or in parallel with a CYP group)
- Whole school or class approaches that work with educational staff to ensure that our schools offer the psychologically informed environment to support children and young people in developing good mental health needed to build resilience,
- Educational workforce are trained and supported when supporting young people’s EWMH
- Targeted/selective interventions that are aimed at groups whose risk of developing MH problems are significantly higher, such as CYP in youth offending services (YOS) and Pupil Referral Units (PRUs).

11.37 Supporting the designated senior mental health lead in each education setting to introduce or develop their whole school or college approach. Our proposal states that senior mental health leads in schools will be expected to undertake training and support offered by regional DFE colleagues. In addition our model proposes that each MHST will have 1 team leader who is from Education Psychology and another team leader from CAMHS. It is anticipated that the team leaders will work alongside schools senior mental health leads to embed whole school approaches.
11.38 Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education. Work as part of an integrated referral system with community services to ensure that children and young people who need it receive appropriate support as quickly as possible.
12 Financial Profile

The following table summarises our total developments, since 2016, that have been funded by our CAMHS LTP allocations.

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<td>universal element of the EHWT.</td>
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<tr>
<td>Phase Trust Personalised Programme to support CYPS with less complex</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
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<tr>
<td>difficulties to help them cope with their EH&amp;WB challenges.</td>
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<tr>
<td>Additional Therapeutic intervention for CSE - Phase Trust</td>
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<td>15,000</td>
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<td>Undertake a skills audit</td>
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<td>Early Years/Intervention Resilience Worker (Barnardo’s)</td>
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<td><strong>Total</strong></td>
<td><strong>399,233</strong></td>
<td><strong>465,867</strong></td>
<td><strong>989,000</strong></td>
<td><strong>1,160,610</strong></td>
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Allocations

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<th>Year</th>
<th>CAMHS</th>
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<td>2016/17</td>
<td>691,000</td>
<td>174,000</td>
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<td>2017/18 (inc 18% uplift on CAMHS element)</td>
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<tr>
<td>2018/19 (inc 21% uplift on CAMHS element)</td>
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<td>1,160,610</td>
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<tr>
<td>2019/2020 (inc 12% uplift on CAMHS element)</td>
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<tr>
<td>2020/2021 (inc 21% uplift on CAMHS element)</td>
<td>1,337,054</td>
<td>1,511,054</td>
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Appendix 1 - 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 consists 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.

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 2 - Baseline Services

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Service</th>
<th>Description</th>
<th>Cost per annum</th>
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<tr>
<td><strong>Tier 1:</strong></td>
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<td></td>
<td></td>
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<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>
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<tr>
<td><strong>Tier 2</strong></td>
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<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>
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<tr>
<td>Dudley CCG</td>
<td>KOOTH</td>
<td>An online counselling service for young people aged 11-25.</td>
<td>£62,000</td>
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<tr>
<td>Dudley CCG</td>
<td>Children’s Learning Disability Team</td>
<td></td>
<td>£178,111</td>
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<tr>
<td>DMBC</td>
<td>Education Psychology Team</td>
<td>Assessment service for children and young people in educational settings to identify what support children with additional needs require. This includes school counselling services</td>
<td>£473,000</td>
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<tr>
<td>DMBC</td>
<td>The Family and Adolescent Support Team (FAST)</td>
<td>Triple P Parenting Assessments Family Group Conferencing</td>
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<td>DMBC</td>
<td>Early Assessment Team</td>
<td>Completion of Early help Assessments</td>
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<tr>
<td>DMBC</td>
<td>Family Intervention Team</td>
<td>Troubled Families</td>
<td>£1,500,000</td>
</tr>
<tr>
<td>Local Authority</td>
<td>Service Provider</td>
<td>Description</td>
<td>Cost</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>DMBC</td>
<td>Connexions</td>
<td>19 year service supporting young people to enter Education, Employment and Training.</td>
<td>£50,000</td>
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<tr>
<td>DMBC</td>
<td>Teenage Pregnancy Team</td>
<td>Supporting the reduction of conception rates</td>
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<tr>
<td><strong>Tier 3:</strong></td>
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<tr>
<td>Dudley CCG</td>
<td>Specialist CAMHS</td>
<td>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.</td>
<td>£2,774,780</td>
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<tr>
<td>Dudley MBC</td>
<td>Looked After and Adoptive Psychology</td>
<td>Specialist psychologist service for children and young people who are looked after or adopted aged 0-25 years.</td>
<td>£287,255</td>
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<td>Dudley CCG</td>
<td>Neurodevelopment Delay Service</td>
<td>An in depth and holistic medical and social assessment to support children, from birth up to 5 years of age, in need of additional support and input.</td>
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<td>Youth Offending Team</td>
<td>Specialist service to support youth offending team.</td>
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<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</td>
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<td>Tier 4:</td>
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<td>focused treatment system.</td>
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<td>NHS England</td>
<td>Highly specialist CAMHS</td>
<td>Day and inpatient services and some highly specialist outpatient services.</td>
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<td><strong>Total</strong></td>
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<td><strong>£12,315,322</strong></td>
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Appendix 3 - Work Skills Audit Recommendations

