

# SCHEDULE 2 OF NHS STANDARD CONTRACT – THE SERVICES

## A. Service Specifications

<b>1. Population Needs</b>
<b>1.1 Purpose, introduction and context</b>
<p>The purpose of this document is to specify the provision of Children and Young People’s Mental Health Services (CYPMHS) in the community (e.g. from prevention, signposting and early help to delivery of evidence based treatment and meeting complex need) from the provider and delivery partners. It will describe the role, function and responsibilities of these services.</p> <p>Services for children, young people should place them and their families/carers at the heart of everything they do.</p>
<b>1.2 National/local context and evidence base</b>
<p>There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their families/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18.</p> <p>Young people who are not in education, employment or training report particularly low levels of happiness and self-esteem. The Macquarie Youth Index 2014 reported that 40% of jobless young people have faced symptoms of mental health difficulties as a result of being out of work, and one-third of long-term unemployed young people have contemplated suicide. The <a href="#">Healthy Children, Safer Communities Strategy</a> states that over a third of children and young people in the secure estate for children and young people have a diagnosed mental health disorder.<sup>1</sup></p> <p>The <a href="#">mental health of children and young people in the Great Britain survey</a>, last conducted in 2004<sup>2</sup>, estimated that:</p> <ul style="list-style-type: none"><li>• 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder</li><li>• 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder</li><li>• 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder</li></ul>

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[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicy/AndGuidance/DH\\_109771](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicy/AndGuidance/DH_109771)

<sup>2</sup> Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan

- [YoungMinds Impact report \(2014\)](#) identified five key issues that impact on young people's mental health – lack of access to help, sexual pressure, bullying, school stress and unemployment

Effective evidence based treatments have been identified to improve the life chances of children and young people, and to minimise the impact on the long-term health of the population and economic cost to the public purse.<sup>3</sup>

A [new prevalence survey](#) has been commissioned by the Department and will report in 2018. The scope has expanded to include ages 2 to 19 years.

### **Local Needs Analysis**

The joint strategic needs assessment for children and young people's emotional health and wellbeing in Warrington was updated in March 2017 and outlines the likely level of need. The key findings are outlined here:

#### **Poverty and Disadvantage**

Children and young people exposed to poverty and socio-economic disadvantage are at increased risk of developing mental health disorders. In Warrington the percentage of children and young people under 16 living in poverty is 14.5% or approximately 5500 children (compared with 18.6% nationally). There is significant variation in Warrington with 17 of the 127 lower super output areas within the most deprived quintile nationally for income deprivation affecting children. There is increased risk for children that live with parental mental health and/or drug and alcohol issues and domestic violence. Services will therefore need to be able to target those young people most at risk.

#### **Pre-school aged children**

There is very little information available about the prevalence of mental health conditions in pre-school aged children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H et al, 2006 cited in ChiMat 2015). The review focussed on the 5 most common groups of childhood psychiatric disorders: attention deficit hyperactivity disorders (ADHD), oppositional defiant and conduct disorders, anxiety disorders and depressive disorders. Applying this average prevalence rate to the estimated population within Warrington (2015 mid-year population estimates), gives a figure of 2,031 children aged 2 to 5 years inclusive living in Warrington who have a mental health disorder.

#### **Children and young people aged 5 to 16 years**

As discussed in Section 2, robust, consistent and comparable data on the emotional wellbeing of children and young people is not routinely available. At a local level, there is also a lack of robust prevalence information on 'diagnosable mental health conditions'. This section utilises

<sup>3</sup> Department of Health, HM Government, '[No Health without Mental Health. A cross governmental strategy for people of all ages](#)', Crown Copyright (2011)

Green et al, '[Mental Health of children and young people in Great Britain](#)', Office of National Statistics (2004)

Kim-Cohen, J. et al, '[MAOA, maltreatment, and gene-environment interaction predicting children's mental health: new evidence and a meta-analysis](#)', Molecular Psychiatry (2006) v.11, 903-913

The Prince's Trust Macquarie, '[Youth Index 2014](#)', Prince's Trust (2013)

the nationally available prevalence estimates and applies them to the latest local estimates of the number of children and young people aged 5 to 16 years (2015 mid-year population estimates). This provides an indication of the likely numbers of children and young people experiencing a mental health problem in Warrington. The following table presents the estimated prevalence of any mental health disorder in Warrington for those aged between 5 and 16 years. The estimated prevalence (8.9%) was based on the 2004 ONS survey (Green et al, 2005) and then adjusted by Public Health England to take into account the age, sex and socio-economic classification of children resident in the area. It is estimated that there may be approximately 2,600 children and young people aged 5 to 16 years experiencing a diagnosable mental health problem in Warrington.

**Table 1: Estimated Warrington prevalence rates applied to population aged 5-16**

Diagnosis	Prevalence (all)	Estimated Number (all)
Emotional Disorders <sup>4</sup>	3.5%	1,030
Conduct Disorders <sup>5</sup>	5.3%	1,560
Hyperkinetic Disorder	1.5%	441
Any Disorder	8.9%	2,619

Source: Public Health England, 2016

Note: an individual may have more than one disorder

The estimated figure has been based on a limited number of mental health conditions, the list of codes used to extract this data is not exhaustive, and therefore some uncommon conditions may be excluded (see footnote 4). It is unknown how complete coding of mental health conditions are within GP Practices, this may also reduce the number of children and young people reported as having a mental health condition.

Nationally a new comprehensive mental health services minimum dataset (MHSMDS) has been developed and is currently being populated by mental health services. Data is expected to be made available during 2017.

**Emerging Personality Disorders:** The prevalence of personality disorders in the general population is estimated to be between 0.7% and 2%, however under current diagnostic systems, antisocial personality disorder is not formally diagnosed before the age of 18 but the features of the disorder can manifest earlier as conduct disorder (NICE 2013b). Borderline personality disorder is often not formally diagnosed before the age of 18, but features of the disorder can be identified earlier (NICE 2009).

As symptoms of personality disorders tend to emerge during adolescence, the following estimates are based on children and young people aged 12 to 17 years. It is estimated that there are between 101 and 289 young people aged 12 to 17 years with an emerging personality disorder living in Warrington.

<sup>4</sup> Includes: Separation anxiety, specific phobia, social phobia, generalised anxiety and depression.

<sup>5</sup> Includes: Oppositional defiant disorder, unsocialised and socialised conduct disorder.

### **Psychotic disorders**

The prevalence of psychotic disorders in children aged between 5 and 18 years has been estimated to be 0.4% (NICE 2016). However, the first episodes of psychotic disorders are not normally experienced until adolescence/teenage years. Therefore the following estimates are based on population estimates covering 12 to 17 year olds. Based on the prevalence of 0.4%, it is estimated there are 58 children aged 12 to 17 years with a psychotic disorder living in Warrington.

### **Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorders (ADHD)**

The Warrington Autism JSNA Chapter (written in 2015) estimated there to be approximately 500 people with autism who are aged 19 years and under (1% prevalence based on 2013 population estimates).

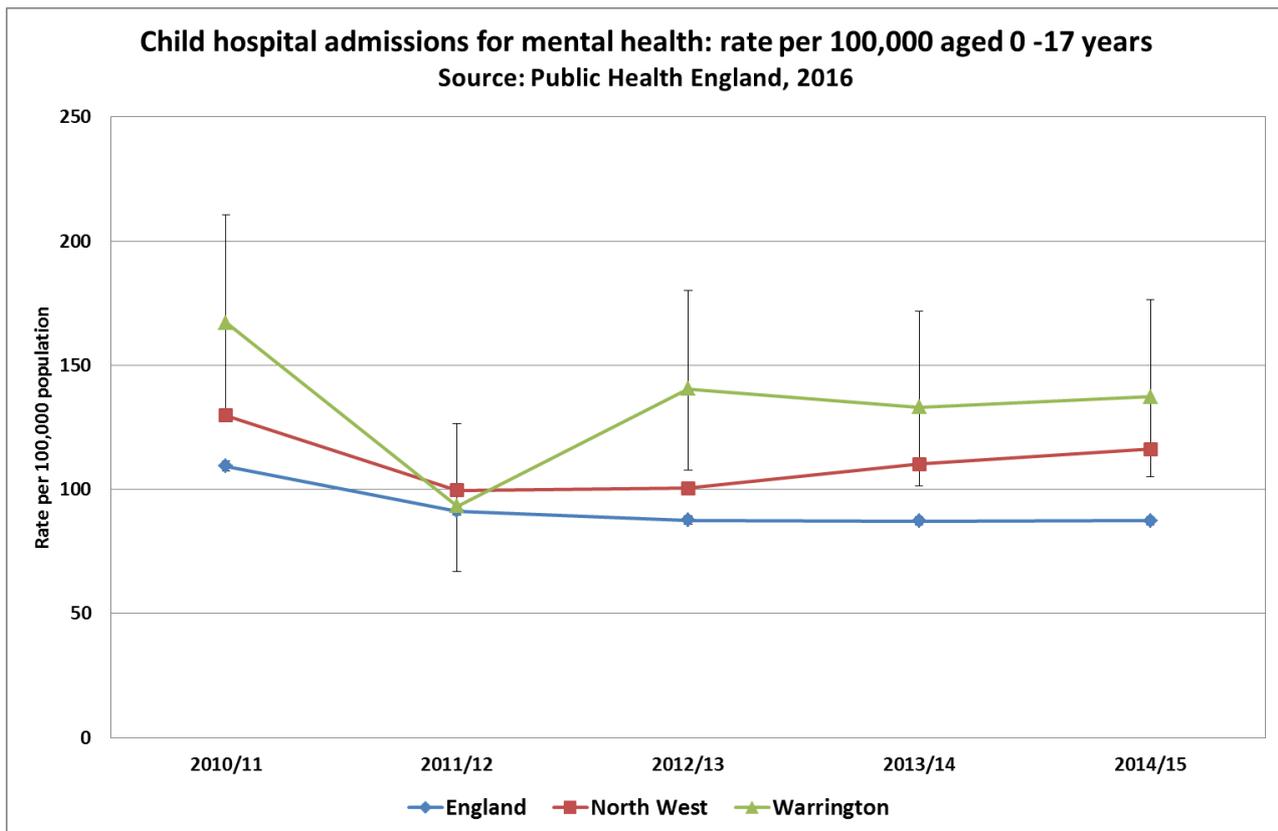
It is estimated there are between 2% and 5% of school-aged children may have ADHD. When applying these percentages to the Warrington population aged between 5 to 18 years, it is estimated there are between 687 and 1,718 children and young people with ADHD.

### **Hospital Admissions**

The PHE Children's and Young People's Mental Health and Wellbeing profile draws together various mental health (and related known risk factors) data sets to present a picture of mental health need by Local Authority. Children and young people who consume alcohol or drugs are at increased risk of developing mental health disorders, as are children exposed to abuse. The PHE profile presents hospital admissions where the primary cause of admission was due to alcohol for those aged less than 18 and due to substance misuse in those aged between 15 and 24 years. For both of these indicators, Warrington had admission rates that were significantly higher than England (admissions made between 2012/13 and 2014/15). Hospital admissions due to unintentional and deliberate injuries in children (aged 0 to 14 years) and young people (aged 15 to 24 years) were both significantly higher than England from 2010/11 through to 2014/15.

**Mental health conditions:** The PHE profile presents an indicator illustrating the rate of hospital admissions for those aged less than 18 years where the main cause of admission is due to a mental health condition. This indicator illustrates that there were 61 admissions made by Warrington residents during 2014/15, this resulted in a rate of 137.2 per 100,000 population; this rate was significantly higher than England (87.4 per 100,000). What is unknown from this dataset is if the admissions were made by 61 individuals or a smaller cohort being repeatedly admitted into hospital.

### **Chart 1: Child hospital admissions for mental health**



To gauge an indication of the numbers of young people being admitted into hospital due to mental health conditions on more than one occasion, further analysis of a local hospital admissions dataset<sup>6</sup> revealed that of those admitted to hospital over a three year period (2012/13 through to 2014/15), approximately 15% of the admissions were made by patients who had been admitted on more than one occasion (over the three year period there were 119 admissions made by 101 individuals).

The most common cause of admission was due to *mental and behavioural disorders due to psychoactive substance use* (41 admissions); more specifically, the majority of these admissions were due to acute intoxication from alcohol. The second most common cause of admission was due to *behavioural syndromes associated with physiological disturbances and physical factors* (30 admissions); the majority of these admissions were due to eating disorders.

