Havering Children and Young People’s Mental Health Transformation Plan

December 2015
## Contents

Foreword .................................................................................................................................................. 4

Executive summary .................................................................................................................................. 6

1. Vision.................................................................................................................................................. 8
   1.1 Principles of a comprehensive service ......................................................................................... 8

2. Emotional and mental health needs of children and young people in Havering ............................ 9
   2.1 Joint Strategic Needs Assessment ............................................................................................ 9
   2.2 Autism in Havering ...................................................................................................................... 16
   2.3 Transforming Care Programme .................................................................................................. 17
   2.4 Case for change ............................................................................................................................. 18

3. Current mental health service provision for children and young people ......................................... 19
   3.1 Current model – tiered approach ............................................................................................... 19
   3.2 Service provision by tiered support ............................................................................................ 20
      3.2.1 Tier 1 breakdown .................................................................................................................. 20
      3.2.2 Tier 2 breakdown .................................................................................................................. 22
      3.2.3 Tier 3 breakdown .................................................................................................................. 27
      3.2.4 Tier 4 breakdown .................................................................................................................. 28

4. Underlying principles for the transformation of mental health services for children and young people in Havering ..................................................................................................................... 30
   4.1 Local principles ............................................................................................................................. 30
   4.2 Whole system approach ............................................................................................................... 30
   4.3 Building resilience and promoting prevention ............................................................................. 30
   4.4 Make mental health everyone’s business ..................................................................................... 31
   4.5 Early intervention ......................................................................................................................... 31
   4.6 A system without tiers ................................................................................................................. 32
   4.7 No gaps ......................................................................................................................................... 33
   4.8 Better supporting children, young people and families with mild/emerging behaviour difficulties .......................................................................................................................................................... 33
   4.9 Reducing inequalities ...................................................................................................................... 33
   4.10 Lowest form of help first ............................................................................................................. 34
   4.11 Directed self-support ................................................................................................................... 35
   4.12 Better supporting vulnerable groups of children and young people ......................................... 35
   4.13 CAMHS looked after care specialist clinicians ......................................................................... 36
   4.14 Crisis support ............................................................................................................................... 37
   4.15 Recovery pathways ....................................................................................................................... 37
   4.16 Reintegrating young people into the community on leaving care .............................................. 38

5. Future model and proposed plan .................................................................................................. 39
   5.1 New model: quadrant approach .................................................................................................... 39
      5.1.1 Quadrant 1 ............................................................................................................................ 40
Appendix B

Appendix A

9. Governance, transparency and implementation plan ........................................... 55
10. Measuring outcomes ......................................................................................... 56
  10.1 Evidence based and outcome focused ....................................................... 56
  10.2 Designing our outcomes ......................................................................... 57
  10.3 KPIs identified ......................................................................................... 57
Appendix A – Model of care .................................................................................. 59
Appendix B – Finance tracker for in-year spend 2015/16, plus 2016/17 forecast .......... 59
  Additional detail on spend against allocation ..................................................... 60
Foreword

A message from the accountable officer of Havering CCG

We are delighted to have this opportunity to work with our partners, stakeholders, children and young people, their carers and families to change the way mental health services are delivered in Havering. We want all children to benefit from stable mental health and psychological wellbeing throughout their development into adulthood.

We are committed to ensuring that the development and delivery of the transformation plans for Children and Adolescents’ Mental Health Services (CAMHS) will be a whole-system approach. It will make services truly accessible and integrated for children and young people in the borough. We are confident that users of CAMHS will, over time, experience a significantly improved service and most importantly have positive outcomes.

The support of CAMHS transformation funds will enable us to accelerate these improvements, building capacity and capability across the system while being truly transformative in our approach – exploring new ways of working and new relationships with the community and voluntary sector to make our vision a reality.

Promoting emotional and mental health is a key priority for Havering CCG, the London Borough of Havering and our partners in the NHS, schools and voluntary and community sector organisations. We want all children in Havering to enjoy good emotional wellbeing and mental health. We want them to have happy and safe childhoods, and develop the skills and attitudes they need to become successful adults. A key part of this is to make sure that they have the emotional resilience that we all need to cope with life’s challenges.

The next five years will almost certainly be characterised by considerable challenges resulting from likely reductions in public expenditure. But these challenges also present opportunities for us to deliver innovative services, achieving the best outcomes for patients while providing the best value for money. The Health and Wellbeing Board is well placed to provide the strategic oversight to ensure the transformation plans are fit for purpose and delivered to the challenging timescales.

As local partners we look forward to developing and delivering transformed mental health services for children and young people in the borough, a transformation that crucially will be co-designed by the people who matter: our young people, their carers and families.

Conor Burke
A message from the director of public health and on behalf of Havering Health and Wellbeing Board

We want the very best for children and young people in Havering. We want them to have happy and safe childhoods, and develop the skills and attitudes they need to manage adult lives. A key part of this is to make sure that they have the emotional resilience we all need to cope with life’s challenges.

We know that many children and young people experience poor emotional and mental health, and that many lifelong mental health conditions begin in adolescence. We need to make sure that these children and young people have access to the best quality support at the earliest opportunity.

The emotional and mental health of children and young people is also a priority for the NHS nationally. In May 2015, a national taskforce for children and young people’s mental health published a major report, ‘Future in Mind’. This looked at how services for children and young people’s mental health are organised, the problems and issues with the current system, and what needs to change to make services better. The findings of this report were very consistent with the conclusions we had reached through our recent review of children’s emotional health and wellbeing services locally in Havering.

NHS England, the national body that coordinates the work of the NHS, asked clinical commissioning groups to develop a transformation plan for their local area, setting out what they want children and young people’s mental health services to look like in 2020, and how they intend to get there. We have been delighted to work with the CCG on this and are proud to present our transformation plan for Havering.

Dr Susan Milner
Executive summary

Havering has worked closely with its partners to develop a new approach to supporting children and young people in achieving good mental health. This new approach moves from a tiered structure to a seamless quadrant, within which young people can move around services according to their needs. We will establish a single point of access called the wellbeing hub, which will improve access and support for young people presenting with any mental health need, either through direct support or referral to other appropriate resources. The hub will remove previous limitations of access due to threshold criteria and will better support crisis management. We are also responding to local need by extending hours of access and we aim to reduce waiting times through the addition of extra capacity into the services.

Our new approach focuses on promotion of mental health and prevention of ill health through local initiatives including building resilience and early identification and support. We are taking a life-course approach, providing more early help services for new parents and a support framework via attachment classes and parenting courses. We will work closely with schools to provide resilience training to teachers and support staff so they are better equipped to support children with the many challenges facing them today.

We are responding to local service need by embedding a multi-disciplinary team approach to mental health, providing joint physical and mental health clinics for young people involved with the Youth Offending Service and pupil referral units. This will aim to reduce health inequalities among these young people in this area and tackle any barriers to improving mental health by addressing any physical health needs.

Key elements that Havering has considered within this local plan include:

- Improvements in early intervention to include building support for emotional needs (distinct from mental health), targeting investment in lower level and earlier help, such as counselling and cognitive behavioural therapy (CBT).
- Redesign services to remove the traditional tiers of CAMHS and have a single point of access for referrals, while exploring options for a dedicated service for looked after children.
- Investment in skills and training of parents, children themselves, and staff in universal services.
- Make use of new technologies, including developing a digital directory of services and digital platforms for assessing outcomes and for use in clinical settings.
- Joint working between agencies and co-location of workers, with a single point of access to services and integrated electronic records.
- Health promotion, prevention and early intervention through effective outreach into schools, primary care and hard to reach groups.
- Promote children’s self-help and self-management.
- Outcomes monitoring that looks at the whole pathway, and goals that are compatible with the new CAMHS payment by results and personal budgets.

These elements fit into five core themes, which are identified for specific development and investment for the remainder of 2014/15:

- Theme 1: Building resilience and promoting prevention
- Theme 2: Developing a wellbeing hub
- Theme 3: Maximising use of digital resources and guided self-support
- Theme 4: Better support for children, young people and families with mild/emerging behaviour difficulties
Theme 5: Better support for looked after children and those leaving care.

We are establishing a time limited children and young people’s mental health working group which will merge with the Adult Mental Health Partnership Board at a later date. This group will have responsibility for delivering this plan. We have budgeted for support staff to ensure evidence-based programme delivery. Governance arrangements have been agreed at the Health and Wellbeing Board, where updates will be presented.

A full breakdown of the in-year plans to spend our funding allocation for 2015/16, the anticipated spend for 2016/17, and additional detail of the spend against allocation; can be found in the appendices.
1. Vision

We want all children in Havering to enjoy good emotional wellbeing and mental health. Our vision is that children and young people in Havering are empowered to be resilient and able to cope with the challenges of everyday life. We envisage mental health to be seen as ‘everyone’s business’ and that people within a child’s sphere of influence understand their role to prevent poor mental health and to promote good mental health.

We want children, young people, their parents, and all professionals who work with them to be aware of local services and of how to access extra support where there are identified additional needs. Further, where those needs are indicative of underlying mental health conditions, support must be easily accessed and interventions are timely, evidence-based, and delivered by friendly, caring professionals.

We envisage services that are flexible and integrated, responding to varying levels of need including the additional needs of vulnerable children and young people, including looked-after children, children needing post traumatic recovery support, and children and young people with special educational needs and disabilities.

Our intention is to deliver seamless, integrated services that are flexible and graduated in their response to need. The support of CAMHS transformation funds will enable us to accelerate improvements, building capacity and capability, and exploring new ways of working.

Our new model is rooted in a new emphasis on prevention and promotion which seeks to enhance our existing offer to children and young people in Havering. We aim to improve knowledge and identification of low level mental ill health at universal level. We will put in place robust pathways for access to earlier help and support for young people and their families.

Where intervention and treatment is needed we will ensure children and young people receive services in accordance with access and waiting time standards. Our proposed new quadrant approach moves away from a tiered structure and will enable children and young people to move seamlessly between services. We will also ensure access is proportionate to need, in an effort to reduce health inequalities.

The next five years will almost certainly be characterised by considerable challenges resulting from likely reductions in public expenditure. We will work hard to deliver the best services while providing the best value for money. This can be done by achieving the vision of seamless, integrated services that are flexible and graduated in their response to need. The support of CAMHS transformation funds will enable us to accelerate these improvements, building capacity and capability across the system while being truly transformative in our approach, and exploring new ways of working and new relationships with the community and voluntary sector to make our vision a reality.