An audit of skills was undertaken between 2016 and 2018 with a range of professionals supporting children and young people’s mental health in Dudley Metropolitan Borough. The skills audit aimed to understand better:

- the range of skills in place in the Dudley workforce to support children’s mental health and wellbeing
- how these matched presenting needs
- what training was being accessed to support skills
- gaps in skills, provision and training.

The skills audit built on the findings of the Dudley needs assessment completed in 2016. As overarching context, this needs assessment noted that the greatest gap between need and the reach of services affected those 8% of children and young people with common diagnosable mental health difficulties. In 2016, on the back of these findings, a number of investments were made in this area of the local system as well as more broadly. In total, 80 multi sector professionals in Dudley were involved in the skills audit including:

- 25 professionals in specialist CAMHS who completed the Chimat SASAT skills audit questionnaire as part of a team meeting
- 28 professionals from the broader Dudley children’s workforce who completed a semi structured interview based on the SASAT skills audit questionnaire
- 27 professionals from universal and targeted services in Dudley who attended two focus groups designed to understand strengths and areas for development locally in relation to Yorkshire and Humber’s Essential Competences for the children’s workforce.

The Centre for Mental Health also analysed bespoke data on the needs of children and young people presenting to specialist CAMHS between August 2017 and November 2017. All data were triangulated and analysed and coded to create a thematic framework which form the basis of these findings.

Main findings and recommendations are:-

a) The need for a strategic approach

Many professionals in Dudley have skills and opportunities to support children’s mental health and wellbeing but they are not being mobilised and developed in a way that would promote integrated activity. There is a need to develop an overarching multi-agency workforce development strategy based on a framework of stepped competences for universal, targeted and specialist staff and linked to local data on presenting needs. The strategy should seek to improve the way that the Dudley workforce and system intervenes at an earlier age to promote positive parenting and good child mental health right from the start.
b) **The importance of developing clear whole-system pathways**

The biggest skills challenge for non-specialist workers is making sense of the local system of support and of referral systems – particularly to the network of voluntary sector, parenting and NHS services supporting children and young people with common mental health difficulties. Whole system pathways should help local professionals and children, young people and parents understand how they can get help when mental health difficulties are identified. A number of other more detailed pathways are also required for specific conditions and for important risk factors on the basis of difficulties identified by staff during this audit (e.g. pathways supporting children from LGBT communities’ mental health and wellbeing, a whole system pathway supporting early action to reduce domestic violence; whole system pathways to reduce self-harm and risk of suicide). These pathways should be developed through whole system co-production and should be linked to the strategic workforce development plan.

c) **Service development priorities**

This audit has highlighted some ongoing areas where there is potential for further investment to extend the reach of local services to meet local children and young people’s needs. These include:

- There is an urgent need to extend the reach of evidence-based parenting provision strategically in Dudley. Nearly 9 out of 10 children and young people presenting to specialist CAMHS were affected by early starting behavioural difficulties. We believe that the previously inadequate reach of NICE guidance compliant parenting interventions for these children is having a knock-on effect on referrals into specialist CAMHS. The specialist CAMHS team currently lacks the capacity to employ simpler NICE guidance compliant parenting programmes which around a half of these children in Dudley with early starting problems will need.

- Given the scale of the gap between need and service reach for those remaining 8% of children with common mental health difficulties, there is a need to continue investment in the Positive Steps team and in the voluntary sector supporting common mental health difficulties backed by a clearer pathway coordinating this landscape of services.

- Based on the 2015 data, specialist CAMHS would appear to lack capacity to meet need adequately based on Royal College of Psychiatrists’ workload guidance by 0.5 wte.