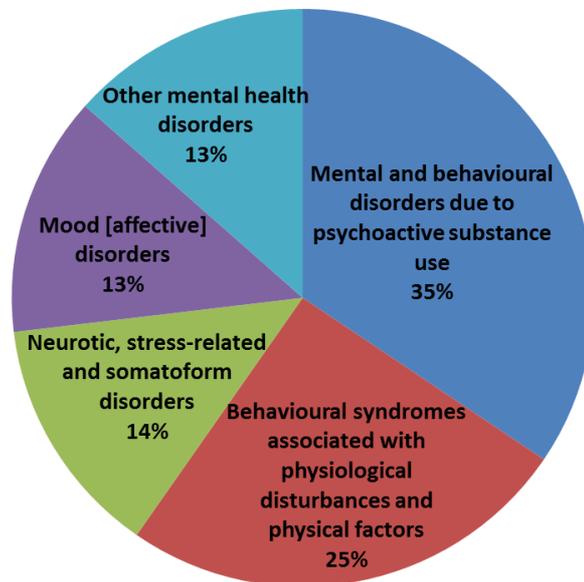
The following pie chart illustrates the main causes of mental health admissions made between 2012/13 to 2014/15 for Warrington residents aged 0 to 17 years.

<sup>6</sup> Direct comparisons between data sourced from PHE and the local hospital admissions dataset should not be conducted as slightly differing search queries were conducted when extracting the datasets. The PHE dataset is based on first finished episodes for each financial year, whilst the local hospital admissions dataset is based on the date of admission falling within the three year period of 2012/13, 2013/14 and 2014/15.

**Chart 2: Mental health hospital admissions - main cause of admission**

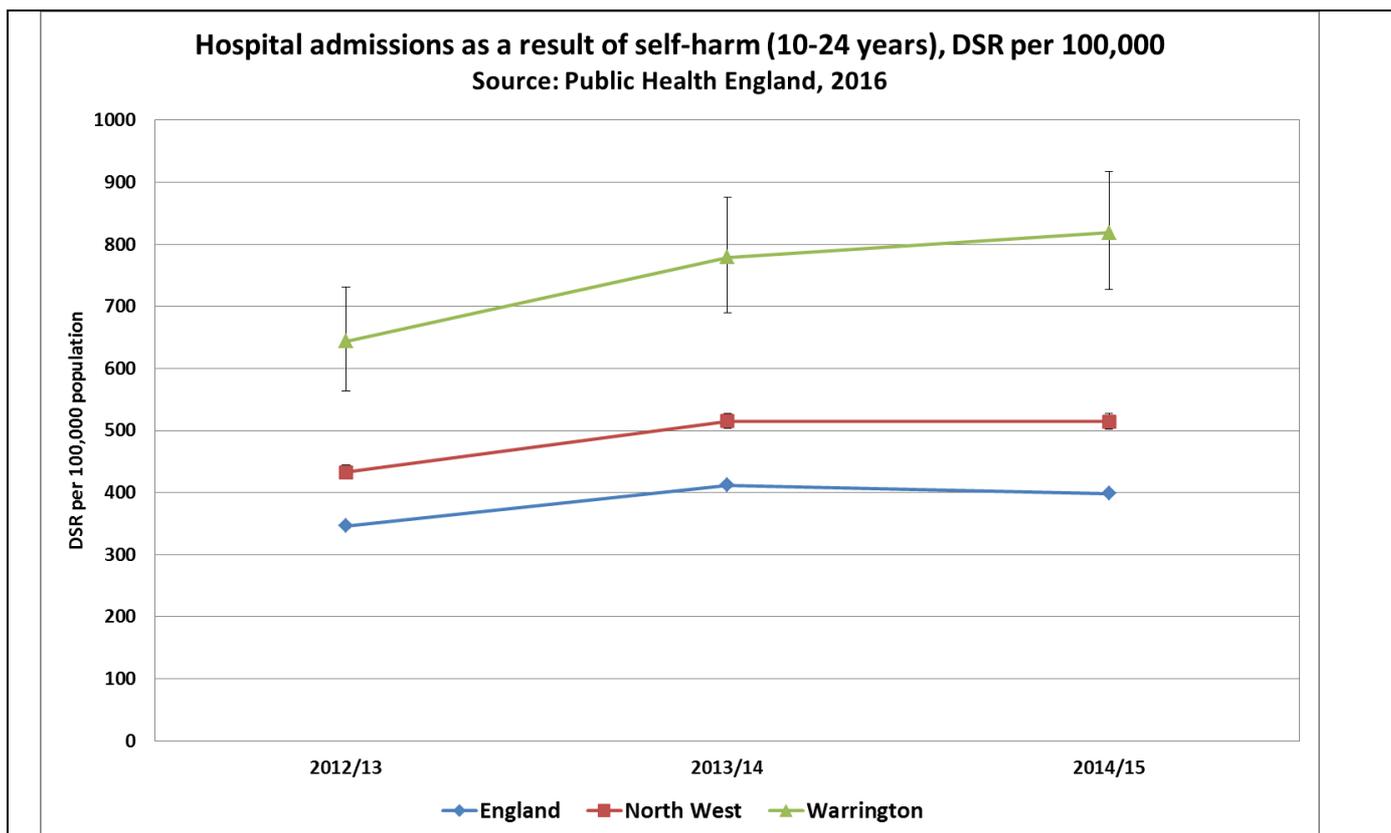
Mental health hospital admissions - main cause of admission, 0 to 17 years,  
2012/13 to 2014/15, Warrington residents

Source: Warrington CCG, St Helens CCG



**Self-Harm:** Nationally, admissions to hospital due to self-harm have increased in recent years, with admissions for young women being much higher than admissions for young men (PHE 2016). The following chart examines the rate of hospital admission due to self-harm for those aged between 10 and 24 years. Between 2012/13 and 2014/15, Warrington consistently had significantly higher rates of admission when compared to England and the North West. During 2014/15 there were 293 admissions made by Warrington residents. As with mental health admissions, it is unknown from this dataset if there were 293 individuals admitted to hospital or a small group being repeatedly admitted to hospital.

**Chart 3: Hospital admissions as a result of self-harm**



As with mental health admissions, further analysis has been conducted to understand the scale and causes of admission in Warrington<sup>7</sup>. The analysis showed that over the three year period of 2012/13 through to 2014/15, approximately 36% of admissions were made by patients who had been admitted on more than one occasion (over the three year period there were 778 admissions made by 497 individuals).

The most common cause of admission was due to *Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics* (318 admissions); these include substances such as pain medication, aspirin and medications used to treat rheumatoid arthritis. The second most common cause of admission was due to *Intentional self-harm by sharp object* (142 admissions). The third most common cause of admission was due to *Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified* (127 admissions); these include sedatives/tranquillisers, mood/behaviour altering medication and medications used to treat epilepsy and Parkinson's disease.

An initial audit has been conducted between Warrington CCG, Warrington Council and North West Boroughs Partnership NHS Trust that has identified that a high proportion of children and young people who repeatedly attend hospital Emergency Departments (ED) due to a mental health condition (a child or young person in crisis) are also known to social services (a

<sup>7</sup> Direct comparisons between data sourced from PHE and the local hospital admissions dataset should not be conducted as slightly differing search queries were conducted when extracting the datasets. The PHE dataset is based on the number of finished admission episodes for each financial year, whilst the local hospital admissions dataset is based on the date of admission falling within the three year period of 2012/13, 2013/14 and 2014/15.

vulnerable child or young person).

## **Children and Young People emotional health and wellbeing surveys**

### **What about YOUth survey**

The 'What about YOUth' (WAY) survey is a newly established survey to collect robust Local Authority level data on a range of health behaviours amongst 15 year olds, the survey took place during 2014/15. The survey included a number of questions about wellbeing, life satisfaction and bullying.

A set of questions were asked which formed the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). WEMWBS is formed of 14 statements covering a range of feelings and attitudes towards life. Participants were asked to rate how often they felt like each of the 14 statements, ranging from 'None of the time' to 'All of the time', which are scored from 1 to 5. Each participant is given a single score based on their responses to the 14 statements which ranges from 14 – 70 (a sum of their scores to the individual statements; 70 is the highest possible score of wellbeing, while 14 the lowest).

The mean (average) score for Warrington was 47.7; this was very similar to the North West (47.8) and England score (47.6).

The WAY survey asked the following question about life satisfaction: 'Overall, how satisfied are you with your life nowadays?' 12.4% of respondents from Warrington reported low life satisfaction; this percentage was slightly lower than the North West (13.3%) and England (13.7%).

Questions were also asked about bullying (either being bullied or being a bully). In Warrington 56.4% reported that they had been bullied in the past couple of months, this percentage was slightly higher than both the North West (54.2%) and England (55%). 8.3% of respondents admitted that they had bullied someone in the past couple of months; this percentage was similar to the North West (8.5%) but significantly lower than England (10.1%).

### **Strengths and Difficulties Questionnaire for looked after children**

Children who are looked after by Local Authorities are required to have completed a Strengths and Difficulties Questionnaire (SDQ). This is a tool used for assessing a child's emotional wellbeing, looking at the likelihood of problems being already present or of developing in the future. During 2015/16, 62% of children completed the questionnaire, whilst for England as a whole, it was 75%.

Subsequently, one of the outcomes from the SDQ is the identification of 'a cause for concern'. As with WEMWBS, each child is given a single summary figure (the total difficulties score), ranging from 0 to 40. A higher score indicates greater difficulties (a score of under 14 is considered normal; 14-16 is borderline cause for concern and 17 or over is a cause for concern). During 2015/16, 46% of children in Warrington recorded a score which gave 'a cause for concern'; this percentage was higher than both the North West (33%) and England (38%).

### **Warrington children and young people survey**

The Warrington children and young people survey was run during the spring/summer 2014. A questionnaire was provided to students in Year 6 (age 10/11), Year 8 (age 12/13) and Year 10

(age 14/15) and was completed by 926 primary school pupils and 2,553 pupils in secondary schools. Detailed findings of the survey can be found on the Public Health page of the Warrington Council website.

**Happiness/unhappiness:** Positively, on the whole the majority of respondents said they were very/quite happy. However, only 46% of Year 8 girls, and 29% of Year 10 girls, said they felt quite/very happy about their appearance. Appearance by far was the main reason girls felt very/quite unhappy, the proportion feeling unhappy about their appearance increased with age (20% in Year 6, 29% in Year 8 and 43% in Year 10). Boys were also unhappy about their appearance (but in much lower proportions), boys were also unhappy about school. 7% overall said they felt very/quite unhappy about the overarching "Unhappy with their life as a whole". The group with the highest proportion who said this were Year 10 girls (12%).

**Worrying:** A high percentage of pupils reported worrying a lot/quite a lot from a list of reasons provided in the questionnaire (63% of Year 6, 60% of Year 8 and 74% of Year 10); girls were more likely to report worrying a lot/quite a lot when compared to boys. The main causes of worry for all year groups were exams/tests/SATS and older pupils reporting worries about careers and plans for the future.

**Bullying:** Over half of pupils had experienced some form of bullying in the previous month (57% of Year 6, 60% of Year 8 and 56% of Year 10, these percentages reflect the findings from the WAY survey); a lower proportion responded that they had been a victim of cyberbullying (7% of Year 6, 11% of Year 8 and 12% of Year 10). Over a quarter responded that they had been afraid to go to school due to bullying at least sometime in the previous month (29% of Year 6, 31% of Year 8 and 23% of Year 10).

#### **Estimated need for services at each tier**

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from the Child Adolescent Mental Health Service (CAMHS) at Tiers 1, 2, 3 and 4 have been provided by Kurtz (1996). A description of the services offered at each tier can be found in the following section. The following table shows these estimates for the population aged 17 and under in Warrington (based on 2014 mid-year population estimates) (ChiMat 2015).

**Table 2: Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS**

	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>	<b>Tier 4</b>
Warrington	6,670	3,115	825	35

#### **Youth Offending**

During 2015 there were 29 first time entrants to the youth justice system in Warrington. This resulted in a rate of 149.6 per 100,000 population; this rate was significantly lower than England (368.6 per 100,000) and the North West (336.1 per 100,000). The trend in the rate of first time entrants has been steadily reducing in Warrington since 2010 when there were 167 first time entrants (814.7 per 100,000) (PHE, 2015a).

A Young Offender Health Needs Assessment (HNA) conducted across Halton, Warrington, Cheshire West and Chester during 2015 identified that young offenders in the sample population had higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas – mental health, learning difficulties, substance

misuse and social issues. It was also identified that this population also experienced high levels of dual diagnosis, in which young people experienced both mental health and substance misuse needs.

Within the sample population who resided in Warrington (47):

- 36% had their functioning impacted by mental health;
- 9% had received a formal mental health diagnosis;
- 19% were in contact with mental health services;
- 19% had either in the past or currently self-harmed or attempted suicide.