1.1 Principles of a comprehensive service

A comprehensive child and adolescent mental health service (CAMHS) incorporates all services that contribute to the emotional wellbeing and mental health care of all children and young people, which could be provided by health, education, social care or other agencies. A good CAMHS service should be able to provide care that:
• covers all ages (pre-birth to 18 years) as a minimum, with exceptions up to the age of 25 for those with special educational needs and disabilities where required
• addresses all emotional, behavioural and mental health needs
• provides services for children and young people with intellectual disabilities
• works across all interfaces: education, social care, youth justice, paediatrics and child health (including acute care, community child health, primary care, substance misuse, and adult mental health)
• addresses all levels of severity from prevention and early intervention through to intervention for children and young people with severe and complex problems
• supports other agencies and professionals working with children and young people
• focuses on the relationships and systems surrounding the child or young person, rather than simply taking an individual-based approach
• works through networks, collaboration and pathways with other agencies
• is based on identified need, taking into account the prevalence of mental health difficulties in childhood and adolescence on a recognised diagnostic model
• prioritises NICE clinical guidelines where these exist. Although they are not mandatory for trusts and commissioners, services as still expected to conform to them in the design and delivery of care.

2. Emotional and mental health needs of children and young people in Havering

2.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) on the mental health of children and young people in Havering provides a rigorous picture of the mental health needs of children and young people in the borough. It sets out the government strategy for mental health\(^1\), recognising that mental health problems contribute to creating cycles of inequality across generations. Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. All data below is from the JSNA.

2.1 Population level

Pre-school children
There is relatively little data about prevalence rates for mental health disorders in pre-school age children. A literature review of four studies looking at 1,021 children aged between two and five years found that the average prevalence rate of any mental health disorder was 19.6\(^2\). According to the Child and Maternal Health Intelligence Network, in 2013 there were 2,230 children aged between two and five years living in Havering who had a mental health disorder\(^3\).

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1 HM Government. (2011). No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages
3 CHIMAT [Accessed 1 November 2013]
**School-age children**

CAMHS services in Havering are heavily skewed toward secondary school aged children, with the 11 to 17 age group accounting for 64% of service users. We also know that demand for CAMHS is rising.

Current and projected numbers of children with mental health issues are based on prevalence rates using national predictive models. The following data estimates are likely to be an underestimation of local prevalence⁴:

- 9.1% of children aged five to 16 years (3,093 children) have a mental health disorder compared to 9.6% nationally.

This figure can be partially broken down as follows:

- 3.5% (1,194) have emotional disorders such as phobias, anxiety, OCD
- 5.5% (1,862) have conduct disorders such as aggression and vandalism
- 1.5% (505) have hyperkinetic disorders including hyperactivity and ADHD.

**Figure 1: estimated number of children in Havering with a mental health condition (2012)**

Based on the assumption that prevalence rates in Havering are in line with the CHIMAT annual needs assessment and the work of Green et al⁵, the following chart shows the expected numbers of children with a mental health disorder by age group and sex in Havering⁶ in 2013. The skewed profile of childhood deprivation across Havering means it is likely that the prevalence of mental health disorders is not uniform across the borough.

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⁴ Public Health Profiles, PHE, [Accessed July 2015]
⁵ http://bjp.rcpsych.org/content/191/6/493
⁶ Source: Office for National Statistics mid-year population estimates for 2012
Figure 2: estimated number of children with mental health conditions by age group and condition, 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>Boys (age 5-10)</th>
<th>Girls (age 5-10)</th>
<th>Boys (age 11-16)</th>
<th>Girls (age 11-16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less common disorders</td>
<td>186</td>
<td>33</td>
<td>139</td>
<td>92</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>228</td>
<td>33</td>
<td>209</td>
<td>34</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>186</td>
<td>206</td>
<td>348</td>
<td>512</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>583</td>
<td>231</td>
<td>705</td>
<td>428</td>
</tr>
</tbody>
</table>

Hospital Admissions
206 per 100,000 (279) young people 10 to 24 years were admitted to hospital as a result of self-harm in 2013/14. This is lower than the England average.

Results from an audit in A&E showed that there are ‘avoidable’ paediatric admissions. Staff reported seeing increased numbers of children with behavioural difficulties brought in by parents who are unable to cope with their behaviour, and whose GP did not know what to do.

A range of risk factors has been identified as making children and young people less resilient or more vulnerable to mental ill health:

- 19.6% of children aged under 16 (8,755) are in poverty (similar to England average)
- 11.8% of children in reception class (326) are obese (significantly higher than England)
- 1% of children aged under 15 (443) are providing unpaid care (similar to England average)
- 4.6% of young people aged 16 to 24 (1260) are carers (similar to England average)
- 130 per 100,000 parents of children aged 0 to 15 (58) are in drug treatment (similar to England average)
- 124 per 100,000 parents of children aged 0 to 15 (55) are in alcohol treatment (similar to England average)
- 10.5% of adults (20,191) are separated or divorced (lower than England average).

CAMHS client profile (Tiers 2 and 3)
The table below shows the number of individuals accessing CAMHS services in Tiers 2 and 3 by condition or concern. The services in these tiers include Havering specialist CAMHS, bridging service INTERACT, perinatal services and perinatal infant mental health services (PIMHS). A full description of these services can be read in section 3.2 or this report. The data provided does not allow separation of services provided directly to children and young people from those provided to support their mothers in parenting.

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7 DSR per 100,000 (age 10-24 yrs) for hospital admissions for self-harm, 2013/14, Havering Child Health Profile, PHE, 2015
8 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/
Number of individuals receiving Tier 2 or 3 Havering CAMHS in 2012/13:

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorders, including obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD)</td>
<td>542</td>
</tr>
<tr>
<td>Hyperkinetic disorders including attention deficit hyperactivity disorder (ADHD)</td>
<td>237</td>
</tr>
<tr>
<td>Autistic spectrum disorders</td>
<td>169</td>
</tr>
<tr>
<td>Conduct disorders, including anti-social behaviour</td>
<td>124</td>
</tr>
<tr>
<td>Deliberate self-harm, including overdose</td>
<td>116</td>
</tr>
<tr>
<td>Not possible to state</td>
<td>73</td>
</tr>
<tr>
<td>Developmental disorders</td>
<td>45</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
</tr>
<tr>
<td>Habit disorders including tics, soiling</td>
<td>34</td>
</tr>
<tr>
<td>Moderate to severe learning disabilities</td>
<td>32</td>
</tr>
<tr>
<td>Eating disorders including preschool problems</td>
<td>12</td>
</tr>
<tr>
<td>Substance abuse, drug and alcohol misuse</td>
<td>10</td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td>8</td>
</tr>
<tr>
<td>Null</td>
<td>623</td>
</tr>
<tr>
<td>Total</td>
<td>2065</td>
</tr>
</tbody>
</table>

The majority of CAMHS service users (84.2%) were white British, 4.3% were of unknown ethnic origin and the remaining 11.5% from a range of minority ethnic backgrounds. Services are heavily skewed towards adolescents, in line with the estimated mental health profile in Figure 1.

The profile in Figure 2 is markedly different to the profile of CAMHS service provision as set out in the above table, with the majority of CAMHS Tier 2 and 3 service provision\(^9\) focused on emotional disorders. This needs to be considered in light of the inclusion of data for two services that provide support to mothers, rather than directly to children.

Assuming the 124 individuals listed are children receiving a direct service (i.e. are not mothers aged 18 and over), CAMHS services for conduct disorders as the primary concern are currently provided to 0.2% of the 0 to 17 population and accounts for 8.6% of CAMHS service provision, excluding ‘null’ presentations from calculations (6% if null presentations are included).

Figure 3: number of children and young people receiving CAMHS by age

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\(^9\) Services include: ADHD Management, CAMHS Triage, INTERACT, Paediatric Liaison Team, Parent Infant Mental Health, Perinatal Team, Primary Mental Health Team and Tier 3 CAMHS
In 2012/13, Havering’s CAMHS provided Tier 2 and 3 services to 2,065 individuals. Not all those supported through Havering’s CAMHS live in Havering, and not all are registered with a Havering GP – 1,956 were registered with a Havering GP and 105 were registered with a GP out of the area\(^\text{10}\).

The majority of children receiving a CAMHS service are recorded as living in the RM1 area (47.8% or 987 individuals) and RM3 (22.9% or 473 individuals). These postcodes cover Romford town, Harold Wood, Harold Hill, Noak Hill and Harold Park. The RM7 postcode, which includes Rush Green, Mawneys and Romford, saw 11.7% of referrals.

**Most common primary need for CAMHS as a percentage of age cohort – females:**

<table>
<thead>
<tr>
<th>Age band</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Emotional disorders including OCD, PTSD 29%</td>
<td>Figures are suppressed</td>
<td>Figures are suppressed</td>
</tr>
<tr>
<td>5-10</td>
<td>Emotional disorders including OCD, PTSD 33%</td>
<td>Autism spectrum disorders 7%</td>
<td>Hyperkinetic disorders including ADHD 6%</td>
</tr>
<tr>
<td>11-15</td>
<td>Emotional disorders including OCD, PTSD 36%</td>
<td>Deliberate self-harm, including overdose 12%</td>
<td>Hyperkinetic disorders including ADHD 5%</td>
</tr>
<tr>
<td>16-17</td>
<td>Emotional disorders including OCD, PTSD 36%</td>
<td>Deliberate self-harm, including overdose 18%</td>
<td>Figures are suppressed</td>
</tr>
</tbody>
</table>

More males than females received a CAMHS service in 2012/13 (56% male, 44% female). The profile of presentation was markedly different based on sex:

- 542 individuals received services for emotional disorders: 313 (57%) were female and 333 (61%) were aged 12 to 17 years. Of these, 388 (72%) lived in RM1 or RM3
- 237 individuals received services for hyperkinetic disorders: 199 (84%) were male and 107 (45%) were aged seven to 11 years. Of these, 167 (70%) lived in RM1 or RM3, and 50 (21%) in RM5 or RM7
- 169 individuals received services for autistic spectrum disorders: 139 (82%) were male and 79 (48%) were aged five to 11 years. Of these, 122 (72%) lived in RM1 or RM3
- 124 individuals received services for conduct disorder: 104 (84%) were male and 88 (71%) were aged 10 to 15 years. Of these, 90 (73%) lived in RM1 or RM3
- 116 individuals received services for deliberate self-harm: 90 (78%) were female and 83 (72%) were aged 14 to 16 years. Of these, 79 (68%) lived in RM1 or RM3.