- There still appears to be insufficient support for children affected by trauma backed up by enhanced training for local multi sector organisations in evidence based interventions.

- There is a need to strengthen the Looked After Children team in the specialist CAMH service. It should provide outreach, practical strategies and support and training to foster carers and residential staff. Dudley has a high proportion of looked after children who are at greater risk of mental health problems but the capacity to support them in specialist CAMHS is low; an ideal solution would be to have a virtual multi-agency team working to the needs of Looked After Children.
d) Support for schools

Strategic workforce development activity should support local schools to trial a network of school mental health leads backed by the workforce development strategy to improve mental health awareness and understanding of the Dudley pathways of care. Awareness training could include the Royal Foundation Mentally Healthy Schools website, MindEd, MHFA Youth, current activity by Educational Psychologists and the Emotional Health and Wellbeing lead, support from school nurses and Positive Steps.

e) Training and development opportunities

Commissioners and providers should continue to build both on modern apprenticeship opportunities and on current CYP IAPT training opportunities – including making these opportunities available to a wider range of staff. This should include continued opportunities for Positive Steps, for the voluntary sector and also targeting and prioritising other key practitioners in universal and targeted services (e.g. school nurses, The Phase Trust, Switch) to undertake CYP IAPT training for low to moderate depression and anxiety.

f) Knowledge and awareness

Commissioners should drive a comprehensive and specific awareness raising and training programme for all multi-agency staff. It should systematically encourage use of free online training identified in this report, link to the adopted essential competences and NICE guidance and integrate with staff Continuous Professional Development (CPD). The training programme should also ensure there is sufficient knowledge in the whole workforce on issues relating to recognising:

- early problems of attachment and parenting;
- and working with children in vulnerable situations;
- and understanding the basic emotional and mental health problems and how to respond to them in different parts of the system;
- the specific problems of lesbian, gay and transgender young people
- the impact of domestic violence on children’s mental health;
- the specific problems of refugees and asylum seekers;
- the problems of and working with children and young people who might be affected by sexual exploitation and trafficking;
- the vulnerabilities and working with children who are looked after by the Local Authority;
- responding to the emotional and behavioural problems that emerge in the classroom;
- working with children and young people who self-harm;
- working with children and young people who are at risk of being admitted or who have been discharged from inpatient settings
- Suicide prevention: the level of suicide in young men in Dudley is above the national average and self-harming rates have been increasing in Dudley; capacity and capability should be increased across all services to recognise and respond early to those young
people who are at a greater statistical risk of self-harming and taking their own lives.

g) Data

We recommend that all universal, targeted and specialist services are able to demonstrate compliance with a basic minimum dataset determined by multi-agency group and that includes the points below in order to enable commissioners to assess impact, quality and value for money, as below:-

- Age and gender.
- Type of problem referred.
- Type of intervention.
- Start and finish Strengths and Difficulties Questionnaire or other outcome measurement tools if more appropriate.
- Length of intervention.
- Outcome and improvement or referral on to specialist services.

Outcomes data from all services should also be used to measure children and families’ experiences of services and to inform commissioning and value for money.

The specialist CAMH service should be consistent with the requirements of the NHS CAMHS minimum dataset and become a member of the CAMHS Outcomes Research Consortium and be in a position to consistently and systematically collect meaningful outcomes data. All services’ outcomes data should be referred to in clinical supervision and intuitively inform professionals’ continuing professional development.

h) Liaison and consultation

There is a need for pathways to be supported through and backed up with expert consultation from specialist staff to build the skills of whole system staff and prevent expensive escalation towards more specialist services. The GP liaison service within Specialist CAMHS should be strengthened by using the expertise of its very experienced psychotherapists to add capacity and extend its reach to a full consultation service for universal and targeted services (supported by a protocol) which should be evaluated and aim to reduce the number of inappropriate referrals whilst supporting and educating potential referrers.

i) Access and referral routes

Commissioners should assess the effectiveness of the current referral management system via school nurses, Positive Steps and specialist CAMHS and consider the usefulness of introducing a multi-agency Single Point of Access hub for all children with emotional, behavioural and mental health problems. This will enhance any existing pathway and any pathways that are
subsequently developed, providing a hub for all concerns to be considered in a multi-agency and multi sector group.