(The Centre for Public Innovation, 2015).

### **Refugee and Asylum Seeking Families**

As in many areas, there has been an increase in refugee and asylum seeking families and unaccompanied asylum seeking children in Warrington. Whilst the numbers are low, the projected numbers continue to change making planning services difficult. Health services will need to plan to respond to and meet the unique needs of this population, including the development of skills within the workforce to respond to the trauma experienced by families.

### **Commissioning Context**

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people. The multi-faceted nature of CYPMH will require a whole system multi-agency approach to commissioning based on the needs of the local population. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways around needs of the population to ensure good communication and transitions.

This specification should therefore be aligned with local delivery of services. For example (this is not an exhaustive list):

Public Health, Health Education, CYPMHS inpatient services, Health and Justice, Health Visiting, School Nursing, Community Child Health, Acute Paediatrics, Accident and Emergency Services, Perinatal Mental Health Services, Youth Services, Support services in schools, Social care including residential care, Adult Mental Health services, Workforce planning and education of staff.

It is important that children and young people, wherever they first seek support or present with difficulties, are enabled to receive appropriate early help and support. This specification details delivery of local integrated, whole system, multi-agency care to ensure access to effective, holistic evidence-based, outcome focused interventions.

### **Children and Young People's Improving Access to Psychological Therapies**

[CYP IAPT](#) involves transforming mental health services for children and young people and their families/carers. The programme is centred on the principles of offering effective and efficient evidence-based, outcome focussed treatments within a collaborative therapeutic relationship, and with full participation of children, young people and their families and carers in service

delivery and design.

These aims are met through a focus on:

- Meaningful participation with children, young people and families/carers embedded within all services and within local, regional and national service planning and development, including co-production wherever possible.
- A range of high quality treatments delivered by staff trained to expert level in evidence based therapeutic modalities
- Greater accessibility to evidence based interventions for children and young people
- A culture of clinically relevant session by session outcome monitoring embedded within routine practice and used to select, guide and evaluate treatment interventions and support collaborative shared decision-making.

Providers should be aware that carers have an entitlement to information and support in their own right. These are covered in the Care Act (2014) and Children and Families Act (2014). Carers may be caring for a child or young person eligible for CYPMHS support or they may themselves be in need of or eligible to use CYPMHS services (young adult carers – up to age 25).

A young carer is someone who, unpaid, helps to look after a friend or family member due to an illness, disability, mental health difficulties or addiction.

Young carers often get forgotten when addressing local need as there are no accurate figures of the number of children or young people with caring responsibilities. It is essential that the specific needs of this often hidden group are considered.

For most services, service redesign will be necessary to achieve these aims. Services will need to change the ways in which they are organised and delivered so that children and young people are offered the right interventions by the right people, with the right skills at the right time and in the right location. This service specification aims to bring a number of providers together to provide clearer and more cohesive pathways of support and to drive service transformation.

### **What children, young people and families/carers tell us they want from CYPMHS and other stakeholders**

Consultation with parents and carers about experiences of children and young people's mental health services for an audit completed for the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme<sup>8</sup>, showed these prominent themes:

- Access - long delays in getting to CYPMHS, often due to a lack of recognition by health professionals including GPs of the seriousness of the child's problems; coupled with long waits for the service
- Family/carer journeys – parents/carers felt frustrated by the need to fight for access for their child and by the lack of consistency in practitioners
- Involvement and support –parent/carers need to be involved and valued in caring for their child but their own needs for support must to recognised too
- Language and information sharing – parents/carers felt frustrated by practitioners

<sup>8</sup> The involvement of parents and carers in Children and Young People's Mental Health Services, GIFT (2014)

inability to use plain words and tendency to patronise. Some parents/carers also felt that judgemental and blaming language was used

- Cultural sensitivity – some practitioners failed to understand the cultural context in which a child was living and to recognise when parents/carers need support to adapt their parenting skills

Children and young people have told us how they want things to change. They want:

- to grow up to be confident and resilient, supported to fulfil their goals and ambitions;
- to know where to find help easily if they need it and when they do to be able to trust it;
- choice about where to get advice and support from a welcoming place. Often this will be somewhere familiar such as school or the local GP practice or could be a drop-in centre or access to help on line. But wherever they go, the advice and support should be based on the best evidence about what works for the mental health problem or difficulty the young person wishes to address;
- access to advice and support should be simple, discreet and confidential;
- as experts in their own care, to have the opportunity to shape the care and services they receive;
- to be offered a wide range of evidence based treatments, rather than medication being the first and only option;
- to only tell their story once rather than have to repeat it to lots of different people. All the services in their area should work together to deliver the right support at the right time and in the right place and as early as possible.
- to not have to wait until they are really unwell to get help. Asking for help shouldn't be embarrassing or difficult and they should know what to do and where to go; and if they do need to go to hospital, it should be in an environment with people around their age and as close to home as possible. While children and young people are in hospital, we should ensure they can keep up with their education as much as possible.

**Some 'I statements' have been developed by children and young people nationally and in partnership with children and young people, these were amended and reviewed to produce a local set of locally specific 'I statements' that have informed the performance metrics for the services going forward.**

#### **Service offer**

- I will receive a caring response that meets my needs.
- I will receive support and treatment at the point I need it.
- I will be able to access support and treatment in an environment that suits me.
- I will be able to start treatment at a time that suits me.
- I will be given a choice of where and when I will be seen, who will see me, and what care I will receive. If this cannot happen I will be told why.
- I will have the choice to be treated by the same professional throughout my care, who I will be able to contact and will follow-up with me.
- If I want my family or carers to be involved, they will be given the information and support they need to help me.

#### **Co-production/empowerment**

- I understand what my need is and why I need help.
- I will be supported and helped to speak up when I feel things are not working out.

- I will be involved in planning what care I receive and how it is provided to me.

### Transitions

- If I need to access other services, I will be supported to access these
- If I need to access other services they will know about me before I arrive.
- I will be involved in deciding whether I need to access other services.

### “Getting better” - thriving

- I will be able to set a clear goal for my treatment.
- I will receive regular reviews to see whether I am getting closer to my goals.
- I will achieve my goal.
- I will feel that the issue that made it necessary for me to get help is improving.
- I will feel better than when I first started getting help from the service.
- I will feel able to get on with my life without the need for help from specialist staff.
- I will feel able to manage the ups and downs of life.
- I will know where to find help if I think I need it again.

### Other personal goals

- I will be supported to carry on with my studies.
- I will be supported to carry on doing the things that are important to me (seeing friends, playing hobbies, following my hobbies).

### Financial cost of children and young people’s mental health problems

The costs incurred to the public purse of not treating children and young people early in their lives are considerable and result in an increased cost to the public purse and to wider society.

For example:

- A study<sup>9</sup> estimated additional lifetime costs of around £260,000 per case – or around £5.3bn for a single cohort of children in the UK. These costs include those relating to crime (71%), mental health disorders in adulthood (13%) and differences in lifetime earnings (7%).
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.<sup>10</sup>
- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.
- In 2012/13, it was estimated the total NHS expenditure on dedicated children’s mental

<sup>9</sup> Friedli L, Parsonage M (2007). Mental Health Promotion: Building an Economic Case. Northern Ireland Association for Mental Health.

<sup>10</sup> Friedli, L. & Parsonage, M. ‘[Mental Health Promotion: Building an Economic Case Northern Ireland Association for Mental Health](#), NIAMH (2007)

health services was £0.70bn.

The impact of mental health disorders extends beyond the use of public services and incorporates the impact of antisocial behaviour and crime on communities etc. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child<sup>11</sup>. For certain young people with very individualized needs this can cost significantly more.

Caring for a child or young person with mental health issues has a negative impact on the physical and mental health of the carer. Carers save the public purse a significant amount of money. Whilst there is no information on carers of children and young people, Carers UK have shown that carers save the UK economy £132 billion per year and the damaging effect caring has on health:

<http://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures>

## 2. Outcomes

### 2.1 Improving outcomes for children, young people and families

Commissioners and providers will ensure clinicians:

1. are supported to use outcome and feedback measures for clinical purposes in sessions, in partnership with young person and /or parent/carer
2. have digital tools and measures available to aid in assessment and formulation planning
3. have digital tools to facilitate the collaborative setting and tracking of the CYP/families personalised goals for intervention
4. have access to information technology that facilitates primary clinical use and collection of measures along with capability for real time data analysis and production of user friendly graphs and charts with statistical (clinical) cut offs that can show reliable change
5. embed use of outcome and feedback measures throughout delivery of an intervention and provide paired data (at least 2 measures at start and end of treatment) for all cases wherever possible
6. use measures to support supervision and case management
7. along with service managers, regularly review and report on data to inform service delivery and development, including to commissioners
8. develop an outcomes framework model of delivery where collection of individual outcomes also contributes to a number of strategic outcomes that have been pre-defined both nationally and locally

<sup>11</sup> Parsonage M, Khan L, Saunders A (2014). Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention. London: Centre for Mental Health

9. look beyond the clinical outcomes to the wider educational and social outcomes or goals that are important to individual CYP and their families, e.g. school attendance, engaging in social activities, being involved in decisions about a safe place to live

## 2.2 NHS Outcomes Framework Domains and Indicators

The provision of good CYPMHS will support improved outcomes across all five domains.

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	X

## 2.3 Public Health Outcomes Framework

Domain 1	Improving the wider determinants of health	X
Domain 2	Health Improvement	X
Domain 4	Healthcare, public health and preventing premature mortality	X

## 3. Scope

### 3.1 Aims and objectives of service

The Children and Young People's Mental Health and Wellbeing Taskforce developed five key themes as part of [Future in Mind](#):

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

It calls on all those involved in supporting children and young people to work together to:

- Place the emphasis on building resilience, promoting good mental health, prevention and early intervention
- Simplify structures and improve access
- Deliver a clear joined up approach
- Harness the power of information
- Sustain a culture of continuous evidence-based service improvement; and
- Make the right investments

The provider(s) shall:

- Work together (with an identified lead provider) to deliver whole system pathways in line with the THRIVE model and national guidance, (see appendices 1-5 for the local overview of THRIVE).
- Recognise the importance of education and early years settings in their role to identify assess and respond to CYP's needs. Work in collaboration with education and early years colleagues to support them to promote positive mental health and wellbeing, develop emotionally health environments and to enable children and young people to develop resilience. Co-develop with education and 'early years' colleagues, pathways and processes that enable them to work with targeted and specialist services to ensure all children and young people receive appropriate support as early as possible through joint working, training and supervision of school staff.
- Provide a virtual 'single point of access' for all young people that require support or intervention for mental health and emotional wellbeing over and above that which can be provided by universal services. This offer, as per the 'getting advice' pathway (See appendix 2), will provide advice and signposting to other local services where appropriate, particularly where there are exclusion criteria for ongoing support from this service or where there is another more appropriate service locally.
- Develop dedicated risk support pathways in line with the THRIVE model (see appendix 5).
- Work with children, young people, young adults and families/carers in co-designing and reviewing care pathways.
- Work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their individual needs, providing a holistic approach.
- Ensure that children, young people and their families/carers are treated with compassion, respect and dignity, without stigma or judgment.
- Ensure that children and young people's physical health, social, educational and cultural needs are considered alongside their mental health needs.

- Ensure that children and young people who access the service receive treatment in a timely manner.
- Ensure pathways (including the broader THRIVE pathways and evidence based clinical pathways) are available online with clear criteria, e.g. getting advice, getting help or more help, getting risk support, eating disorders, early intervention in psychosis etc. Work with commissioners to embed pathways within GP clinical systems (e.g. map of medicine, 111 systems) and ensure these are kept up to date.
- Provide a range of evidence based (NICE approved) treatment interventions to ensure that children and young people's needs can be met.
- Ensure that children and young people's needs are considered in the whole and access to appropriate supplementary therapies and support is encouraged where appropriate.
- Ensure that provision can provide care in response to an emergency or crisis, including out of hours 24/7 provision, (see appendix 6).
- Provide initial and follow-up assessments that are written and shared with the child, young person and/or parent/carer, and with consent with other partners e.g. schools, social care.
- Seek and use feedback in a range of settings, including the use of regular outcome monitoring in therapy, feedback regarding service delivery, and complaints.
- Ensure that children, young people and their families/carers are offered a choice of interventions that are evidence based and appropriate to their needs. Provide information at all stages of the pathway about interventions or treatment options to support children, young people and families/carers to make informed decisions about their care. This must be appropriate to their competence and capacity; information needs to be clear, easy to understand and jargon free.
- Be flexible in the deployment of staff and job planning to respond to need and ensure, wherever possible there is consistency of practitioner working with the young person and family, including if they move through different pathways/parts of the THRIVE model. Care coordination should be a core element of the role for all staff (possibly on a school based cluster model), whilst retaining specialists that lead on the development of specific clinical pathways and provide support and supervision across the team to work effectively within these pathways.
- Ensure the impact of trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions, seeking additional information from partners to ensure clinical decisions are based on all available information.
- Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, autistic spectrum conditions, victim of child sexual exploitation etc.) is properly considered when identifying appropriate interventions. This will involve working in partnership with other professionals to ensure the young person's

needs are met and they don't fall through the gaps in different pathways, e.g. if a neurodevelopmental assessment is required.