\(^{10}\) An additional four children do not have their GP recorded
Most common primary need for CAMHS as a percentage of age cohort – males:

<table>
<thead>
<tr>
<th>Age band</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Emotional disorders including OCD, PTSD 21%</td>
<td>Figures are suppressed</td>
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</tr>
<tr>
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<td>Emotional disorders including OCD, PTSD 15%</td>
<td>Autism spectrum disorders 13%</td>
</tr>
<tr>
<td>11-15</td>
<td>Emotional disorders including OCD, PTSD 22%</td>
<td>Hyperkinetic disorders including ADHD 18%</td>
<td>Autism spectrum disorders 14%</td>
</tr>
<tr>
<td>16-17</td>
<td>Emotional disorders including OCD, PTSD 23%</td>
<td>Hyperkinetic disorders including ADHD 10%</td>
<td>Autism spectrum disorders: 8% Conduct disorders including anti-social behaviour: 8%</td>
</tr>
</tbody>
</table>

Most service users are referred by their GP. Very few referrals are made directly by universal services such as school nurses (although some may have been included within the community health service count) or youth services. However, a review of Havering GP records showed just five children with a mental health diagnosis. Figures from other referral sources such as drugs services, family, friends or neighbours are suppressed due to low numbers.

Figure 1: source of referrals to Havering CAMHS, 2012/13
Figure 5 (right): estimated number of children aged 0 to 17 with mental health problems appropriate to a CAMHS response

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2 and 3 are based on estimates from Kurtz (1996)\(^\text{11}\). These are the standard rates used to inform the Child and Maternal Health Intelligence Observatory's annual CAMHS Needs Assessment for all England local authorities. Estimates are based on national estimates of prevalence; other socio-economic factors have not been taken into account.

Havering CAMHS currently provides Tier 2 and 3 services to a significantly lower number of individuals than average. This could be due to lower prevalence rates in the community, under-identification of mental health disorders in children, barriers to accessing CAMHS, locals accessing services through other providers, or a number of other factors.

### Needs of young offenders and those at risk of offending

The Youth Offending Service in Havering provides a number of services to young people and their families. Some of the concerns highlighted from referrers and young people have related to:

- mental health/emotional wellbeing and its impact on offending
- supporting children and young people to make more informed choices
- the impact of alcohol and drug use/misuse
- sexual health concerns and prevention
- healthy lifestyles
- access to certain therapies
- anger and behavioural issues.

These issues were identified by meeting with young people and asking them directly about their health. There was also a noticeable link between those admitting to have anger management issues and poor diet.

**Needs of looked after children**

Looked after children have many of the same health issues as their peers; however, the extent is often greater because of their past experiences. Almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. Delays in identifying and meeting their emotional wellbeing and mental health needs can have far-reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults. These children are also at greater risk of child sexual exploitation and teenage pregnancy.

Although the number of Havering children becoming looked after has remained relatively stable and is low, there is a significant increase in the number of children looked after or being placed in the area from out of borough, so it is vital that we meet our safeguarding requirements to deliver health assessments to all of these children, and ensure they are able to access a comprehensive service that can meet their emotional and mental health needs.

**Recommendations from the Children’s JSNA 2014**

- In light of the increasing numbers of pre-school and primary aged children residing in Havering, commissioners of mental health services should consider how to meet rising demand for services, particularly for younger children.
- Commissioners and service providers should consider early years screening provision and how this can be used to support preventative interventions and service planning.
- Commissioners may wish to explore how best to ensure that children with behavioural, emotional and social difficulties are being identified at the earliest possible opportunity, and provided with appropriate support.
- In light of the changing population demographic, commissioners may wish to consider the continued and increasing need for accessible services.

Havering CCG has prioritised a wide-ranging review of CAMHS provision across all tiers during 2014/15.

### 2.2 Autism in Havering

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people and the world around them. Autism affects one in every 100 people. It is a spectrum condition, which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. There is no known cure for autism. Some people with autism are able to live relatively independent lives but others may need a lifetime of specialist support. The main areas of difficulty are in recognising and understanding other people’s feelings and managing their own, using and understanding verbal and nonverbal language, understanding and predicting other people’s intentions and behaviour, and imagining situations outside their own routine. People with autism may also experience over or under-sensitivity to sounds, touch, tastes, smells, light or colours.
Local needs
In 2008, there were 191 pupils in Havering with autistic spectrum disorder, rising very slightly to 196 in 2012. This is significantly lower than the average rate for England.\(^{12}\)

Children with autism can experience a range of mental health problems. Some of the most common are anxiety and depression. Others include conduct disorders, ADHD (attention deficit hyperactivity disorder) or ADD (attention deficit disorder) and OCD (obsessive compulsive disorder).

As a borough, Havering is committed to ensuring all children and young people, in particular those with additional needs, are identified early and have timely access to the range of services they need. Training staff to identify and signpost children and families with autism has been identified as an area for further development as part of our transformation plan. A good understanding of autism will help practitioners to understand and work with children, while in some cases autism expertise may be required.

Because children with autism can find communication and ‘self-reporting’ difficult, input from professionals, parents, carers, and others regularly involved in the child’s life, can be valuable and this has been considered as part of the wider transformation plan. It is paramount that professionals working in children emotional and mental health services understand how to identify and support children with autism.

2.3 Transforming Care Programme

Preventative approach:
Skills for Care, Health Education England and Skills for Health are currently working in partnership to enable people who display challenging behaviour to be supported well in their local communities. As part of this work they will be disbursing funding to support the Transforming Care Programme and each applicant can bid for a maximum of £8,000.

The funding will make a significant contribution to the cost of training health and/or social care workers in positive behavioural support (PBS) and/or autism awareness. The funding will be available to social care and/or healthcare employers of all types in England, and will be based on ‘skills around the person’, for example upskilling a team who will be responsible for providing care and/or support to an individual.

The training that can be funded will contribute to the discharge of one or more people who are currently inpatients, or to maintaining and improving community care and support for a person at imminent risk of admission. The emphasis will be on those who support people who have:
- a learning disability
- autism
- ADHD
- other mental health problems
- display, or are at risk of displaying, behaviours which challenge services, specifically those who are currently inpatients awaiting discharge or people at real risk of an admission.

Supporting vulnerable children:
As of November 2015 Havering has an at-risk register for children identified by social workers or key workers as being at risk of a hospital admission under the Mental Health Act. Once these children

\(^{12}\) Public Health England: Havering Learning Disabilities Profile 2013
are identified as at-risk, a community care and treatment review is arranged with a panel of clinical experts, experts by experience, family members and all local agencies involved in the child’s care. This panel discusses findings and recommendations and agrees the next steps to help the child to stay in the community with the right support, and to avoid a hospital admission.

The findings and recommendations are owned by each individual and have to be actioned within set timeframes. Each individual is required to update the commissioner or key worker and from this further actions may be required. When a child is transitioning to adult services, adult services will be involved in all aspects of that child’s care.

2.4  Case for change

As is the case in many local areas, the traditional CAMHS tiered model was useful at the time of its development for helping to differentiate between the forms of support available to children and young people. The structure, thresholds and contract arrangements of the tiered model can lead to a poor experience of care for children, young people and their families. Being passed from one service to another, having to explain the situation repeatedly, and being unable to build a relationship of trust with clinicians is not conducive to effective treatment or a good experience. Children and those who care for them have complained that the model is too difficult to navigate and understand.

Recent reviews, engagement and local intelligence have highlighted some significant challenges of the current model and performance of services:

- the development of divisions between services
- unnecessary waits between tiers
- lack of accessibility, such as no choice of venue, after hours’ services, or self-referral/drop-in services
- children and young people having to re-tell their stories to different teams/professionals
- lack of clarity about the threshold for accessing treatment
- many young people attend the service only once and many others have fewer than three contacts
- lack of local curriculum for schools focusing on mental health issues and classes around anger and stress management
- lack of signposting within schools, libraries or youth centres to external services such as FRANK (confidential substance misuse advice line), the Samaritans, or CAMHS
- lack of service information in accessible formats, languages and technologies
- referral pathways, information and access to services are not clear
- transitions to adult mental health services are not well defined, planned or managed
- non-attendance rates are higher than average, and the policy for following up DNAs needs attention
- outcomes are not adequately measured and reported
- service specifications between Tier 2 and 3 services are not well integrated and contract monitoring across the pathway does not occur
- interventions and pathways not always commissioned or delivered in accordance with NICE guidance
- there is a gap in support for under-fives and those with autism
- better capacity and support is needed in schools
- lack of self-help resources for young people
- disjointed relationships between agencies and providers
• lack of investment in promotion, prevention and early intervention
• vulnerable children and young people require improved care and support during key transitions
• lack of anti-stigma campaign to raise awareness of mental health issues for children and young people.

This mental health transformation plan sets out our high-level priorities for local transformation. It describes an approach that encompasses the whole system of support available to meet the needs of all children and young people across the borough. It has been developed in collaboration with a range of partners and stakeholders and captures our shared vision. We have recognised the need to adopt a multi-faceted approach. This requires a combination of building resilience to stem the rising tide of young people presenting with emotional needs in the first place, supporting better knowledge and self-help resources and guided self-management support to extend our reach and provide more young people with support while achieving high impact and value for money.

Our approach also focuses on the powerful role and impact that parents, peers and non-specialist professionals can have on the emotional and mental health of children and young people, and includes plans to better empower and equip people within a child’s sphere of influence.

3. Current mental health service provision for children and young people

3.1 Current model – tiered approach

Nationally, CAMHS operates within a four-tiered model. Although services are organised into tiers, these are not hierarchical. The four tier model has been used for over a decade to conceptualise the planning and delivery of mental health services. We recognise that this model is well embedded within the culture and systems of health services. Across children’s services more widely, there has been a recent move toward a concept of universal, targeted and specialist services.

Both models are subject to local interpretation and differences in understanding, although they share the basic aim of helping people understand which services are available to everyone and which are available to some. Although the four tier model provides a useful framework for understanding comprehensive CAMHS, it is important to recognise that children and services rarely fall neatly into one tier. Children and young people may enter the system at any point and do not necessarily move up the tiers. Services and interventions may also span multiple tiers.

**CAMHS four tier structure:**

<table>
<thead>
<tr>
<th>Tier 1 - Universal</th>
<th>This tier comprises contact with professionals who are not necessarily employed for the primary purpose of promoting or working in mental health, but who directly and indirectly influence the mental health of children through their work with them, for example health visitors, school teachers, school nurses, social workers, the voluntary sector and GPs.</th>
</tr>
</thead>
</table>


The function of this tier is to provide a comprehensive community resource that supports mental health promotion through universal services.