As evidenced in this plan a number of these recommendations have been implemented.
Appendix 4 – CAMHS Structure

LEARNING DISABILITIES TEAM
- Consultant Psychologist x 0.8 (6C)
- Clinical Psychologist x 0.6 (7)
- Learning Disabilities Nurse x 1 (6)
- Mental Health Practitioner x 0.5 (6)
- Psychology Assistant x 1 (4)
- 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)

LIGHTHOUSE LINKS (Pending)
- Clinical Lead x 1 (BA)
- Psychiatrist x 1 (7)
- Nurse x 1 (6)
- Family Support Worker x 0.5 (4)

CAMHS LAC SERVICE
- Psychotherapist 0.8 (7)

DUDLEY CAMHS TEAM
- Clinical Nurse Specialist x 1.5 (7)
- Senior Mental Health Nurse x 1.6 (6)
- Consultant Psychologist x 1 (BC)
- Psychotherapist x 1 (7)
- CSE Lead Psychiatrist x 1.6 (8A)
- Trainee Psychiatrist x 1
- Family Therapist x 0.3 (8A)
- Clinical Psychologist x 0.8 (8B)
- Clinical Psychologist x 2.15 (7)
- Assistant Psychiatrist x 1 (4) FT
- Senior Clinical Lead x 0.8 (6A)
- Senior Occupational Therapist x 0.72 (7)
- Occupational Therapist x 1 (6)
- Social Worker x 1
- Family Support Worker x 1.3 (4)
- Project Coordinator x 0.5 (7)
- Senior Administrator x 1 (4)
- Team Administrators x 1 (3)
- Administrators x 1.8 (2)
- Receptionist x 1 (2)
- Modern Apprentice x 2

PAN TRUST EATING DISORDERS TEAM
- Lead Nurse x 1 (7)
- Senior Mental Health Nurse x 1 (6)
- Consultant Psychiatrist x 0.6 (7)
- Family Therapist x 0.3 (BA)
- Team Administrator x 0.5 (8)

CAMHS MEDICAL TEAM
- Consultant Psychiatrist x 3.6
- Staff Grades 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 2 (6)
- Team Administrator x 0.5 (3)

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

0.5 ASD LINKWORKERS
- CAMHS Practitioners x 1.5 (7)
Appendix 5 – CAMHS Escalation Process

**CYP in crisis**
- Referral made within core hours of 9am to 5pm directly from PAU/Hussell Hall
  - CYP is assessed by ICAMHS on PAU if medically fit
    - Discharged and will be followed up by ICAMHS according to need
  - CYP is referred to A&E if risk is high
    - CYP is referred to A&E if risk is high
      - CYP remains on PAU for a Psychiatric assessment
        - CYP reman on ward if Tier 4 bed needed (ICAMHS remain involved)
          - CTR is arranged with Children's commissioner
        - CTR is arranged with Children's commissioner
      - CYP is discharged back to ICAMHS
        - CTR is arranged with Children's commissioner
      - CTR is arranged with Children's commissioner
      - ICAMHS to initiate admission process to Tier 4 along with Psychiatrist on call
        - ICAMHS to initiate admission process to Tier 4 along with Psychiatrist on call
- Follow up sessions agreed according to need (can be seen daily)
- Discharged and will be followed up by ICAMHS according to need

**Referral made outside of core hours**
- CYP is assessed Psychiatric Liaison Team if urgent and CYP remains on PAU
  - CYP is assessed Psychiatric Liaison Team if urgent and CYP remains on PAU
    - CYP is assessed Psychiatric Liaison Team if urgent and CYP remains on PAU
      - Discharged and will be followed up by ICAMHS according to need

**Referral made within core hours of 9am to 5pm directly from GP**
- CYP offered an urgent appointment at 4pm same day
  - Follow up sessions agreed according to need (can be seen daily)
  - Discharged and will be followed up by ICAMHS according to need

**Abbreviations**
- CYP: Child or Young Person
- ICAMHS: Intensive CAMHS
- PAU: Paediatric Assessment Unit
- CTR: Care Treatment Review
Appendix 6 - NHS CAMHS Benchmarking Network 2018-19

NHSBN
CAMHS_2019_Regis
Appendix 7 – HoNOCA

<table>
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<tr>
<th>HoNOSCA Dataset Completed</th>
<th>Average Score</th>
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<td>Follow-up - Case Closure</td>
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Scores for: April 2017- October 2017

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Scores for: April 2016- March 2017

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![Graph showing HoNOSCA scores for 2016-2017 (16/17 in blue, 17/18 in orange)]