- Agree the aim and goal of interventions with the child/young person or family/carer; monitor the changes to agreed and shared goals as well as symptoms, and amend therapeutic interactions as a result of these changes, to deliver the best possible outcome.
- Provide written information to the child/young person and family/carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free.
- Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012.
- Work collaboratively with other agencies in the health, social care and education systems around regular case reviews to ensure effective progress through the care pathway. Work with Children's Services to develop agreed shared processes for doing this.
- Ensure that best use is made of technology to support, facilitate and improve delivery of evidenced based treatment. This will include: developing online access to information and signposting; offering access to support and intervention through an online therapeutic offer; and the option to access appointments through remote means, e.g. telephone support, skype.
- Ensure that there is a formal route for referring children/young people to highly specialist mental health services (e.g. inpatient services, specialist outpatient services).
- Ensure that good relationships are maintained with relevant agencies in health, social care and education (including statutory, voluntary and third sector organisations) to aid referral into the service and ongoing support and treatment. This includes using whatever locally agreed systems there are to support joint agency working (e.g., Early Help Assessment (EHA), Team Around the Family), meeting statutory safeguarding guidance and providing clear protocols on information sharing, with children and young people being asked for consent regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).
- Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their families/carers experience a smooth journey through the care pathway.
- Ensure [Routine Outcome Measures](#), Patient Reported Outcome Measures are used to inform individual care plans and wider service improvements. Routine outcomes measures should be reported to commissioners in line with the outcomes and reporting framework.
- Maintain an accurate data set and provide accurate and timely reporting to commissioners (local, regional and national) and national organisations (e.g. NHS Digital – formerly Health and Social Care Information Centre), including reporting against the

national Mental Health Services Data Set when requested.

- Ensure that management information is readily accessible and regularly used for service improvement.
- Have clear reporting processes and standards, for example, as set out by the [MHSDS](#), [Youth Wellbeing Directory](#), [QNCC](#) and [CORC](#).

### **3.2 Legal and regulatory framework**

The provider(s) will ensure that all professionals remain compliant with their relevant professional standards and bodies and be revalidated as required.

The provider(s) will be part of a quality network and where appropriate, contribute to the clinical network.

If appropriate, the provider(s) will be registered with the [Care Quality Commission](#).

The provider(s) will have an indemnity scheme.

The provider(s) will have a governance system to manage and learn from complaints and incidents and to meet the training and supervision needs of its staff.

Providers may wish to consider the use of Independent Advocacy Services to support children and young people to gain access to information, to fully explore and understand their options, and to make their views and wishes known.

### **3.3 Mental Health and Wellbeing Care Pathway**

Intervention must be goals focussed, evidence informed and outcomes focused.

#### **Access to early help**

It is important that the provider considers the holistic needs of the child/young person and where appropriate delivers a wide range of support which may include access to therapies and therapeutic activities. This support will include:

- Partnerships with schools to promote wellbeing, resilience and access to early help
- Work to become 'therapy ready'
- Alternative and family support and building resilience
- Self-help support including the use of online and technology based support materials; especially whilst waiting for formal treatment to commence
- Parenting interventions
- Brief psychological interventions (including group work and counselling)

The provider will establish effective links with schools, colleges, voluntary and community centres in the area and provide a programme of training to enable all children's services to identify and respond to support children and young people in emotional or mental health distress.

#### **Assessment of mental health need**

- Processes around early help and identification of need will be in line with the THRIVE offer (see appendices) and will be aligned with the local prevention services, early help offer, and local education and youth services. The provider will develop a 'getting advice' pathway in collaboration with local partners that can be published on their website which will specify how consultation and information and signposting will work alongside full assessment of need. If a full assessment is required the assessment will be undertaken by someone experienced to do so quickly, in a person-centred, goal focused manner that is active and collaborative, and such that enables a formulation or diagnosis where appropriate and options for help to be decided upon, e.g. Choice and Partnership Approach (CAPA)
- Ensure information from other mental health assessments is accessed e.g. CHAT (Comprehensive Health Assessment Tool) used by community Youth Justice services and children's secure estate, or a summary health record when leaving the secure estate for children and young people, early help/social care assessments, etc.
- Ensure that the rationale for formulation and any associated diagnosis, evidence considered and decisions made will be fully documented. This will be shared with the child/young person and parent/carer in writing as appropriate. Ensure that initial and continuous care planning involves all members of the team providing care, the child/young person and their parents/carers and the young person/family have a written copy of the care plan
- Where appropriate, develop a risk management plan in collaboration with the child/young person and their parents/carers.
- Ensure that informed consent issues around both sharing of information within the family and with other agencies and around treatment are clearly explained and documented. Provide a choice of evidence based, NICE approved, care/interventions that will prevent unnecessary admission to an inpatient bed and promote safe discharge and recovery. Work with commissioners over time to develop an intensive treatment offer that includes home visits to help prevent admissions to secondary care and tier 4, and to support earlier discharge back home.
- Specify pathways for meeting the mental health needs of vulnerable groups, including young people with complex needs. The provider should develop pathways for 'getting risk support' and for specific groups, e.g. children looked after and publish these on their website.
- Provide a crisis response to all appropriate acute units, including a robust clinical emergency service with out of hours, weekend and bank holiday capability or to other CYPMH providers to share information when a child or young person enters the secure estate. Currently this includes a liaison offer between 8pm and midnight and close working with adult liaison services. This will need to be monitored and developed as further work is undertaken across the system to develop crisis response and intensive community support.
- Ensure that legal rights for individuals with regard to choice of mental health provider are implemented. See <https://www.england.nhs.uk/mentalhealth/parity/choice/> for guidance.

- Contribute to other parts of agreed multi-agency care pathways, for example and where relevant, the NHS Continuing Care Pathway and the Section 117 Aftercare Pathway.

### **Access to treatment**

The provider will deliver a range of evidence based therapeutic and preventative services to children and young people, which (not exhaustively) includes:

- Cognitive behavioural therapy
- Dialectical Behaviour Therapy
- Systemic therapy/family therapy
- Psychodynamic psychotherapy
- Counselling
- Other evidence-based psychological therapies
- Evidence based parenting programmes
- Pharmacological interventions
- Psychosocial interventions
- Behavioural Therapy
- Interpersonal psychotherapy for adolescents (IPT-A)

### **Access to treatment with extensive support**

The provider will deliver evidence based therapeutic services for those who have long-term mental health needs and/or additional vulnerabilities that require longer treatment.

### **Access to crisis and intensive response**

The provider will deliver services that can meet the mental health needs and respond promptly to young people who present in a crisis (See appendix 6). The provider will work with partners and commissioners to test out and develop more intensive community based support e.g. offering home treatment to prevent admission and support timely discharge where appropriate. This offer will be developed over time, particularly as the commissioning of tier 4 beds comes back to local commissioning.

## **3.4 Acceptance criteria**

The service has clear acceptance criteria that are available to referrers, children/young people, their parents/carers and other agencies/services that is available on the provider's website. Specific criteria in relation to the THRIVE groupings can be found in Appendices 2-6

The aims of children and young people's mental health service is to provide support to colleagues working with children and young people in need of assessment and treatment in the context of emotional, developmental, environmental and social factors to children/young people experiencing mental health problems.

**Mild to moderate** emotional wellbeing and mental health problems of children/young people alongside their parents/carers either in clinics and/or community settings such as GP practices, schools, youth venues, online or, where appropriate, the home environment.

The service will network with a range of services and other agencies as appropriate, including

community paediatric providers.

Most young people will present with **moderate and severe mental health problems** that are causing significant impairments in their day-to-day lives. These may be acute presentations. There are inter-relationships with other services around support for challenging behaviour, e.g. education, early help, child development centres etc. The service should work with partners in each borough to agree pathways for challenging behaviour.

**The Provider(s) will:**

- Facilitate and review self-referrals from young people and parents/carers
- Accept referrals for children and young people aged 0 – 18 years inclusive living in Warrington or with a Warrington GP where there is a reasonable description that suggests that the child/young person may have an emotional wellbeing or mental health problem. Where a young person from Warrington or with a Warrington GP has ongoing mental health and support needs and is admitted to tier 4 (both in and out of area) or spends time in a young offenders institution, the service will attend care planning meetings, in particular to facilitate safe and timely discharge through robust discharge planning to reduce the risk of re-admission.
- Accept referrals from any source including self-referral, and the development of online access to self-referral. The service will also provide informal access to information, advice, signposting and specialist brief interventions on a drop in basis for young people and families at community venues. Young people should be able to access this autonomously and confidentially where they choose to do so. This will be promoted widely via schools, GPs and online. Where there are concerns around competence and/or safeguarding, Gillick competence would apply. The provider should develop referral pathways, giving consideration to referral in from a range of routes including specialist services (e.g. Sexual Assault Referral Centre (SARC), Liaison and Diversion service, secure settings for children and young people).
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.
- Support the Early Help Assessment/Common Assessment Framework and local protocols.
- Support and ensure inter-agency working.
- Support and ensure discharge or transition planning.
- If the service concludes that the needs of child/young people or family/carer are better met by other agencies. It will ensure that any onward referral is accepted before closing. A pathway for onward referrals should be developed that takes account of where duty of care is held.
- Inform referrers of the outcome following referral (e.g. referral accepted/not accepted, outcome of assessment etc.) and the rationale to support this decision, in line with agreed information-sharing protocols.
- Offer a referral and advice service so that those thinking about referring can have a

discussion prior to the referral, either by phone, or through pre-arranged consultation e.g. through the establishment of named link workers for schools or via an informal first point of contact service e.g. drop-in sessions at a prevention hub.

- The service will, over time, develop an increasing presence within the integrated front door for early help and safeguarding (MASH). In different boroughs there are a range of pilot initiatives, e.g. a member of the team being present within MASH at least once a week to provide consultation and support. This should be evaluated and the service should plan to further develop co-location and integrated working with the MASH.
- Gather the agreed range of information at the point of referral using a locally agreed standardised referral template that can be completed online or sent via secure email. All GP referrals should be sent via the referral and assistance gateway and should not be accepted via any other route.

Through the development of pathways to ensure informal access for first point of contact, there should be an agreed format for a first contact that is recorded electronically but that may lead to advice and signposting only rather than a full assessment. This should be carried out by experienced practitioners only.

Where it is identified a young person requires full assessment and formulation the information collected would be the start of an electronic patient record (this would simultaneously become the point of referral and the first contact) and any further assessment should build on the information collected in order that children, young people and families are not required to repeat the same information.

### **3.5 Exclusion criteria**

It is very important that children, young people, parents/carers and referrers are equally clear about presentations the service is *not* commissioned to accept. This information should be publically available and a system put in place should this be disputed.

Children and young people may *not* be eligible for the service(s) on the basis of:

- Age – new referrals for those aged 18 and above should be made directly to adult services. Those referred at 17 should be seen by the service in line with waiting time standards and with the transition protocol being instigated immediately where appropriate. Children and young people that are already in service and require transition to adult services at 18 should have a managed transition over a period of time. Clinical judgement and the views of the young person and their family will inform the timing. For some young people with more complex needs that are also supported by the Local Authority, transition processes can start as early as their 14<sup>th</sup> birthday. The provider(s) should align with and support this process. Transition should have started by no later than their 18<sup>th</sup> birthday.

Children looked after' and young people with an education, health and care plan should be considered on a case by case basis in partnership with the Local Authority and adult services, with scope to delay transition to adult mental health services until after significant transitions in terms of education and care have been made. Both children and young people's mental health services and adult services can meet statutory requirements for 'looked after children' and those with an education, health and care plan up until their 25<sup>th</sup> birthday and therefore transitions should be made as soon as possible. For children and young people that do not require transition to adult mental health services, robust transition

planning in partnership with the young person and family is required to ensure the best chance of sustained recovery with access to ongoing information, advice and support from wider community based services appropriate to their individual needs.