**Tier 2 - Targeted**

Services at this tier are known as targeted services and are commissioned by the local authority, public health and the CCG. Services are provided for children and young people who are at increased risk of developing mental health problems and those with moderate mental health needs. Primary mental health workers offer support to other professionals around child development, while the tier also includes voluntary sector services such as MIND and RELATE children's counselling.

Other services associated with this tier include the young people’s sexual health service, Youth Offending Service, drug and alcohol service and school counselling.

**Tier 3 - Specialist**

Services at this tier are more specialised and deal with complex problems. Members of multi-disciplinary mental health services, often working in therapeutic teams, ensure that coordinated interventions from several professionals can be used to help children with moderate to severe problems and those too complex to be dealt with at Tier 2, including autism, hyperactivity, depression and early onset psychosis.

**Tier 4 – Acute**

This tier provides for highly specific and complex problems that require considerable resources, such as psychiatric provision, secure provision and very specialised services. Highly specialist Tier 4 CAMHS are commissioned by NHS England specialised commissioning. This also includes inpatient hospital placements; the local facility is Brookside Unit in Goodmayes.

There is one main provider of CAMHS in Havering, NELFT NHS Foundation Trust (NELFT) and elements are funded by both the local authority and Havering CCG. Further mental health support is commissioned by the CCG and local authority through schools and the voluntary sector.

**3.2 Service provision by tiered support**

**3.2.1 Tier 1 breakdown**

**School Health Teams**

There are three school health teams in Havering and they are located in community clinics at central sites within the borough:

- Hornchurch Health Centre
- Romford Health Centre
- Harold Hill Health Centre

The school health team comprises:

- specialist practitioner school nurses (SPSN) who have completed the community health degree
- school nurses (SN), registered general nurses with additional post-registration qualifications and experience working with children and families
• associate school nurses (ASN), the majority of whom are registered children’s nurses with experience of working with children, young people and their families
• clinical assistant school nursing (CASH), skilled and competent to deliver screening and other baseline clinical interventions
• administrative support.

One school nurse who provides services to one special school is funded directly by the CCG. There are two other special schools in the borough which are supported by the mainstream school nursing teams.

Healthy Schools
Havering has had a good take-up of the Healthy Schools London programme across the borough. By the end of the 2014/15 school year a total of 57 schools had registered with the programme.

The Early Help Service
Early Help ensures that problems for children and families are identified early and responded to effectively as soon as possible. The aim is to ensure problems do not escalate to become more acute, and more costly, to the detriment of children and families, by investing in effective community services and multi-agency coordination.

Early Help follows a collaborative approach from all agencies, including education, health, and voluntary community services, with the active involvement of children, young people, families and carers. There is a seamless pathway from universal to acute services, with step-down arrangements to help service users to transition from acute services to mainstream or universal services.

Family support and intervention workers complete Early Help assessments and action plans, with focused outcomes for children and families. It is vital that children, young people and families take an active part in the Early Help process to achieve the most positive outcomes.

Early Help is run from children’s centres and community hubs across the borough:
• North locality: Collier Row, Ingrebourne, Chippenham Road
• South locality: St Kilda, Elm Park, Rainham village.

Services available within the hubs include:
• community midwives
• parentcraft antenatal classes
• birth registrations
• postnatal support group
• perinatal services
• health clinics
• one and two-year developmental checks
• baby massage
• infant feeding cafes
• parenting courses
• parents surgery
• home safety
• Home Start groups
• Book Start
• Havering Adult College courses, including language and play course, English for speakers of other languages (ESOL), and paediatric first aid
• Dads’ Club
• Us Mums
• sexual health services.

Emotional wellbeing is fundamental to every stage in a child’s life – from starting school to entering adulthood – and services should devote everything they can to ensuring families receive support early to avoid crises. Our plan aims to ensure availability and effective promotion of children’s centres and the services they offer to children, young people and their families. People need to feel confident that they can receive support to address emerging problems without fear of stigma.

3.2.2 Tier 2 breakdown

Eating Disorders
Havering CCG commissions the Children and Young People’s Community Eating Disorders Service (CYP-CEDS) with its neighbouring CCGs of Barking and Dagenham, Redbridge and Waltham Forest. The provider is NELFT NHS Foundation Trust (NELFT).

NELFT’s child eating disorder service is an integrated lifespan service providing support to children from eight years of age, easing the transition to adult services where necessary. This service delivery model helps avoid well documented issues of transition that are both damaging and costly.

Given the severe medical risks and associated mortality rates in eating disorders, resources are targeted at those most at risk, such as low weight or ‘at risk’ patients. Data from the National Child Measurement Programme shows us that 0.4% of reception year children in Havering are underweight (compared to 0.9% for England) and 0.8% are underweight at year six (compared to 1.4% for England)13.

In most cases the provider’s triage system will review the referral the same day. Children and young people are offered an assessment within one week and start treatment immediately after their assessment. As a consequence of this, for patients less at risk there is a delay in accessing treatment. However, all clients will receive specialist nurse monitoring immediately following their assessment and be invited to the pre-therapy group.

Activity/performance 2014/15 for eating disorders service for Havering and partner CCGs:

<table>
<thead>
<tr>
<th></th>
<th>BD</th>
<th>Havering</th>
<th>Redbridge</th>
<th>Waltham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New referrals</td>
<td>28</td>
<td>62</td>
<td>40</td>
<td>46</td>
<td>176</td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>421</td>
<td>601</td>
<td>1,135</td>
<td>810</td>
<td>2,967</td>
</tr>
<tr>
<td>Telephone contacts</td>
<td>99</td>
<td>45</td>
<td>178</td>
<td>156</td>
<td>478</td>
</tr>
</tbody>
</table>

Average waiting time

<table>
<thead>
<tr>
<th></th>
<th>BD</th>
<th>Havering</th>
<th>Redbridge</th>
<th>Waltham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-16 weeks non urgent</td>
<td>12-16</td>
<td>weeks non</td>
<td>12-16</td>
<td>12-16</td>
<td>12-16</td>
</tr>
<tr>
<td>cases (individual</td>
<td>weeks non</td>
<td>urgent</td>
<td>weeks non</td>
<td>weeks non</td>
<td>weeks non</td>
</tr>
<tr>
<td>therapy)</td>
<td>urgent</td>
<td>cases</td>
<td>urgent</td>
<td>cases</td>
<td>urgent</td>
</tr>
<tr>
<td></td>
<td>cases (individual</td>
<td>therapy)</td>
<td>therapy</td>
<td>therapy</td>
<td>therapy</td>
</tr>
</tbody>
</table>

In order to improve waiting times and access to the service, we are implementing a step up and step down healthy eating service in schools across the borough. The service will also act as an outreach service to identify children at risk and bring them into support services. The new service will work with schools to help them better identify and support pupils.

**Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT)**

Havering received funding for an IAPT service for children and young people in 2014. The service is yet to be developed locally but will be based on the following core principles:

- better evidence based practice – increasing the availability and knowledge of best evidence based interventions
- better collaborative practice – goal focused and client-centred interventions, using feedback tools to enable better working between mental health professionals and families and young people, leading to more personalised care
- better service user participation – children, young people and their families having a voice and influence at all levels of the organisation
- better cross-agency working – encouraging and supporting collaboration between health, social care, voluntary and independent sectors
- more accountable services – through the rigorous monitoring of clinical outcomes to be able to share outcomes with young people and families and demonstrate effectiveness to commissioners
- increased awareness – working in partnership with organisations delivering mental health services, and those in other sectors working with young people and families, to increase understanding of the importance of emotional well-being and decrease stigma.

**NELFT Perinatal Parent Infant Mental Health Service**

This is a specialist psychiatric and psychological service which is currently commissioned by both NHS England (NHSE) and the CCG. NELFT delivers these services across Havering, Redbridge and Barking and Dagenham and resources are calculated on birth rates. The team is made up of three groups of clinicians:

- perinatal psychiatrists
- perinatal community mental health practitioners
- psychotherapists/psychologists.

The NELFT service is unique as it is an integrated perinatal and parent/infant service and is able to offer psychotherapeutic, psychological and psychiatric treatment. Some areas have CCG-based services, while providers such as NELFT offer services across CCGs. This makes it much easier when patients move boroughs and is more economical as it allows for cross-borough cover and sharing of administration and managerial resources. This is particularly important for NELFT, as the maternity boundary configuration means there are women who deliver outside their catchment area.

The psychiatric component of the service works with women with mental health problems during pregnancy and up to a year postnatally. The psychological component of the service works with parents and children up until the age of three. They aim to address attachment difficulties to prevent complex mental health problems when the babies and toddlers become older.

Perinatal psychiatrists can offer assessment and treatment, including advice on medication during
pregnancy and while breastfeeding, and they work closely with maternity services by holding joint obstetric/psychiatric clinics.

Perinatal community mental health practitioners can provide intensive support and offer home visits to assist in getting help from other services such as children’s centres.

Psychotherapists and psychologists work with the service user, their partner and baby together to help adjust to the changes that can come with pregnancy and caring for a new baby. If the service user already has a care coordinator, this person will remain involved in their care.

Havering residents have consistently accounted for 21 to 25% of all referrals to the service. Between April and August 2013 it received 100 referrals and discharged 23, which equates to 21% of all referrals. Results from the most recent service review show that the perinatal service is well developed and well thought of by health professionals and service users, however referrals are growing and we need to ensure there continues to be appropriate capacity and support for onward referrals and step down services.

Havering Perinatal Service activity:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New referrals</td>
<td>251</td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>842</td>
</tr>
<tr>
<td>Telephone contacts</td>
<td>207</td>
</tr>
<tr>
<td>Average caseload for team</td>
<td>92</td>
</tr>
<tr>
<td>Average waiting time in days</td>
<td>0</td>
</tr>
</tbody>
</table>

Our allocation for perinatal mental health will be used to enhance existing services to provide a robust package of maternal support, which may include baby massage, attachment parenting courses and crèche facilities. By commissioning these services and promoting prevention and support for new parents we aim to provide a better offer of care for all new mothers and their babies. In addition we will redesign the referral route for health visitors and professionals identifying mental health issues in families.

We await the publication of the new access and waiting time standards to determine whether further investment will be needed from year two of the transformation plan.

Relateen
This counselling service is for young people between 11 and 18 years of age and predominantly works in secondary schools in the borough including a pupil referral unit. The service provides four hours of face to face counselling per week in eight secondary schools during term time (39 weeks). The local authority CAMHS grant-funds three hours and each school is invoiced for the other hour. An additional nine hours of counselling is delivered each week at the Relate Centre at Langton’s House in Hornchurch and during the school holidays. Schools have also begun to purchase additional hours, either on a regular basis or as a spot purchase based on demand. In total, 1,880 hours of counselling were delivered in 2013/14 compared to 1,873 in 2012/13.

MIND
MIND’s targeted child and adolescent mentoring scheme operates in Tiers 1 and 2, supporting children and young people between the ages of 10 and 18 who are identified as needing social and emotional support outside the family. The scheme works as a prevention/early intervention service
and is targeted at children and young people who are at risk of social isolation, experiencing social or family crisis and have emotional and mental health issues that do not require a multi-disciplinary Tier 3 service. Referrals are taken from a range of agencies across child and family services and schools. The children and young people are supported by a volunteer mentor who works with them to achieve identified outcomes. The length of the relationship varies dependent on the assessed needs. An activity programme is available for those on the scheme and includes those who are waiting to be matched with a mentor. At the time of this review there were 22 mentors identified in the scheme who between them delivered 1,382 mentoring hours during 2013/14. An increasing number of mentors are staying in the scheme and building up experience that enables them to work with more complex cases that are referred. The average waiting time for referrals to be matched with a mentor is around five weeks.

**Home Start Havering**
This is a local branch of the UK-wide Home Start network, which offers free and confidential support to families across Havering. It recruits and trains volunteers from the local community and matches them with families who are experiencing difficulties, for example relationship break-up, illness or bereavement. All the families supported must have at least one child aged under five. The volunteer visits the family in the home once a week.

**First Steps counselling service**
This is offered to Havering-based parents, carers and adult family members, who have a child or dependent adult with special needs and/or disabilities. A parent and baby service provides sessions for parents and carers along with their pre-school child who has special needs and/or disabilities.

**Sycamore Trust**
This service works at educating the community and empowering individuals affected by autistic spectrum disorders and/or learning difficulties. It offers a range of services designed for young people including youth clubs, football and multi sports projects and under-eights' activities. All staff and volunteers receive up-to-date training to allow them to support young people in the appropriate manner.

**Health and Justice:**

**Overview**
There are no prisons in Havering, so the CCG’s responsibilities lie with young offenders and with children and young people affected by parental offenders. This CAHMS transformation plan seeks to support children and young people requiring mental health services who are at risk of offending or have offended, by strengthening the links between CAMHS and the Youth Offending Team. In addition to this we will improve services for children and young people requiring mental health services, and whose parents are in the criminal justice system, by improving support to the adult and child Multi Agency Safeguarding Hub.

The CCG commissions health services for adults and children serving community sentences and those on probation. The Youth Offending Service (YOS) has a CAMHS mental health worker and as commissioners we are committed to develop stronger relationships with services that address offending behaviour. This offer should be extended to services including the Youth Inclusion Support Programme (YISP), police and local community safety services.

In November 2015 the Local Authority commissioned Barnardos to provide training for frontline staff in working with children affected by parental offenders. This provided skills training and referral
pathways to better support this population group and ensure their needs are met across health and social care.

Evidence suggests there are gaps in provision around the therapeutic interventions received by this cohort. Speech and language therapy has been identified as the main need among young offenders and the transformation plan commits resources to developing this area.

**Youth Violence in Havering**

Serious youth violence has increased dramatically in Havering although the borough still achieves figures that are significantly lower than the London average.

There has been an increase in criminal activity near train stations, particularly robbery and knife crime: statistics show that 25% of serious youth violence involves knives. The high amount of activity near train stations suggests the crimes could be committed by young people from outside the borough travelling to Havering via public transport. The Metropolitan Police’s Operation Omega is allowing for additional resources around these areas at weekends.

The local community safety team is also completing a problem profile to provide greater analysis of this data and understand which young people are predominately involved in crime, by age, ethnicity, gender, or looked-after status.

There is potential for police to raise awareness around public transport hubs of knife crime and new legislation, whereby the second time a person is caught with a knife they could be given a custodial sentence, in the hope of lessening the risk to young people and reducing knife crime. Transport for London and the British Transport Police are not supportive of fitting knife detectors in train stations, and Havering YOS has written a letter questioning this decision.

**Education to employment (E2E)**

Six out of 11 young offenders in Havering are linked to suitable E2E programmes by their Youth Offending Service caseworker (55%). Of the five young people not engaged in E2E, three have no alternative provision while the remaining two are on programmes or courses that equate to less than 25 hours.

Havering YOS wants to target young offenders who are of school age and we are working to achieve this.

**Parenting Orders**

Statutory Parenting Orders have increased from six to 12 in the last year, with Voluntary Parenting Orders also increasing from 29 to 32. This is a pleasing result for Havering YOS and these figures were highlighted in a HM Inspectorate of Probation inspection result.

**Out of court disposals (OOCDs)**

OOCDs as a whole are increasing. There has been a reduction in youth cautions and an increase in youth conditional cautions since last year. Conditional cautions allow for an authorised person or relevant prosecutor to attach conditions to the caution which must be complied with. It is good to see an increase in YCCs, however further analysis will reveal whether the reason behind this is that the offences are becoming more serious.

**First time entrants**

At the time of writing there are 18 first time entrants in the system, with a predicted end of year figure of 32. These high figures are to be expected as more young people move into the borough.
Custody
Havering currently has four young people in custody, which matches last year’s figure, and there had been no new custodial cases in the month prior to writing.

Access to suitable accommodation
All young people in the borough have access to suitable accommodation.

Youth Offending Service
Havering has one post in the Youth Offending Team (YOT) jointly funded by the local authority and CCG, and a youth offending mental health nurse. A dedicated CAMHS worker based within the team provides assessments to the whole cohort, delivers interventions and signposts to other services. In Havering there is ambition to improve the mental and physical health offer to youth offenders, which includes joint assessments as well as a more coordinated approach when referring to services. All staff deliver assessments to children and young people; however there is a gap in training to deliver brief interventions and this will be explored further in the transformation plan.

One of the main needs is a speech and language therapy offer to the YOS. Within the service there are many young people who have been assessed as having a need, however there are no established links to accessing services and due to the high number of older children, many do not recognise this as an issue and are unlikely to engage with external services. Having this offer built in to the service model will provide direct access to specialist interventions as part of the whole YOS healthcare package. Children and young people would benefit by having direct access to a service without waiting lists, as well as an increased likelihood of engaging with a speech and language therapist. Having a dedicated provision within YOS is something many other boroughs including neighbouring Redbridge already offer.

In relation to section 136 of the Mental Health Act 1983, the local policy is that police cells are not used to detain people. NELFT has confirmed that for the last five years no NELFT patient has been detained in police cells under s136 in the whole of the BHR area.

3.2.3 Tier 3 breakdown

CAMHS Tier 3 specialist provision (NELFT)
Barking and Dagenham CAMHS offers help to children and young people who are experiencing emotional, behavioural or mental health difficulties. The services are available to families with children and young people from birth to their 18th birthday (some counselling services work with people to age 21). Support is offered in a variety of settings such as specialist community clinics, home visits, schools, and in hospital paediatric wards and A&E departments.

Community CAMHS support is offered in a variety of ways. In the main this takes the form of face to face talking therapies such as family therapy or counselling. Group work and various specialist assessments are also offered, and it may also involve psychiatric input or medication.

The providers of Tier 3 services for Havering are based in Pettit’s Lane, Romford. All CAMHS professionals are trained and experienced in working with children and young people with mental health problems. Some staff have targeted specialist skills, which they may use for specific conditions or treatments. The Tier 3 CAMHS team comprises:

- child and adolescent psychiatrists
- clinical psychologists
- child psychotherapists
- family therapists
- social workers
- mental health practitioners
- mental health clinical nurse specialists.

**Primary Mental Health Team**
Havering’s primary mental health team (PMHT) works with young people up to age 18, and their families, who are experiencing social, emotional, behavioural or mental health difficulties. In addition they offer a community-based initial assessment and can offer six to 12 sessions with regular reviews. PMHT workers in the borough can also offer therapeutic approaches including:

- behavioural management
- solution focused therapy
- psychodynamic therapy
- cognitive behavioural therapy
- anger and anxiety management
- parenting programmes
- family work/groups
- assertiveness training.

**Current Tier 3 staffing WTE:**

<table>
<thead>
<tr>
<th>Grade/role</th>
<th>WTE</th>
<th>Actual cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin band 3</td>
<td>1</td>
<td>17,915</td>
</tr>
<tr>
<td>Non NHS: nursing</td>
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<td>6,653</td>
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<tr>
<td>Nursing Band 7</td>
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<td>Psychotherapist Band 7</td>
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<td>Senior managers Band 8B</td>
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<td>Therapist band 6</td>
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<td>Total pay</td>
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<tr>
<td>Non pay</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>344,283</strong></td>
</tr>
</tbody>
</table>

**3.2.4 Tier 4 breakdown**

Since April 2013 NHSE has been responsible for commissioning CAMHS Tier 4 services, while CCGs are responsible for ensuring a robust infrastructure is in place at Tiers 2 and 3, including provision of effective early help services to prevent problems escalating to a point where hospital admission becomes necessary. Tier 4 services are shared across ONEL and we are keen to commission appropriately to ensure residents can access their treatment in their local borough. The services currently comprising Tier 4 are:

**Table: Tier 4 activity and costs (NHS England)**

<table>
<thead>
<tr>
<th>CCG Name</th>
<th>Cost 2014/15</th>
<th>Activity 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Havering CCG</td>
<td>990,738</td>
<td>1,884</td>
</tr>
</tbody>
</table>
Although Tier 4 services are the responsibility of NHS England, we understand the need for more robust coordination between step up and step down services to ensure children and young people are supported at the right time in the right place. We aim to provide clear pathways to access support in the community for young people and their families.

**INTERACT**

This is NELFT’s outreach service based at Brookside Tier 4 unit in Ilford. All young people who live in Barking and Dagenham, Havering and Redbridge, as well as Waltham Forest, referred to Brookside are initially seen and assessed by mental health practitioners via INTERACT. The service is also able to support young people recently discharged from hospital, helping them to adjust to being back at home. INTERACT also assesses and supports young people who attend A&E or local paediatric wards and need the support or advice of mental health services. Essentially, INTERACT works between Tiers 3 and 4 as a bridging service, to prevent escalation to Tier 4.

In addition to the core funding from NHSE, a number of Havering schools contribute to funding some of these NEFLT services from their Dedicated Schools Grant (DSG). Some schools also have their own commissioning arrangements in place to support their pupils’ emotional health and wellbeing needs.