- Children and young people from 8 – 18 years with concerns regarding an eating disorder should be seen by the specialist community based eating disorder service in the first instance. The teams will work flexibly in the best interests of individuals, with supported transition out of the eating disorder service for ongoing support, e.g. when depression persists; or offer joint working where there is a specific need.
- Children and young people from age 14 that present with possible psychosis should be seen by the 'early intervention in psychosis' team in the first instance. The teams will work flexibly in the best interests of individuals, with supported transition out of the 'early intervention in psychosis' team e.g. if it is identified that their needs are better met by a different treatment pathway.
- Assessment for diagnosis of neurodevelopmental difficulties is currently provided by a different provider. However, joint working e.g. attending allocation meetings and providing consultation or timely assessment when a mental health opinion is required to support the assessment process, will be part of the remit of this service. In addition, referrals into this service for children and young people undergoing assessment for neurodevelopmental disorders or that already have a diagnosis, and where there are concerns regarding co-morbid mental health issues must be accepted. This should be supported by continued joint working and joint pathway development with the provider for neurodevelopmental assessment so that decisions can be made on a case by case basis to ensure no young person falls through the net.
- Specialist assessment following sexual assault. Once specialist assessment has been carried out by the commissioned provider, any referrals for ongoing support should be treated in the same way as any other referral.
- This service is not commissioned to provide an assessment of every child being taken into care by the Local Authority that would, for example, inform decisions around appropriate care placements. However, all referrals for children that are looked after should be accepted for an assessment.
- The referred problem may be best treated in an alternative service (and the protocol by which the service will refer to the alternative must be clearly defined and available on the provider's website).
- Where a more clinically appropriate service has been commissioned from an alternative provider (e.g. other specialised community service or in patient service, or children with severe disabilities)

### 3.6 Where a full mental health assessment is required

The outcome of the assessment should be recorded in the child or young person's notes and be passed on to any other service involved in the care of the child or young person with their informed consent of and/or their parent/carer.

#### Providers will:

- Respond to crisis/emergency referrals where there is significant concern about the level of risk the young person poses to themselves or others and start an assessment within 1 hour (see appendix 6), in line with national guidance once published. This process could start by phone or other digital means; however this should only support a timely response and not replace a full assessment or delay the agreement of a care plan/start of treatment. If a young person does not have physical healthcare needs that requires attendance at hospital, wherever possible the crisis response should be in the community. Referrals that have historically been categorised as urgent should equally receive this initial response. However it is recognised that the support and treatment offered will vary greatly and that follow up will vary depending on the level of risk.
- For all other children and young people that require a full mental health assessment (refer to national guidance for definition of clock start), they should receive a full assessment and the agreed intervention should commence within 6 weeks (42 days) of the referral based on a 7 day working week
- Ensure that the member of staff undertaking the full mental health assessment is appropriately trained and experienced to undertake assessment, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate, and to identify any risks.
- Work in collaboration with the child/young person and, where possible, the parents/carers on the decision to refer for further assessment and/or treatment or to discharge and/or signpost, based on the combined assessment of their needs and risk.

### 3.7 If mental health need is identified

#### Providers will

- Commence treatment for **crisis/emergency referrals**, in line with national guidance (once published) within 4 hours. A care plan should be agreed with the young person (and family) within 4 hours and any immediate treatment required should also commence within 4 hours. All young people that meet the criteria for a specific treatment pathway should have commenced their treatment within the maximum wait time for routine referrals; however it is expected that the follow up for those that present in crisis will be based on individual assessment and need. Wherever possible, if a young person is already known to the service, there should be continuity of staff.
- **Start treatment for routine referrals** (in line with national guidance), within 6 weeks (42 days based on a 7 day working week).
- Work in collaboration with the child/young person and, where possible, the parents/carers throughout treatment through to discharge/ transition of care

based on the combined assessment of their needs and risk.

### **3.8 Continuing care and assessment**

#### **Providers will:**

- Ensure that care plans are in place for all people receiving support for mental health problems. These plans should be coordinated across agencies, teams and or disciplines, be clearly written, identify the key coordinator and be developed in collaboration with children/young people and families /carers where possible. A copy should be given to the service user, parent/carer (if appropriate) and other agencies including an electronic copy to the GP. Where a child/young person is known to children's services, there should be an agreed, multi-agency approach to care coordination to ensure a whole family centred approach. This will include clinicians inputting into the children's services care planning process and a copy of the shared plan being recorded in the health record.
- Ensure that the care plan includes appropriate risk management and crisis planning.
- Review the care plan with the child or young person and their family/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. The dates for review should be set out in writing and will vary depending on the nature of the problem. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.
- Select treatment options in consideration of:
  - Age-appropriate best practice/evidence-based psychological intervention
  - Pharmacological and psychosocial interventions
  - Environmental and occupational/educational interventions or provision
  - The availability of a psycho educational website online prevention packages with access to other face to face support available and mechanisms for any deterioration to be detected and acted upon whilst waiting
  - Engagement, flexibility and choice.

The provider will work with partners to ensure it meets its statutory responsibilities around special educational needs and the education, health and care (EHC) planning process. This should include involvement in multi-agency care planning processes and ensuring the agreed mental health care plan is integrated with and supports the holistic EHC plan. Care planning should take account of educational needs and where a child/young person has an EHC plan, the must be considered as part of case management.

### 3.9 Individualised Commissioning

Where all options for intervention have been exhausted and there appears to be limited progress in mental health conditions, it may be appropriate to apply for NHS Continuing Care for funding which can be used to develop a more suitable treatment option for the young person that is above and beyond commissioned service specifications.

The provider will:

- complete the NHS Continuing Care assessment with the CCG and other relevant professionals
- remain involved with ongoing CYP care and treatment.

When a young person is detained under the Mental Health Act on a treatment section, they become eligible for Section 117 Aftercare. This is a package of care which is created on an individual basis to meet their needs in the community in order to support the CYP to remain in the community and not return to an inpatient setting.

- Follow the local Section 117 Aftercare policy and pathway
- Complete referrals to the Borough Council to ensure Social Care involvement
- Inform the CCG that a CYP has been detained under the Mental Health Act on a treatment section
- Ensure relevant professionals are invited to Care and Programme Approach reviews for multi-agency care planning
- Involve professionals, the CYP and, where relevant, families in care planning to ensure personalised support is arranged prior to discharge

CYP who are at risk of admission to an inpatient setting and who have a diagnosis of LD or ASD require a Care, Education and Treatment Review (CETR) prior to admission. Professionals will inform the CCG if there is a CYP in this situation for the CCG to arrange a 'blue light' meeting. This is in order to review the package of care that the CYP receives in order to offer them further support if necessary to remain in the community. If the CYP is admitted following the blue light meeting, the responsibility for CETR's then becomes NHS England's as they are currently the Commissioner for inpatient settings.

### 3.10 Does Not Attend (DNA) /Re-engagement policy

A specific policy should be developed in partnership with commissioners and local authority colleagues and published on the provider's website.

The risks and causes of children or young people not attending for appointments are particularly acute for mental health services. Children, young people or their family/carers who do not attend appointments should not be automatically discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage as needed.

A standard NHS DNA policy of a set number of DNA's leads to automatic discharge would not be appropriate. To ensure that there is not significant wasted capacity due to non-attendance at standard clinic appointments, the provider(s) will need to consider how to deliver services differently in line with THRIVE, e.g. offering choice of venue, joint

assessments with partners, home visits as required etc.

The provider must have a robust plan in place to act when a child or young person does not attend. In each case, a risk assessment should be made and acted upon. The service should have explicit procedures in place to ensure that the child, young person and family/carer are contacted following a DNA and that all appropriate measures are taken to:

- Ensure attendance at any future appointments
- Ensure the safety of the child or young person, including notification of other people involved in their care if appropriate

The service should have clear re-engagement policies and make these available to referrers, children/young people and family/carers.

The provider will maintain good relationships with relevant agencies in health, social services education, youth justice and, where appropriate and with consent, will share information about non-attendance, to mitigate against the risks inherent in the fact that children and young people are often dependent on others to access care.

### **3.11 Care transition protocols**

Transitioning out of CYP MHS is a period of high anxiety for the children, young people and their parents/carers and therefore it is vital that transitions are managed to ensure a seamless experience in partnership with all parties, including the child or young person and parent/carer. The service must have protocols in place to ensure that transitions between 'sending' services (CYPMHS) and 'receiving' services (AMHS, other related services or relevant to the child or young person's mental health needs, or primary care) are robust. Services must work together with the child or young person and, where appropriate, parents/carers to plan in advance for transition. The needs of the whole family should be taken into account. If a family member is identified that needs advice, support or help then they should be supported to access appropriate help.

For some young people with more complex needs that are also supported by the Local Authority, transition processes can start as early as their 14<sup>th</sup> birthday. The provider(s) should align with and support this process.

Otherwise, as a minimum, a child or young person leaving CYP MHS should have:

- A meeting to prepare for transition, at least six months before transitioning or, for those who are less than six months from transition age on joining CYP MHS, at least one month before transition. The meeting should include:
  - the child or young person;
  - the appropriate key worker from the sending service;
  - where applicable, a dedicated point of contact for transition from the receiving service; and
  - where appropriate, and the young person agrees, the young person's parent(s)/carer(s).

Where a face to face meeting is not practicable, for example when a young person is moving out of area, this can be done remotely, for example via a video conference.

- A complete transition plan at least 6 months prior to transitioning, signed off by:
  - The sending service;
  - Where applicable, the receiving service;
  - The child or young person;
  - Where appropriate, and where consent is given, the young person's parent(s)/carer(s).

The transition plan must include personal transition goals, jointly agreed with the child or young person. For those entering CYPMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYPMHS and no later than one month before transition.

- A named and contactable transition key worker, at least 6 months prior to transition, in the sending service or, where transitioning into AMHS or other relevant services, at the receiving service. This key worker must be known to the child or young person and their contact details shared with them.

For those entering CYP MHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYP MHS and no later than one month before transition.

- Those leaving CYP MH services that will not transition to another service, but back to primary care, should have a discharge plan that has been developed and shared with the child or young person and shared with primary care. This plan should ensure that the child or young person and, where appropriate, parents/carers can support self-management where possible to maintain their wellbeing, and will know what to do if they become unwell.
- Follow up after the transition, ordinarily conducted by the receiving service and within six months, to ensure appropriate interventions are in place and transition goals have been met.

Service Transition Protocols should ensure that:

- Children and young people are involved in the process throughout and properly prepared for transition out of CYP MHS;
- Children and young people have continuity of care wherever possible;
- Any risks or safeguarding concerns are clearly considered and documented;
- Joint-agency transition planning takes place, as detailed above.

### **3.12 Accessibility**

Providers will:

- Provide written assessments, care plans, etc. that are easy to understand and jargon free; any technical terms in these assessments/care plans should be defined. Consideration will have to be given to ensuring that those with particular communication needs, e.g. hearing/sight impairment, speakers of other languages, have access to information in a suitable format.
- Ensure that the service is accessible and provided in an appropriate setting that

creates a safe physical environment. This will take into account issues such as stigma and, where appropriate, gang violence.

- Use venues to deliver treatments that are fully accessible in terms of mobility and other impairments and that have good access to public transport and parking.
- Ensure that services have age-appropriate physical settings. If located alongside services for adults then there should be a separate entrance and waiting area for children, young people and their families/carers.
- Ensure services are available to all children and young people without regard to age, gender, sexuality, religion, ethnicity, social, or cultural determinants. This will likely include some adjustments in service delivery to ensure equity of access and outcome. Local engagement indicates that special consideration should be given to young people that identify as lesbian, gay, bi-sexual or trans gender; or unaccompanied asylum seeking children.
- Where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Offer children, young people and parents/carers age and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed and about their care.

### **3.13 Staffing arrangements, recruitment and training, supervision/appraisal requirements**

The national vision<sup>12</sup> is for everyone who works with children, young people and their families/carers to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them
- excellent in their practice and able to deliver the best evidenced care with integrity and openness
- committed to partnership and integrated working with children, young people, families and their fellow professionals
- are respected and valued as professionals
- promote equality, diversity and inclusion and reduce inequalities
- practicing with cultural sensitivity and awareness

#### **Providers will:**

- Ensure staffing is within the expected establishment numbers for the investment and that there are adequate workforce plans in place to mitigate against any recruitment and retention issues in order to avoid high numbers of staff vacancies. Ensure there are sufficient number of staff educated and trained with the required skills, competencies and experience within teams. The skill set required in the team may be subject to change according to changes in local needs. This should include relevant training provided through the CYP IAPT programme.
- Ensure the workforce has the necessary outlook, compassion, values and

<sup>12</sup> Future in Mind, Department of Health (2015)

behaviours to provide person-centred, integrated care and enhance the quality of experience through recruitment, education, training and regular continuing personal and professional development (CPPD) that instils respect for children/young people and parents/carers.