**Brookside Child and Adolescent Inpatient Unit**

This specialist mental health inpatient unit for children and young people provides a 24 hours a day, 365 days a year service. It provides assessment, care and treatment for young people aged 12 to 18 with severe psychological, behavioural and emotional difficulties. Brookside cares for young people primarily from Havering, Redbridge, Barking and Dagenham and Waltham Forest, although where appropriate may also accept referrals from parts of Essex and elsewhere.

Young people with mild to moderate learning disabilities can be referred to the service as long as there is a co-morbid mental health difficulty. Among a wide range of other services, Brookside supports young people and their families to return to the community, with signposting to the appropriate community support after an acute episode of mental ill health. Brookside has an in-house school in order to reduce the need for patients’ education to be disrupted during their period of acute need. This provision is individually tailored to the young person’s needs and aims to enable them to continue their education on discharge. Brookside also supports families, carers and guardians of patients with support and advice during admission, and recommendations post discharge.
4. Underlying principles for the transformation of mental health services for children and young people in Havering

4.1 Local principles

This CAMHS transformation plan is underpinned by a local model which reflects the requirements for change as outlined in Future in Mind\textsuperscript{14} and builds in our knowledge of local need, our baseline service delivery position, current system outcomes and aspirations for change. This plan sets out the strategic priorities in which all transformation activities, from commissioning to delivery, will be rooted:

- more children and young people will have good mental health
- fewer children will suffer avoidable harm
- more children and young people with mental health will recover
- more children and young people with mental health problems will have good physical health
- more children and young people will have a positive experience of care and support
- fewer children and young people will experience stigma and discrimination.

4.2 Whole system approach

Today’s children will shape the future of the country; which is why we are committed to making mental health everyone’s business by promoting a whole systems approach which includes businesses, schools, parents, professionals, friends and the community.

In Havering the responsibility for children’s mental health care is shared across multiple systems, of which the first system is the family. Our transformation plan acknowledges that family members and caregivers will be equal partners with schools and professionals in selecting, implementing, evaluating, and sustaining interventions delivered children and young people. At a local level, decision making mechanisms and processes that include family members as equal participants will continue to be strengthened.

Our children and young people’s mental health review in 2015 identified a gap in mental health services for children with additional needs and learning disabilities. Recommendations were made that mental health services should conduct caseload reviews for children with additional needs to ensure their specific needs are being met and to incorporate the views of all involved. All children and young people who need more specialised support, and their parents and carers, should have access to clear information about what to do if things do not go according to plan. This should include specific information on signposting for referrals that have been declined for children with additional needs.

4.3 Building resilience and promoting prevention

We will work to develop the capacity of our children to be resilient and maintain their wellbeing. Life can be challenging and may include many stressful situations, which could cause parents and children to feel overwhelmed. Children and young people in Havering have talked about having the necessary self-confidence to deal with setbacks such as unkind comments from peers, and to form healthy friendships with others.\textsuperscript{15}

\textsuperscript{14} Future in Mind: Promoting protecting and improving our children and young people’s mental health and wellbeing.\par Department of Health and NHS England\par \textsuperscript{15} Havering Mental Health for CYP Service Review 2015
We know that more and more children, young people, parents and teachers are seeking help to deal with emerging emotional needs, which early help and directed self-support may help to address.

We do not want specialist help to be the first option for mental health. We believe that emotional health, wellbeing and mental health are not the exclusive business of experts, especially when it comes to promoting good mental health and preventing ill health. All people within a child’s sphere of influence have the potential to support them; including peers, parents and teachers who may be well placed to listen and understand how they can best support them through adversity.

Currently there is a range of services accessible via universal settings where early support for a child’s or family’s mental health can be provided. However, due to high demand, these services are geared to delivering support for those families that fall just short of requiring local authority statutory services. Such services include The Troubled Families Programme, Early Intervention Panel and Parenting Courses.

This plan proposes a whole system solution to resilience building, accessible to all, including support for parents. Through activities to educate and empower children and young people, and those who know and work with them, we expect to see a return on investment in future years with fewer referrals for additional support or specialist CAMHS services. We will also work closely with schools, implementing a training programme for all teachers and support staff to help them build resilience with their students.

4.4 Make mental health everyone’s business

If you care, you can is a campaign to raise the profile of emotional health and wellbeing and awareness of how everyone within a child’s sphere of influence can support them. It aims to:

- deliver training via IAPT for staff working with children in universal settings including schools. Aim to deliver resilience building support in school and train staff to identify early and refer children and young people with emerging additional needs
- develop a peer support programme in schools, exploring how to make use of national initiatives
- develop a local online resilience information resource/toolkit for parents and children, for example ‘kids can cope’
- better support schools to deliver PSHE Association resilience guidance\(^{16}\) and lesson plans
- improve local information about mental health support, including better integration with the local offer and clear publication of services, pathways and access details
- offer self-help intervention resources to support parents and young people
- provide online support via local forums such as Big White Wall and Silver Cloud.

4.5 Early intervention

Intervening early and positively makes a real difference at every stage of life. Mental health problems are widespread, they affect people of all ages, and the longer they remain hidden, stigmatised and untreated the worse they become and the greater the losses people experience in their lives. We know that what happens in early life sets the foundation for everything that follows, which is why early intervention is vital in making children happy and healthy adults, improving

\(^{16}\) Personal Social Health and Economic Education Association
outcomes and saving money. Our proposed model recognises the need for all services that are working with the child to be engaged in the assessment and care planning process and to offer professional support and guidance where necessary. We cannot improve overall mental health outcomes for children and young people unless we pay equal attention to addressing the issues surrounding their mental health.

Intervening earlier not only means earlier identification of need, but also by an earlier age. Childhood and adolescence is the time when mental health is developed and patterns can become set for the future, so we will begin by making efforts to ensure all pregnancies are healthy to provide the best possible start in life.

The role of universal services in mental health promotion and prevention is key to delivering messages and providing access to information and signposting for children and young people and their families. The recent implementation of the local offer as part of the Children and Families Act 2014 provides the perfect platform for accessing information on all services available to support a young person’s mental health journey, and Havering is committed to utilising this mechanism as the main information point for all families to access help from services to support their children.

Expanding the next level of provision would also enable earlier intervention and more prevention work to be delivered as part of the early help offer for children and young people. This plan recognises the importance of building a model that intervenes at the earliest sign of difficulty while acknowledging that it is also never too late to support good mental health.

We are committed to helping children under 10 years of age through a range of prevention and support services.

In 2015 NHS England and the Department for Education invited proposals from CCGs working with partners to apply to become a pilot to improve joint working between school settings and local NHS-funded CAMHS. While Havering was unsuccessful in its bid, there is a commitment to replicate the programme locally in approximately 40 primary schools, which is where a majority of the initial interest was expressed.

Included in this plan is further detail of our intention to deliver training in building resilience in primary schools. The outcomes for this training will be to raise awareness and improve knowledge of mental health issues among school staff, improve CAMHS understanding of specific mental health and wellbeing issues within schools, and support more effective joint working between schools and CAMHS.

Feedback from primary schools is that we need a deeper understanding of the local needs around suicidal ideation and self-harm in primary-age children. Particular local issues are young children tackling issues around positive self-image. Support for these children could be given via bespoke training packages delivered in schools.

4.6 A system without tiers

Problems associated with the current tiered CAMHS model are well documented. The model creates barriers between services which can be compounded by complex commissioning arrangements. Care can become fragmented, and the barriers and varying thresholds for treatment can result in children moving in and out of different services with no overall responsibility for ensuring that the child receives the care they need. Locally we are aware that children can start a referral to one service where they may not meet the criteria and then have to start again with a new
referral to another service. We also know that there is uncertainty among many professionals, including teachers and GPs, about how to refer for support and to which service.

At best this causes confusion and dissatisfaction, while at worst it delays providing the right level of care at the right time.

This plan outlines the intention to create a ‘single route to support’ to create a seamless pathway of care from the point of referral. The full detail of how this single route will work is explored in section 5.2 of this report.

4.7 No gaps

Reviews and published papers including the health select committee report on child and adolescent mental health 2014\(^1\)\(^7\) highlight growing concerns around gaps in children’s mental health provision. Findings from this and subsequent publications highlighted the tiered approach as being an ineffective model to deliver such services as it often unintentionally creates barriers between internal and external services and gaps in provision.

In addition, it has been identified that there can be a lack of consistent links between CAMHS and adult services which creates further gaps and an increased risk of disengagement from services altogether.

The model that is being proposed not only moves away from the tiered approach but operates on a quadrant model in which children and young people are supported to build resilience skills through universal services including schools and community settings. Quadrants 2, 3 and 4 will operate via a wellbeing hub which will act as a single point of access to services with direct links to all quadrants. Children and young people are able to move around the quadrants depending on the level of need. In principle, children and young people will be able to move down the trajectory as interventions are delivered and outcomes are produced. The wellbeing hub allows less opportunity for gaps to develop and provides a seamless pathway of care for those who need it.

4.8 Better supporting children, young people and families with mild/emerging behaviour difficulties

Unsurprisingly, having a conduct disorder during childhood is linked to adverse outcomes in adult life, therefore providing children and young people with early intervention has long-term benefits. Affected children are best managed by a range of professionals including social workers, teachers, paediatricians and GPs. This multidisciplinary team approach should be well coordinated between agencies to provide good quality care, as research has shown that children with a conduct disorder or displaying challenging behaviour often find themselves exposed to ineffective interventions, misdiagnosis and social exclusion\(^1\)\(^8\).

4.9 Reducing inequalities

Our approach to inequalities starts at strategic level, using the JSNA to identity the needs across the population of the borough to target service development. This includes establishing new


\(^1\)\(^8\) Emerson E., & Einfeld S. (2011). Challenging Behaviour (3\textsuperscript{rd})
services to address specific needs of a particular population – for example a community sickle cell service. We introduced a service for a small segment of a population who previously had secondary care access to healthcare. We introduced an integrated community model covering physical, mental and social care needs. We will consider the most appropriate location for new or existing services to best address local need, for example with adult IAPT services a session was introduced at a children’s centre so parents can access it while their children are supervised.

We monitor how services are used by different segments of the population and then work with providers to improve accessibility for those not accessing them. We have used this experience to develop these plans. For example the mental health lead analysed use of the adult IAPT service compared to the local need and discovered that it was not being accessed by older people. As a result we have now embedded an IAPT worker into older people’s services, training support staff and providing one to one interventions. We also successfully implemented integrated physical and mental health work in adult services, with GPs available in mental health clinics.