- Ensure all staff are trained and educated to deliver the care and support they are tasked to do. Where appropriate staff delivering evidence based interventions will be accredited in those modalities and particular consideration will need to be given to development of skills for some of the most vulnerable groups e.g. children looked after. It is expected that significant workforce review will be required to deliver the THRIVE model, including the development of new roles, e.g. psychological wellbeing practitioners, peer support and navigator roles or subcontracting to third sector or other providers to widen the range of roles, skills and experience available.
- Ensure that the providing organisations provide relevant Continuing Professional Development (CPD), appropriate supervision and regular appraisal to staff, and there is a clear, whole system workforce plan that takes account of the changing needs of the local population.
- Anticipates the numbers and capabilities of the workforce needed currently and for the future, ensuring an appropriate skill mix in teams and across provider organisations that can deliver a range of recommended evidence-based interventions with a delivery model that best focuses the capacity of the service to the demands of the population.
- Ensure the workforce is informed about other providers, and has the knowledge and ability to communicate effectively with other relevant services.
- Ensure the workforce is educated to be responsive to changing service models, innovation and new technologies, with knowledge about effective practice and research that promotes adoption and dissemination of better quality service delivery by evaluating impact of the service and care delivered.
- Ensure that there is compliance with the recommendations of the [Francis Report \(2013\)](#) and in particular the [statutory Duty of Candour](#).
- Monitor caseloads for staff to ensure safe, effective and compassionate delivery of services.
- Ensure that the workforce has suitable training to identify and support families/carers

Further guidance can be found at the links below:

- [National Child and Maternal Health Intelligence Network \(Part of PHE formerly ChiMat\)](#)
- [CAMHS Workforce Guidance](#)<sup>13</sup>
- [SASAT tool to support integrated workforce planning for CYP MH care](#)
- [CYP IAPT Principles in CAMHS Services: Values and Standards: “Delivering With and Delivering Well”](#)<sup>14</sup>

### **3.14 Activity to improve outcomes**

The NHS contract will focus on delivering improved outcomes in line with principles of IAPT outcome reporting and other outcomes outlined in the quality schedule. This will require continuous improvement using effective demand and capacity planning. The provider(s) will work with commissioners to meet the nationally required access targets.

### **3.15 Information governance and accountability**

The provider will comply with all relevant legislation and guidance to record information, in particular to comply with Data Protection acts, and comply with requirements to keep records for an appropriate period.

The Provider will have robust arrangements to meet the requirements set out in the Mental Health Services Data Set for CYP MH and include a staff training/development plan to increase capacity and capability.

### **3.16 Interdependence with other services/providers**

Providers should ensure they have excellent links with services regularly used by young people, families and carers:

- Schools, academies, FE colleges and other education providers
- General Practice
- Children centres and early years settings (nurseries)
- Early Help provider
- Health visitors
- Other mental health services (adult, specialist, forensic)
- Voluntary sector providers
- Independent providers

<sup>13</sup> Nixon, B. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014), adapted from ‘*Delivering workforce capacity, capability and sustainability in Children and Young People’s Mental Health Services*’ National CAMHS Workforce Programme, CSIP, (2006)

<sup>14</sup> CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

- Inpatient or paediatric services
- Youth services
- Safe guarding – children and adults (Local Safeguarding Children Board)
- Local authorities
- Emergency departments
- Community child health
- Youth justice system – including youth offending teams, liaison and diversion services, children and young people’s secure estate.
- Substance Misuse services
- Sexual Assault Referral Centres (SARCs)
- Job centres and careers advice
- Local independent providers.
- Local Mental Health Trust’s
- Housing providers

### **3.17 Transparency and openness**

Providers will be required to be open about their service and share relevant information publicly whenever possible. They will:

- Shared information as appropriate with NHS Digital
- Will be open when errors occur and harm is caused, in accordance with the Duty of Candour
- Meet in full the local reporting requirements

## **4. Applicable Service Standards and Treatment Pathways**

### **4.1 Applicable national standards (e.g. NICE) and Evidence Based Treatment Pathways (including Referral to Treatment timeframes)**

This specification links to the following NICE Quality Standards and will be reviewed upon the publication of further guidance.

Please note that the list is not exhaustive.

**NICE quality standards relating to mental health and emotional wellbeing of children and young people**

NICE Quality Standard/ Guideline number	Title and link	Published	Review	Age range
QS31	<a href="#">Health and wellbeing of looked-after children and young people</a>	April 2013	Apr 2018	0–18
QS34	<a href="#">Self-harm</a>	June 2013	June 2018	Children and young people from 8 and adult
QS39	<a href="#">Attention deficit hyperactivity disorder</a>	July 2013	July 2018	Children and young people from 3 and adult
CG28	<a href="#">Depression in children and young people</a>	Sept 2005	Dec 2015	<18
QS48	<a href="#">Depression in children and young people</a>	Sept 2013	Sept 2018	5–18
QS51	<a href="#">Autism</a>	Jan 2014	Jan 2019	Lifespan
CG 128	<a href="#">Autism diagnosis in children and young people</a>	Sept 2011	Nov 2014	<18
QS53	<a href="#">Anxiety disorders</a>	Feb 2014	Feb 2019	Lifespan
PH 4	<a href="#">Interventions to reduce substance misuse among vulnerable young people</a>	March 2007		< 25
QS59	<a href="#">Antisocial behaviour and conduct disorders in children and young people: pathway</a>	April 2014	April 2019	< 18
CG 158	<a href="#">Antisocial behaviour and conduct disorders in children and young people: recognition,</a>	March 2013		<18

	<a href="#">intervention and management</a>			
CG9	<a href="#">Eating disorders</a>	January 2004	Tbc 2017	Children and young people from 8 and adults
CG78	<a href="#">Borderline personality disorder</a>	January 2009	January 2015	Adults and young people (<18)
CG 155	<a href="#">Psychosis and schizophrenia in children and young people</a>	January 2013		< 18

### Evidence based treatment pathways

Over the next five years, NHS England will be working with ALB partners to develop **evidence-based treatment pathways** and the supporting infrastructure required to enable their implementation. Each of the pathways will be designed to span the journey from 'referral to treatment and recovery' including start of NICE concordant treatment. Below are the published and pending publications relating to meeting the mental health needs of children and young people.

#### Already published

- [Early intervention in psychosis](#) – the standard is targeted at people aged 14-65.
- [Community services for eating disorders in children and young people](#) (this will be extended during 2016/17 to include in-patient and day patient services within the pathway)

#### Planned for 2016/17

- Generic children and young people's mental health – to be published 2017
- Perinatal mental health
- Urgent and emergency mental health care for children and young people (including 'blue light' mental health response - all ages)
- Acute mental health care

#### Planned for 2017/18 and 2018/19

- Self-harm

## 4.2 Standards for children and young people and parents'/carers' participation

It is important that children and young people and their family/carers are involved at every level of service provision. This includes on an individual treatment level where we know it improves outcomes when children, young people and their family/carers are involved in shared decision making on their own treatment, setting goals that have a meaning for them, and using their feedback to guide their treatment.

It is also essential to involve children and young people, family/carers and others that

come into contact with children and young people regularly such as schools, in the development and improvement of services.

Children, young people's and family/carers feedback, when combined with other outcome metrics, is an important part of service monitoring and effective ways to capture feedback from children and young people and their families/carers should also be considered.

Providers will ensure that all service developments and/or redesigns are undertaken using co-production with children and young people and their families/carers as well as all other relevant agencies.

#### **4.3 Applicable standards set out in guidance and/or issued by a competent body**

For example

- [Quality Network for Community CAMHS Standards](#) (QNCC)
- [Quality Network for Inpatient CAMHS Standards \(QNIC\)](#)
- [Youth Wellbeing Directory and ACE-V Quality Standards](#)
- [Child Outcome Research Consortium](#) (CORC)
- [Choice and Partnership Approach](#) (CAPA)
- [THRIVE Framework](#)

**Associated policy documents:**

- [Implementing the Five Year Forward View for Mental Health](#)
- [Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21](#)
- [The Five Year Forward View for Mental Health](#)
- [Future in Mind \(2015\)](#)
- [Achieving Better Access to Mental health Services by 2020](#)
- [No Health without Mental Health. Department of Health \(2011\)](#)
- [Talking Therapies, a 4-year plan. Department of Health \(2011\)](#)
- [Closing the Gap. Department of Health \(2014\)](#)
- [NHS and Social Care Act \(2011\)](#)
- [Children and Families Act \(2014\)](#)
- [Mandate to Health Education England](#)

- [Chief Medical Officer's Annual Report on State of Public Health \(2014\)](#)
- [Behaviour and Discipline in Schools, Department of Education \(2014\)](#)
- [Public Services \(Social Value\) Act 2012](#)
- [Five Year Forward View](#)
- [Forward View into action: Planning for 2015/16 guidance](#)
- [Personal Health Budgets](#)
- [Choice of Provider Initiative](#)
- Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England, March 2015  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf)
- House of Commons Education Committee: Mental health and well-being of looked-after children, Fourth Report of Session 2015–16  
<https://publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf>

#### 4.4 Applicable local standards

The provider will meet the following local standards:

**INSERT FRAMEWORK HERE**

### 5. Applicable quality requirements and CQUIN goals

#### 5.1 Applicable quality requirements (See National Contract Schedule 4 Parts A-D)

CYPMHS are not included in the National Operational Requirements or the National Quality Requirements. Quality will therefore be regulated through local quality requirements. The most effective quality requirements will be those developed through frank and realistic dialogues between commissioners, providers and the children/young people and families/carers in the local population. This process has informed the development of a local outcomes and performance framework that will be the basis for the quality schedule

**INSERT FRAMEWORK HERE**

Full reporting of this should occur in accordance with local agreement (typically monthly).

Quality requirements should work from existing quality levels and function as a mechanism for driving continuous improvement in achievable and sustainable ways, and towards quality standards set out in Section 4, and according to Health and Social Care Outcomes Frameworks. Where possible, quality requirements should be aligned with specific measurable outcomes (see 5.3).

Quality requirements should be operationalised so that progress can be tracked on a quarterly basis and measured in steps that are agreed through dialogue with stakeholders.

## **5.2 Data recording must include:**

All services providing NHS-funded CYPMHS must be locally collecting and using [Mental Health Services Data Set](#) which has been approved by the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England.

Full reporting of the local outcomes and performance framework should occur in accordance with local agreement (typically monthly)

## **5.3 Health and Social Care Outcomes Frameworks**

The [Department of Health and Social Care Outcome Frameworks](#) are an interrelated architecture of indicators to guide the setting of quality requirements.

## **5.4 Feedback and Outcomes Tools**

Providers should use the tools that best facilitate continuous quality improvement in their clinical practice to ensure quality requirements are meaningful both in tracking progress and for day-to-day clinical work and collaborative practice.

- **Applicable CQUIN goals (See Standard Contract Schedule 4 Part E)**

## **5.6 CYP MHS (CAMHS) Currencies Programme**

NHS England has commissioned work to develop a new system of payment for CYP MH services. Rather than being based on specific conditions or treatments, the programme is developing a system based on the relative need of individuals. An initial phase of the project ran from October 2011 until 30th April 2015. The [final report](#) identified potential needs based categories and advocated further testing and research prior to introduction of a payment by results payment system. A second phase of the programme, testing the groupings with providers commenced in summer 2016.

## **5.7 CYP MH / CAMHS Modelling tool pilot**

NHS England are developing a [Strategic Modelling Tool](#) to help plan and improve the commissioning and delivery of Children and Young People's Mental Health Services across health, education, third sector, and local authority services. An initial model has been developed designed to help commissioners and their partners across health and care communities to take a system-wide overview of local need and services, and support decision-making to improve services efficiently. It directly supports the recommendations in [Future in Mind](#) and the Five Year Forward View for Mental Health. NHS England is

considering potential improvements to aid implementation, including a web-enabled version.

## 6. Location of Provider Premises

**The provider's premises are located at:**

**Main site:**

North West Boroughs Partnership NHS Foundation Trust  
Hollins Park House  
Hollins Lane  
Winwick  
Warrington  
WA2 8WA

The majority of children and young people's mental health services will be provided from a range of borough specific venues.

## 7. Individual Placement

Not applicable

## APPENDIX 1 – SPECIFICATION OF SPECIFIC GROUPS WITHIN THE THRIVE MODEL

THRIVE is described by its originators as “a radical shift in the way that services are conceptualised and potentially delivered”.<sup>15</sup> Rather than adopting the tiered approach that determines need in relation to types of service provision, the THRIVE model tries to identify “resource-homogenous groups ... who share a conceptual framework as to their current needs and choices.” In doing so, it creates four “clusters” or “groups” of types of young people with mental health issues among the wider population in the community who are “thriving”. These groups are:

- Getting Advice
- Getting Help
- Getting More Help, and
- Getting Risk Support

The THRIVE model is set out diagrammatically below.



The groups or “clusters” are intended to be distinct in relation to:

- The needs of the young people in each group
- The skill mix required to work with the young people in each cluster
- The dominant metaphor used to describe the needs of young people in the cluster (for instance whether young people are described in terms of ill-health or needing support)
- The resources required to work with young people in the clusters

<sup>15</sup> THRIVE Elaborated, Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust, 2015, p.6

It is important to note therefore that the clusters do not focus on diagnostic need – that is as there is no one-to-one relation between severity or type of problem and grouping.

**Weightings per cluster for Warrington – comparing the prevalence where 90% are Thriving and current treatment population**

	Expected prevalence figures using 90% who are THRIVING	50% of expected prevalence	Current treatment population
Getting Advice	1,345	673	492
Getting help	2,689	1,345	985
Getting more help	224	112	82
Getting risk support	224	112	82
<b>Total</b>	<b>4,482</b>	<b>2,241</b>	<b>1,641</b>

Local co-design has led to the development of a local 'THRIVE' model – see appendices 2 - 5.

## Appendix 2 - Scope

### Aims and objectives – GETTING ADVICE

**Key principles of ‘getting advice’:** one to three contacts which end by mutual agreement. This level of support is sufficient to normalise behaviour and provide reassurance or to provide full assessment to identify treatment goal/pathway.

The lead provider shall, in partnership with sub contracted providers:

- Provide system wide and clinical leadership across the local authority area, including working with partners (e.g. third sector, public health, universal services, early help, schools) to ensure a ‘getting advice’ offer is embedded within the local authority footprint and integrated within local processes (e.g. prevention hubs, multi-agency safeguarding hub etc.).
- Provide a rolling programme of core training across the local system based on local need and in consultation with each local authority, e.g. training for foster carers.
- Partner with one or more non-NHS organisations (e.g. the third sector) to develop a blended offer. This should ensure robust evidence based practice and a right decision first time approach, yet at the same time capitalise on the ethos and flexibility of non-statutory organisations to provide non-stigmatizing, easily accessible ways to access early information, advice and signposting that will promote resilience and help prevent emotional wellbeing issues from escalating. Innovative approaches to workforce development and planning should be developed to support this.
- Ensure there is an electronic referral process to allow direct referral in for intervention primarily for confident referrers, e.g. primary care, school nursing. Referrals should only be accepted electronically, (and from primary care only through the referral assistance gateway); the option for direct booking through eRS should be developed. It is suggested this be a central administrative function, possibly across a number of boroughs (with a triage function if needed to ensure prompt allocation to appropriate pathways, e.g. eating disorders, early intervention in psychosis (see relevant service specifications), and appropriate THRIVE/other clinical pathways).
- Use capacity and demand planning to inform the number of clinical sessions required within ‘getting advice’ and consider developing direct online booking to help with service planning.
- Develop a ‘no wrong front door’ approach to ensure quick and easy access to the full range of need from very mild and transient to severe and complex. By offering consultation, indirect information, advice and support and direct access through ‘drop ins’ it is anticipated that more young people will receive more timely, higher quality brief interventions whilst those that require further assessment and intervention can be directed to the appropriate THRIVE pathway in a more responsive way (including direct access to crisis support). This ‘no wrong front door’ offer should include:
  - The development of a central emotional health and wellbeing hub and/or a number of spokes within each borough (wherever possible within local community venues) that provide information, advice and signposting/support for families to navigate the local offer AND the option for drop in appointments with experienced mental health practitioners that can provide brief interventions (typically 1-3 contacts). This may

also include consultation or a screening assessment to ensure that young people get on the right pathway first time e.g. for full assessment and formulation, transfer to the right THRIVE/clinical pathway.

- Access to telephone advice and support for referrers including from potential self-referrals with an out of office hours component that is developed and increased over time
- Access to online information, advice and counselling.
- The development of a core offer for schools including a named mental health link person that can provide consultation on a regular basis from an experienced mental health practitioner to enable schools to improve their confidence and skills in responding to mental health and wellbeing needs and to ensure that where there are concerns that there is effective and timely decisions about the appropriate pathways to follow.
- Provide a supervision offer across the system to support wider practitioners that offer interventions, e.g. school staff, youth service staff
- Integrated approach to supporting the needs of the most vulnerable children and young people by ensuring mental health expertise and consultation is embedded within the safeguarding 'front door'.
- A pro-active approach to providing support to the most vulnerable groups who may not access health services in the traditional way, e.g. children and young people known to children's services and social care, young offenders, those with disabilities including neurodevelopmental concerns.
- Ensure there is clearly defined and agreed, robust direct access to pathways for children and young people in mental health crisis, that wherever safe to do so, provides support at home and avoids admission, (see appendix 6 re: crisis response) and that young people can move between the THRIVE pathways flexibly depending on current need.
- Ensure all meaningful direct and in-direct contacts from all partner providers are captured electronically and reflected in the mental health services data set. Consideration will need to be given in particular to how valuable indirect contacts and consultation are recorded and reported.

Young people are very clear that they want to be able to access advice and support autonomously and confidentially without requiring a referral or having to go via their GP. These principles should be embedded within the 'getting advice' offer and young people should be lead partners in the design of this offer. In 'getting advice' children and young people would typically be expected to receive between 1 and 3 contacts.

### **Getting Advice Care Pathway**

[Insert overview pathway here](#)

#### **Hours of Operation:**

This element of the THRIVE model will not have set hours of operation but will be flexible to ensure it is available when service users would prefer to access it. It should cover a minimum of 6 days per week. Elements of the service that are provided into schools should be provided between 8.30am and 4.30pm. Other elements of the service, e.g. drop ins, should primarily be provided on weekday afternoons/evenings and Saturday 11am – 3pm.

**Does Not Attend (DNA) /Re-engagement policy**

DNA policies will not apply for the flexible, drop-in elements of this service. Where booked appointments are offered this should align with the requirements outlined in section 3.9

**Acceptance criteria**

- Must be a Warrington resident or registered with a Warrington GP
- Ages 0-18 years inclusive (0-25 years inclusive for looked after children and children with education health and care plans – see section 3.5 above regarding transition and accepting referrals post 18 years).

No formal referral will be required, though the consultation or contact may generate a referral into another part of the THRIVE pathway. Where it is identified a young person requires full assessment and formulation the information collected should be added to an electronic patient record (this would simultaneously become the point of referral and the first contact) and any further assessment should build on the information collected in order that children, young people and families are not required to repeat the same information. The provider should work pro-actively to ensure vulnerable groups are fully represented within this cohort. All direct and indirect contacts should be recorded electronically.

**Exclusion criteria**

- 18 years and over (or 26 years and over for looked after children and young people with education, health and care plans – see section 3.5 regarding transition).
- Not a resident of Warrington or registered with a Warrington GP.

## Appendix 3 - Scope

### Aims and objectives – Getting Help

**Key principles of ‘getting help’:** children and young people who benefit from time limited, goal-focused, evidence-based interventions with clear aims. The number of contacts will vary, however the THRIVE authors propose the mean number of contacts will be around 10, but that fewer children and young people will be seen for extended periods of time if the intervention is not proving effective.

The lead provider shall, in partnership with sub contracted providers:

- Ensure there is a clear route in via ‘getting advice’ pathways.
- Provide time limited, goal focussed, evidence based ‘talking therapies’ for a range of needs (typically mild to moderate in nature) in a range of community based, school and health locations, and via remote access e.g. skype/online, including but not exhaustively:
  - Anxiety including generalised anxiety disorder/social anxiety disorder
  - Bipolar disorder
  - Depression
  - Emotional/behavioural difficulties and/or conduct disorder
  - Emerging personality disorder (likely to be in ‘getting more help’)
  - Learning disabilities
  - Mental health concerns secondary to neurodevelopmental difficulties
  - OCD
  - Phobias
  - Post-traumatic stress Disorder of difficulties relating to trauma, including that related to abuse and neglect.
  - Self-harm
- The lead provider in partnership with other partners will ensure the full range of evidence based pathways can be offered to meet local need making best use of workforce across partners to ensure choice for families and efficient use of resources.
- Typically this level of support would NOT include psychiatric involvement but there should be the option to receive this support where required.
- IAPT principles should be embedded within this pathway – in particular there should be a focus on developing a culture of service user engagement and participation and consistent and embedded use of routine and goal based outcome measures and a focus on the use of evidence based interventions.
- Ensure there is clearly defined and agreed, robust direct access to pathways for children and young people in mental health crisis, that wherever safe to do so, provides support at home with consistency of practitioner, and avoids admission (See appendix 6 re: crisis) and that young people can move between the THRIVE pathways flexibly depending on current need.
- The service should ensure vulnerable groups are represented at the levels expected for the local population. This will require design of pathways (in partnership with vulnerable or minority groups) that are flexible and proactive with scope for reasonable adjustments to achieve equity of outcome. For example, timeliness of intervention for young people on the edge of care or

entering the youth justice system which might include joint home visits with a social worker or youth justice worker.

### Getting Help Care Pathway

#### **INSERT or REFERENCE PATHWAY**

**Hours of Operation:** This will typically be between the hours of 9am – 5pm (with a choice of providers and venues). The online offer should include offer bookable counselling sessions up to 10pm including weekends. The service should provide the option for evening or weekend appointments where this is needed to ensure a young person's needs are met.

#### **Does Not Attend (DNA) /Re-engagement policy**

Where booked appointments are offered this should align with the requirements outlined in section 3.9

#### **Acceptance criteria**

- Must be a Warrington resident or registered with a Warrington GP
- Ages 0-17 years inclusive (0-25 years inclusive for looked after children and children with education health and care plans – see section 3.5 above regarding transition and accepting referrals post 18 years).
- It has been identified, either via the 'getting advice' pathways or following intervention in 'getting help' that a young person could have improved mental health and wellbeing outcomes following an episode of evidence based intervention and there is no other clinical pathway that can better meet that need.

#### **Exclusion criteria**

- 18 years and over (or 26 years and over for looked after children and young people with education, health and care plans – see section 3.5 regarding transition).
- Not a resident of Warrington or registered with a Warrington GP.
- Meets criteria for specialist pathways where available, e.g. eating disorders, early intervention in psychosis.

## Appendix 4 - Scope

### Aims and objectives – Getting More Help

**Key principles of ‘getting more help’** - provide more intensive, specialist evidence based treatment interventions, that aim to keep young people at home and prevent admission, however it should have a strong inter-relationship with and clear pathways into and out of in-patient units where this is needed. Note: this would exclude those young people with an eating disorder or psychosis whose needs should be met by the separately commissioned pathways. It is therefore anticipated that this group will include young people with emerging personality disorder or difficulties of severe impact/high risk where self-harm or severe conduct issues may feature.

The lead provider shall, in partnership with sub contracted providers:

- Ensure there is a clear route in via ‘getting advice’ pathways.
- Ensure this is not a completely separate team to the other groupings. Rather the focus should be on robust clinical pathways and flexible use of workforce across the groupings to enable a flexible response to need. For example, where a young person is initially offered support more akin to ‘getting help’ but it becomes evident that they require more intensive, coordinated support, it is expected this will be a natural continuation of support wherever possible with consistency of practitioner.
- Provide goal focussed, evidence based treatment for a range of more complex or severe presenting need in a range of community based, school and health locations, and via remote access e.g. skype/online. This will include those that require more intensive support including appropriate ‘talking therapies’ with greater need for (but not exclusively) to include systemic interventions and pharmacological interventions, multi-agency care planning and management of risk, including intensive home based treatment when required. Clear clinical pathways will be developed.
- IAPT principles should be embedded within this pathway – in particular there should be a focus on developing a culture of service user engagement and participation, consistent and embedded use of routine and goal based outcome measures and a focus on the use of evidence based interventions.
- This grouping should be closely aligned with crisis pathways and where a young person who is already ‘getting more help’ requires a response due to crisis, this should wherever possible be provided by the staff currently working with them and in line with national access and waiting time standards.
- The service should ensure vulnerable groups are represented at the levels expected for the local population. This will require design of pathways (in partnership with vulnerable or minority groups) that are flexible and proactive with scope for reasonable adjustments to achieve equity of outcome. For example, timeliness of intervention for young people on the edge of care or entering the youth justice system which might include joint home visits with a social worker or youth justice worker.