We will use this methodology to reduce health inequalities for children and young people with mental health conditions in Havering. Access to and outcomes from public services can be affected by various factors including age, ethnic background, gender, disability and sexual orientation. There are also factors that will influence how individuals interact with services; these can include religion and belief, sexual orientation and social and economic factors. These combined factors are widely known as determinants of health and can lead to individuals experiencing poorer health outcomes.

All local commissioning partners are committed to ensuring that services are accessible, appropriate and sensitive to the needs of individuals, and that we reduce inequalities in access and outcomes in the way we plan, procure and deliver services.

In addition to the existing organisational strategies, plans and activities to address and reduce inequalities, as part of the development and delivery of our transformation plan we will:

- ensure all providers who are commissioned to deliver services are committed to, and evidence, their approach to reduce inequalities
- ensure our engagement and co-production work with children and young people with protected characteristics to ensure our services reflect their needs and preferences
- implement robust data quality strategies to enable us to effectively monitor the access to and outcomes of services received by protected groups
- introduce new pathways for vulnerable children and young people to mitigate the effect of any barriers to achieving good access and positive outcomes from services
- undertake a comprehensive Equality Impact Assessment (EIA), both of the plan and prior to recommissioning and/or procurement of services
- undertake further work to better understand the needs of the local population and identify those experiencing the poorest health outcomes, including the CAMHS needs assessment which is underway and due to report in spring 2016
- promote the plan and its content across all groups and in a range of formats and languages, and ensure that all commissioned digital resources are accessible.

4.10 Lowest form of help first

Starting at the bottom, this plan recognises that every family needs key messages about promoting mental health, healthy behaviour and wellbeing in children, and that where possible this process should begin before birth. This builds further on the principle of making mental health everyone’s business and supporting young people and those around them to take early responsibility for
intervening early. As part of our plan, a wellbeing hub will provide a single route to support to ensure children are referred to a single point for assessment, there is active case management and that children can ‘step up’ in the system in a timely manner where the need is greater or symptoms worsen.

This transformation plan will help us to promote earlier intervention by ensuring local services are designed with children and young people, and give them easy access to support for their mental health to reduce problems and long term risk.

4.11 Directed self-support

To prevent problems presenting further downstream, early targeted intervention in response to an identified additional emotional need will be part of our approach to reduce demand on specialist services and meet lower level needs. This will require a particularly innovative and low cost approach, to maximise the reach of support and offer a range of options for support. The present offer is a face to face counselling service delivered by MIND; support is delivered for up to 12 weeks and there is currently a four month waiting list.

With additional funding we will explore how we can be more innovative, and co-design with young people high impact and wide reaching ways to deliver support for those with additional emotional needs, such as:

- online counselling
- group therapy
- peer support networks
- telephone talking therapies
- supervised self-management, such as Fear Fighter panic and phobia treatment
- introducing a new behaviour pathway for children and families experiencing mild/emerging behavioural difficulties (strengthening existing outreach).

4.12 Better supporting vulnerable groups of children and young people

Certain groups of children and young people may be more at risk of developing mental health problems, including looked-after children, those at risk of exclusion and young offenders. Services must be available to meet the emotional and mental health needs of vulnerable groups, with better assessment and delivery of specialist services where appropriate. We have evaluated the level of mental health support available to vulnerable groups, as well as the need for it, and this has been considered as part of our proposed model.

There is a body of evidence that supports associations between mental health outcomes and poor educational attainment, which often includes exclusion. Research also suggests some young people are more likely to experience mental health difficulties than the general population, for example children in special schools for behavioural, emotional and social difficulties (BESD schools) or pupil referral units (PRUs).

There are three PRUs in Havering, with Manor Green Campus being the largest. Our latest review found no CAMHS presence in any of the work they do on or offsite. A high proportion of staff felt there were no pathways between themselves and mental health providers, and there was a general lack of understanding of how to address low level concerns. This is further exacerbated by the fact that most young people accessing the PRU are there for poor choices, behavioural difficulties or challenges and exclusion so identification of potential issues may not be easy. It is vital that these
young people are provided with high levels of wraparound support to help them realise their potential and increase the chance of positive outcomes.

Our plans for increasing capacity at universal level will enable us to identify vulnerable children and young people earlier, using data on the needs of vulnerable groups to inform future service design. We will dedicate resources to ensure children have access to specialist provision while attending a PRU to reduce the need for more specialist services down the line.

Prior to leaving care all young people should have support around their health needs as recommended by NICE guidance. There are designated specialist doctors and nurses for young people in care, however once they leave care this support falls away and they need to manage their health needs independently, primarily through their GP.

With our new investment we are developing a vulnerable children and young people’s pathway with appropriate resource to ensure access to additional support, such as health assessments and speech and language therapy. One of our approaches is to explore local voluntary sector services who are delivering successful interventions to children and young people, particularly looked after children and those who are difficult to engage.

We know the transition from paediatric to adult services can be challenging, particularly in relation to mental health difficulties. If the young person does not meet the high threshold for adult services, they do not receive a service. There is likely to be a significant number of young people leaving care in this position.

Locally we have a process to support children transitioning to adult services. Children in Year 9 have a meeting with their key worker, with the purpose of the meeting to collect information from a range of people involved in the young person’s life so a detailed transition plan can be compiled to help the young person move into adulthood and the world of work or further education.

As part of the Adult Social Care and Commissioning Service Plan we committed to developing a robust transition protocol by January 2016. This will help us to better commission tailored services that support the transition of young people to adulthood as well as improving outcomes.

4.13 CAMHS looked after care specialist clinicians

As an outer London borough, Havering attracts children who are looked after but not by this authority. The CAMHS looked after children service will endeavour to see all children on the basis of clinical need. Where a looked after child is the responsibility of another borough, funding will be sought from the originating CCG19.

The local authority provides funding for specialist therapeutic intervention for Havering looked after children, and their carers, with particular emphasis on children in transition and placement planning. The direct work the service provides includes specialist assessments, consultation and therapeutic intervention.

The current post holder of this role is co-located across both CAMHS and Children and Young People’s Services, and will develop close relationships with professionals within children’s services, Tier 3 CAMHS and other appropriate agencies, offering assessment, clinical support and treatment

19 In accordance with the Department of Health’s Responsible Commissioner Guidelines, 2007
to children and adolescents with mental health problems in a variety of settings including at the child’s placement.

A key part of the role is the development of seamless links and pathways for transition between children’s services, adult services and young people leaving care. Also, to focus on supporting placement stability of young people placed both in and out of the borough. The post is designed to be the central point of contact for external agencies and will be a champion for the relevant service within the children’s social care team.

The comprehensive service model proposed in this plan covers all ages from birth to age 18 (up to 25 for young people with special educational needs and disability).

**Havering CAMHS model for looked after children and those leaving care**
The transformation plan includes a specific approach to commissioning services for looked after children:
- a dedicated clinician-led service for looked after children and care leavers
- fast-tracking to mainstream CAMHS and other universal and targeted/specialist services where needed
- covers both emotional health and diagnosable mental health conditions
- work with schools to build resilience
- work with foster carers to build resilience
- for those at risk of placement breakdown
- children placed for adoption or who have been adopted
- children in complex settings
- foster carer resilience working
- consultancy for key professionals
- clinical and psychological assessment
- child psychiatry
- family support and CBT
- group work
- family assessments.

### 4.14 Crisis support

Emergency support for children and young people with mental health issues has been highlighted as a national priority and identified as a key area for development locally. With waiting lists and access to services being identified as a problem across the country, there are concerns that current waiting lists may include some who are in need of additional crisis support.

The transformation plan seeks to ensure those who are in need of crisis services receive them in a timely manner. However there is also a need to ensure these services are not clogged up by those who could potentially achieve better outcomes with lower level packages or a mix of interventions. Delivering this ambition is necessary as it comes at a time when we are seeing a significant increase in demand for services with an added rise in the complexity and severity of cases, which impacts on the high level part of the service.

### 4.15 Recovery pathways

In order to support recovery in those using mental health services, we need to deliver high quality services whose interventions will lead to key recovery outcomes. We know we need to better
support children who have been victims of abuse or trauma. In Havering there were 30 children under 13, and 74 young people aged 13 to 17, who received services from the forensic medical examinations provider, Havens, between 2004 and 2014. On average this is 10 children and young people per year.

A recent review of sexual assault centres identified that these do not currently offer any mental health recovery interventions for children, and there is an expectation that community mental health services are able to offer the appropriate support. The transformation plan will incorporate specific developments (in later phases) so children who require trauma and abuse recovery work will be treated as vulnerable children and can access prioritised treatment, delivered by professionals trained and skilled in this particular area of work. This is likely to include working with professionals in the community and voluntary sector who have the expertise and experience to support children.

### 4.16 Reintegrating young people into the community on leaving care

Young people entering the local authority care system will already have had trauma and difficulties over and above those experienced by most of their peers. Most will have suffered abuse or neglect, or experienced bereavement, disability or serious illness in one or both parents. Many will be from disadvantaged backgrounds. All children who have been in care should be supported to ensure any aftercare plans provide clear links to all sources of support, including the community.

Havering has consistently low rates of children in care and on average there are 190 children in its care at any one time. Despite this, we want to see all care leavers receiving high quality services that meet their needs and support them to make the transition into adulthood. We already know there is a significant gap between the educational achievements of care leavers and their peers; therefore we aim to ensure a good standard of education is available to all those leaving care – a key driver to achieving positive employment outcomes in adulthood. We will achieve this by using personal advisors, and encouraging and supporting care leavers to remain in education, take up training opportunities and undertake activities aimed at improving employability. We will also:

- ensure all care leavers have robust transition plans in place that make use if the wider benefits of the community
- ensure care leavers requiring support and guidance receive this both before and after they turn 18
- use the Department for Education’s Transitions to Adulthood guidance, which sets a clear expectation that local authorities continue to stay in touch with and support young people when they leave care, until young person reaches 21, or beyond if they are in education (underpinned by the Care Leavers’ Charter 2012)\(^20\).

In 2013 the Government developed a cross-departmental strategy for young people leaving care\(^21\). Havering has used the guidance to support changes frontline local service provision, as well as building on the best local practices. The overall aim in Havering is to ensure that:

- care leavers receive high quality on-going support from their local authority so they do not feel lonely or isolated
- looked after children and young people leave care at a time when they are ready.


5. **Future model and proposed plan**

**Improving access to an effective system without tiers**

The process of developing the transformation plan has provided us with the opportunity to make dramatic changes to the way mental health services for children and young people are delivered in Havering. Our plan is to redesign services to remove the traditional tiers of CAMHS, having a single point of access (the wellbeing hub) for all referrals to the service. By implementing this approach we seek to remove the potential for young people to fall between the services, while reducing waiting times and providing a holistic package of care that is supported jointly across services. The plan has been developed in collaboration with a range of partners and captures our shared vision.