**Getting More Help Care Pathway**

INSERT PATHWAYS HERE

**Hours of Operation:** Due to the nature of the needs of this group, the provider(s) should engage with young people, families and partners to understand the most appropriate times of operation to meet need and achieve the desired outcomes. It is anticipated that this will require flexibility to deliver services in the evenings and weekends and this should be an area of development for the service.

**Does Not Attend (DNA) /Re-engagement policy**

Where booked appointments are offered this should align with the requirements outlined in section 3.9

**Acceptance criteria**

The service has clear acceptance criteria that are available to referrers,

- Must be a Warrington resident or registered with a Warrington GP
- Ages 0-17 years inclusive (0-25 years inclusive for looked after children and children with education health and care plans – see section 3.5 above regarding transition and accepting referrals post 18 years).
- It has been identified that a young person could have improved outcomes from an extended period of coordinated, evidence based treatment/support.

**Exclusion criteria**

- 18 years and over (or 26 years and over for looked after children and young people with education, health and care plans – see section 3.5 regarding transition).
- Not a resident of Warrington or registered with a Warrington GP.
- Meets criteria for specialist pathways where available, e.g. eating disorders, early intervention in psychosis.

## Appendix 5 - Scope

### Aims and objectives – Getting Risk Support

**Key principles of ‘getting risk support’** – this group includes those children and young people who are currently unable to benefit from evidence-based treatment but remain a significant concern or risk, including those who routinely go into crisis or don’t make use of help. The focus of ‘getting risk support’ is a multi-agency approach/having joint processes to share and manage risk. It should be noted that in this grouping, an evidence based health intervention is NOT being offered. The locally developed model has focussed on this being a ‘team around the professional’ approach. Young people should be able to move in and out of this grouping as needed, for example, once their home circumstances stabilise or when they are ready to move into ‘getting help or more help’.

The lead provider shall, in partnership with sub contracted providers:

- Develop robust integrated pathways in partnership with the Local Authority that are embedded within the early help, safeguarding and social care frameworks, and include close working with education.
- Explore co-location of staff to facilitate joint working and robust shared processes.
- Ensure psychiatric oversight and support and where needed psychiatric input.
- Develop and agree clear criteria for when a young person would benefit from ‘risk support’.
- Provide consultation and indirect support to children’s services to enable informed decisions about the most appropriate THRIVE grouping for a young person.
- Endeavour to work with partners to provide a ‘team around the professional’ approach that supports partners to support the young person/family and enables shared management of risk.
- Work with colleagues across early help, education, social care and health to identify with the young person/family who is best placed to be the young person’s key person. An effective relationship based on the principles of ‘therapeutic alliance’ will support improved outcomes and reduce the risk of disengagement caused by ‘hand offs’ in order that a team around the professional approach can be delivered.
- Work with partners to develop a joint approach to young person and family centred care planning. This should include care planning with the young person/family to identify how best to keep themselves safe and what to do in a crisis.
- Work with the Local Authority to develop robust, shared policies and processes for safe and effective shared management of risk that are approved through individual organisational governance processes. This should include protocols for information sharing and consent.

It is anticipated that significantly higher levels of vulnerable young people will access ‘risk support’ pathways, including those that have experienced neglect, abuse and trauma. This will certainly require design of pathways (in partnership with vulnerable or minority groups) that are flexible and proactive to ensure risk is reduced and the

chance of a young person moving from risk support' to another THRIVE grouping is increased. Typical NHS policies around non-attendance would not apply.

Workforce planning and staff training and development will require careful consideration due to the complex nature of the needs of the young people and the development of new multi-agency pathways, policies, processes and governance.

### **Getting Risk Support Care Pathway**

Insert here

#### **Hours of Operation:**

Due to the nature of the needs of this group, the provider(s) should engage with young people, families and partners to understand the most appropriate times of operation to meet need and achieve the desired outcomes. It is anticipated that this will require flexibility to deliver services in the evenings and weekends and this should be an area of development for the service.

#### **Does Not Attend (DNA) /Re-engagement policy**

Typical NHS policies around non-attendance would not apply – the provider(s) should work with partners e.g. social care and education, indirectly where required, to ensure risk is managed.

#### **Acceptance criteria**

The service has clear acceptance criteria that are available to referrers,

- Must be a Warrington resident or registered with a Warrington GP
- Ages 0-17 years inclusive (0-25 years inclusive for looked after children and children with education health and care plans – see section 3.5 above regarding transition and accepting referrals post 18 years).
- It has been identified that a young person presents as high risk but is not currently able to access help in terms of evidence based mental health interventions. It is considered a multi-agency approach in partnership with the family to share and contain risk is required at this time.

#### **3.5 Exclusion criteria**

- 18 years and over (or 26 years and over for looked after children and young people with education, health and care plans – see section 3.5 regarding transition).
- Not a resident of Warrington or registered with a Warrington GP.
- Would have improved outcomes from any other support, pathway or intervention that is available locally (not just those offered by mental health providers).

## Appendix 6 - Scope

### Aims and objectives – Crisis Response

**Key principles of ‘crisis response’** – some young people may not receive the appropriate help at an early enough stage or their mental health may continue to deteriorate. Despite the ongoing continuous improvement of services to work to intervene earlier and prevent deterioration, there will be occasions when a young person experiences a ‘mental health crisis’. “This can be very difficult to manage, for family and friends, and the services that respond. All may have to deal with suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control, or irrational and likely to endanger the person or others” (Crisis Care Concordat, DOH, 2014).

Locally, partners will work together to deliver the THRIVE model to increase access, reduce waiting times and provide appropriate, evidence based support by appropriately skilled practitioners based on need. However, it is essential that there is also a robust pathway that ensures a very timely response for young people in mental health crisis, delivered by the provider along with a range of partners, that aligns with the THRIVE offer in each borough.

There is already a well-established crisis response service for children and young people that is provided by the CAMHS assessment and response team (CART). This provides a duty service and assessment/response for young people in crisis between the hours of 8am and 8pm. Typically, this involves a response within 24 hours, most often to the hospital where a young person has presented to A&E/has been admitted, but can also include a response/assessment at home, in custody or at another health venue. In addition, there is a dedicated young people’s hospital liaison service between the hours of 8pm and midnight, 7 days a week (see the liaison psychiatry service specification), and sleeping on call for overnight.

Across the boroughs of Halton, Knowsley, St Helens and Warrington, there are higher than national average levels of presentations to A&E and admission for mental health and self-harm; and in some of the boroughs, very high levels of admission to tier 4 beds, with extended length of stay and high levels of re-admissions. It has also been identified that there are ‘frequent attenders’ – those young people that require more than one crisis response because they re-present on a number of occasions.

Nationally, there is mental health crisis guidance for children and young people currently in development. With this in mind, and given the provider(s) will be working to implement the THRIVE model, there is agreement across provider(s) and commissioners that the current crisis offer will need to evolve and change. A particular driver for this is the expectation that there will be new ambitious national waiting time standards of a 1 hour response to start of assessment and a 4 hour response to start of treatment (to be confirmed on publication).

It is therefore only possible at the time of developing this service specification to outline that the provider will continue to deliver the current crisis offer and outcome and performance indicators, whilst work is undertaken to consider how the current local crisis pathway needs to develop to meet new guidance and standards and align

with the emerging THRIVE model of delivery.

The lead provider shall:

- Continue to provide a robust crisis response, that as a minimum provides assessment within 24 hours while the service is developed to align with THRIVE and new national waiting time standards for crisis response.
- Provide a crisis response in the most appropriate location for a young person including A&E/paediatric wards at hospital, in custody, at home or other health/community venues. If there are no physical healthcare needs, a young person should not be asked to attend A&E for a crisis mental health assessment.
- If a young person is already known to mental health services, wherever possible, the assessment should be carried out by a clinician known to the young person.
- Ensure a full assessment is carried out that includes a thorough risk assessment. Work with the young person and family to agree a care plan which should include a risk management plan where relevant. The care plan (which should be provided in writing) should outline plans for any follow-up, treatment or onward referrals. Where timely intervention is required to reduce risk and enable a young person to function, treatment should commence immediately or in a timely way within the subsequent days. Where ongoing treatment is required, the team should work with the young person and the borough based teams to support transition to the appropriate THRIVE pathway.
- Where required, work in line with the mental health capacity act (1983).
- Ensure team members have the appropriate knowledge, skills and experience to provide a crisis response. The team will have support and oversight from Consultant Psychiatry.
- Have in place systems to identify young people that have previously required assessment in crisis. Work closely with borough teams, social care and other partners to identify young people at risk of crisis and put in place a proactive risk management plan.

### **Crisis Pathway**

Insert here

### **Hours of Operation:**

8am – 8pm 7 days a week, with sleeping on call overnight.

This team also provides a liaison offer 8pm – midnight (part of the liaison psychiatry service specification) at local hospitals.

### **Does Not Attend (DNA) /Re-engagement policy**

Not applicable

**Acceptance criteria**

The service has clear acceptance criteria that are available to referrers,

- Must be a Warrington resident or registered with a Warrington GP
- Ages 0-17 years inclusive
- Presents in mental health crisis, including when at significant risk of self-harm or suicide.

**3.5 Exclusion criteria**

- 18 years and over
- Not a resident of Warrington or registered with a Warrington GP.

**Appendix 7 - Scope****Aims and objectives – Warrington Schools Initiative (October 2017 – March 2019)**

**Key principles of Warrington School's Future in Mind Offer** – the vast majority of children and young people are accessing some form of education and/or training provision where staff have a duty of care, including for their mental health and wellbeing. Education colleagues often get to know the young people in their care very well and are therefore well placed to identify concerns around their wellbeing. It has been recognised nationally that schools/education settings have a significant role to play in promoting positive mental wellbeing and resilience. Whilst this is a responsibility that schools already undertake, historically there has been a 'disconnect' between schools and mental health support services for children and young people.

In Warrington (from 2016), NHS Warrington Clinical Commissioning Group has been working in partnership with schools and Public Health to support the training and development of education colleagues. An evaluation of this work identified the need to provide continued support, supervision and consultation for staff to enable them to confidently and competently support young people with mental health needs that are mild to moderate in nature. This has led to discussions to develop more joined up pathways and processes between CYP's mental health services and schools/education settings.

A number of secondary schools have therefore committed some collective resource to part fund the equivalent of 1.0 whole time equivalent band 6 practitioner to develop an extended link school offer. The aims of this offer (for the participating schools) are:

- to embed a culture of joint working across health and education to ensure the wellbeing needs of all young people are met
- to enable school staff to have a named contact from children's mental health

services

- to provide regular consultation to key pastoral and SEN staff within each school
- to set up a system of supervision and support for staff that have undertaken specific training around mental health and are regularly involved in providing support or brief interventions to young people
- to identify training needs and in partnership with Public Health and schools, provide a regular training offer for school staff.

The lead provider shall:

- provide one consultation session for each participating school per half term.
- Set up systems for ongoing supervision for school staff that have undertaken mental health training and support young people on a regular basis.
- support the monitoring and evaluation of targeted students, making appropriate recommendations to school staff for further action and intervention.
- be familiar with appropriate specialised programmes and support and enable school staff in the delivery of the programmes.
- work with school staff effectively to ensure effective interventions and support for students.
- support the assessment of students' needs and further interventions.
- help support and produce relevant resources for mental health and wellbeing programmes.
- work in partnership with schools to identify training needs and agree with partners which training needs can be met by the training offer provided (separate from this specification). Facilitate general student sessions through other providers, e.g. Kooth
- report to school staff, confidentially, regarding outcomes and nature of referrals and support
- work closely with the schools where a young person remains on roll but is out of school to ensure that young person receives any appropriate support and intervention from CYPMHS which could facilitate them returning to school
- Monitor and evaluate the effectiveness of this initiative
- produce concise reports (at least x3 a year either on a termly basis or in line with contractual reporting to the NHS Warrington Clinical Commissioning Group – to be agreed) to school leadership teams including the reporting of agreed performance indicators and some narrative outlining support undertaken, actions and developments with school staff

**INSERT REPORTING FRAMEWORK HERE**

### **Schools Pathway**

Insert here

### **Hours of Operation:**

8.30 – 5pm, 5 days a week – exact times to be arranged with individual schools.

### **Acceptance criteria**

This is primarily a training and consultation offer. Schools will be able to (confidentially and where consent from parents/carers has not been gained, anonymously) get advice and support from the practitioner regarding any young person in their school. The service will put in place robust processes for recording and monitoring these discussions. Schools will need to ensure their own internal processes are robustly developed to meet their own requirements and support the effective delivery of this work. Where a young person is currently under the care of the mental health service, all discussions should be recorded in the clinical record in line with the main service specification.

### **3.5 Exclusion criteria**

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