Current demand levels and service capacity suggest there are unmet needs in the borough, confirmed by information we have about current waiting times for assessment and treatment for lower level needs, and the treatment gap where current service provision cannot keep pace with demand.

We need to adopt a multi-faceted approach to meet the needs of all children and young people who require support with their mental health. This requires a combination of building resilience to reduce the rising number of young people presenting with emotional needs, and ensuring better knowledge, self-help resources and guided self-management support, to extend our reach – providing even more young people with support while achieving high impact and value for money. The approach also focuses on the powerful role and impact that parents, peers and non-specialist professionals can have on children and young people’s emotional and mental health and includes plans to empower and equip those people within a child’s sphere of influence.

5.1 **New model: quadrant approach**

The proposed model, illustrated in the figure below, demonstrates a step-change in service delivery – moving from a tiered and hierarchical approach to a seamless pathway into and out of four quadrants of service provision. It is based on key principles of preventing ill health and promoting wellbeing from before a child’s birth to 18 years of age.
5.1.1 Quadrant 1

Our model is based on key principles of preventing ill health and promoting wellbeing from antenatal to 18 years (or flexibly according to need).

As part of our work around promotion and prevention we aim to build on our existing offer of support for those with emotional needs (distinct from mental health). We will do this by targeting investment at lower level and earlier help interventions including counselling, cognitive behavioural therapy and other targeted therapies.

Schools
We will collaboratively commission with local schools to support whole school approaches to mental health, to build both emotional and academic resilience.

Training
We are committed to investing in upskilling parents, children themselves, school workers and staff in other universal service settings, to enable them to identify and support children and young people earlier:

- Professionals
  It is our aim that all non-mental health professionals are trained to identify vulnerable children and those at risk of developing emotional or mental health needs or those requiring early help. Ensuring staff are fully trained, qualified and competent and are continuing to develop professionally is the responsibility of all services working with children and young people. As part of this plan, universal services will be working with their staff to ensure their staff are able to understand what mental health and wellbeing is, know what they can do to support its improvement, and know what support is available for parents and carers or where they can find out.

- Parents and carers
  Parents will have access to effective and up to date emotional and mental health service provision for children and young people via the local offer. When we consulted with parents, they told us they would like to receive training on how to offer practical and effective support to their children at difficult times and cited conflict resolution as one of the main issues.

- Mental health champions
  The introduction of mental health champions will help us to reinforce the key message of mental health being everyone’s business, as will coordinating local campaigns to raise awareness.

5.1.2 Quadrant 2

This quadrant will focus mainly on coping. Aimed at both children and young people and their families, it also provides guidance on parenting resilient young children and young people, highlighting both risk and protective factors and what parents can do practically to build resilience in their children. Our new model will promote a self-referral approach for young people to access targeted digital learning resources such as Big White Wall – a 24-hour online counselling offer. We will also provide parents with the ability refer themselves to access parental learning modules, as this has been identified as a gap in current service delivery as well as a model of good practice.

This quadrant provides timely and proactive support to children in the Youth Offending Service, pupil referral units and looked-after care.
It will also provide direct access to the proposed single point of access (wellbeing hub), which will enable those with higher level needs to receive assessment, referral and onward treatment in a timely manner.

5.1.3 Quadrant 3

The third quadrant will provide treatment from specialist services where a child or young person may present with mental health needs that could be diagnosable. The specialist staff working in this quadrant help to build capacity within the system by providing training, support and advice to staff in lower areas of need (e.g. universal services) to increase their capacity to support a child effectively.

As part of this plan, we will work with providers to develop and produce clear pathways for children requiring specialist mental health assessment or intervention. The new service model will be clearly communicated to service users and the wider public. Robust structures for delivering services at this level will also be created as well as clear boundaries regarding the contributions of individuals to providing those services.

5.1.4 Quadrant 4

This quadrant has a focus on children in need of crisis support and higher level interventions from specialist services. Waiting times and access to this level of care have been highlighted as areas for improvement and we know that care pathways can often be unclear. Our aim for transformation of this quadrant will include ensuring all children and young people who need more specialist support and their parents and carers, will have clear information on what to do if things do not go according to plan.

5.2 The wellbeing hub: a system without tiers

We want to create a ‘single route to support’, to provide a seamless pathway of care and support from the point of referral. This will support professionals working with children who will be able to make a single referral and a multi-disciplinary mental health team will assess which would be the lowest level of appropriate treatment to meet the child’s needs. From this point the referral is not re-referred but referred for treatment. Expectations of the Wellbeing Hub include:

- receive professional referrals for children with additional emotional or mental health needs including those who would not currently be eligible for CAMHS
- act as advisors and gatekeepers, redirecting back to universal services where appropriate, or providing the gateway to targeted early support or more specialist services
- undertake an initial multi-disciplinary assessment and agree the lowest level of appropriate support for each child. This could include supervised self-management, telephone and online counselling, group therapy, behaviour pathway, or specialist treatment. Alternatives would be offered while on the waiting list if appropriate
- have overall responsibility for case management and ensure stepped care can occur so that children do not have to start again and be re-referred should their needs change while they are already in the system
- provide and coordinate CAMHS key workers to supervise and provide strategic oversight for self-directed support that is actioned via the single route to care, such as telephone counselling and online CBT
- be open 24/7, with reduced staffing at weekends and evenings
• deploy higher grade, senior mental health specialist resources in addition to other therapists and counsellors from the community and voluntary sectors.

There is a range of entry points into CAMHS, however in future children and young people who need any form of extra help will access support through the single hub, with the ability to move between as many or as few of the quadrants are appropriate to their individual needs.

5.3 Crisis intervention team

Havering’s mental health service provider, NELFT, is committed to caring for to young people in mental health crisis in line with the principles of the Mental Health Crisis Care Concordat22. The four key themes of the concordat are:

• access to support before crisis point
• urgent and emergency access to crisis care
• the right quality of treatment and care when in crisis
• recovery and staying well, and preventing future crises.

There will be one crisis intervention team for the four boroughs in which NELFT provides mental health services, and it will expand the services currently offered by INTERACT at Brookside Unit. The proposed team will be available 24/7 and will work with children and young people from birth to age 18; its remit will cross both community work and inpatient work. The model of the team is similar to home treatment teams in adult services, where they will have the ability to work with young people and their families in their homes, seeing cases on a daily basis if required. The work will be aimed at crisis management, risk management and prevention of admission. If the latter cannot be avoided, the team will work effectively with the Tier 4 unit to ensure a short stay in hospital with intensive post discharge follow-up.

The team, which will be managed by a dedicated crisis team manager, will share an open-plan office and be equipped to work in an agile capacity. All contacts with children, young people and their families will be off site, either in the family home or at school or another venue acceptable to the young person, such as a coffee shop. Those young people who are in hospital will be seen in hospital, either in A&E or the paediatric ward.

Crisis pathway

The team’s core hours of work will be 9am to 9pm on weekdays. Outside these hours shift workers will be available to attend to A&E within four hours of receiving an emergency call.

The team will assess the young person’s mental state, social circumstances, level of risk, past history, and any other relevant information, to inform the management and risk management plan. Each child, young person and family will be involved in the development of their care plan and will receive a copy. The team will work jointly with Tier 3 CAMHS staff and other relevant partners, who will hold joint responsibility for the case. This will ensure seamless transfer back to Tier 3 or partner services once the crisis is over.

The following are examples of clinical scenarios that may emerge after hours and how the team would respond:

• Presentation of a suicide attempt at A&E: The crisis team will see the young person within four hours in A&E to assess them and to advise the paediatric team on how to manage

22 http://www.crisiscareconcordat.org.uk/about/
them. If medical cover or advice is required, the team will liaise with the on-call duty psychiatrist. In accordance with NICE guidance, the young person will be admitted to the paediatric ward and the team will see and assess the young person again the next morning. If the patient is able to go home, the team will provide intensive support at home as well as manage a referral to Tier 3 CAMHS for joint working. If the risks are too high for discharge, the team will liaise with Tier 4 services to find a mental health inpatient bed. Once admitted to the unit, the crisis team will work closely with Tier 4 staff to try to keep the hospital stay under two weeks if possible.

- Presentation of a known case to Tier 3 services where an escalation in risk and complexity is apparent: Tier 3 can bring in the crisis team to work alongside them manage the case more intensively in order to prevent deterioration and admission.
- Presentation of a known case to Tier 3 who suddenly goes into crisis at the weekend: NELFT proposes that all cases held in Tier 3 should have a written crisis plan with an emergency number to call in case of crisis. Under the new model, this would be the crisis mental health out of hours number, diverted from the wellbeing hub. The aim is to prevent the families in distress turning up in A&E, as the crisis can be handled by the crisis team effectively.
- At times it may be necessary for the crisis team to attend the paediatric ward when a patient has an acute mental health presentation. If psychiatric medical help or advice is needed the crisis team will liaise with the on call CAMHS psychiatrist.

There is also opportunity for future development in line with hub functionality. This is yet to be fully scoped in terms of capacity, but initially it would be an additional function to the above, and as confidence and capacity grows within the wider children and young people’s workforce it is then anticipated to offset some of the demand for crisis support work, and potentially the demand for higher interventions. These opportunities are:

- Outreach support for practitioners working with a child or young person. The practitioner can be supported with a plan of action, intervention discussions and recognition of escalation points, enabling them to provide effective early intervention and support. This can be via telephone, email or face to face contact with the practitioner.
- Development and delivery of training packages and programmes for the wider children’s workforce, delivered by skilled and knowledgeable practitioners. The training would be linked to the outreach support.

6. **Specific deliverables for 2015/16 by service**

6.1 **Overarching service deliverables**

Appendix A includes an overview of spend against specific deliverables, both for the remainder of the current year and for next year. The CAMHS assurance data collection template, which includes our financial tracker outlining specific deliverables with key spend, outcomes and milestones can be found at Appendix B.

Havering CCG is the lead children’s mental health commissioner and main source of funding, with current investment of £2 million, potentially rising to £2.5 million once the plan is assured. The CCG is well placed to lead given its role in contract negotiations, provider performance management and service development.

The Havering transformation plan will make provision to deliver all recommendations of the most recent CCG and council service review. This will include (but not be limited to) improvements to:
Havering Children and Young People’s Mental Health Transformation Plan

- building resilience to common insults and life events such as exams, bereavement and bullying
- referral criteria and pathways of care
- Tier 2 provision to ensure timely early intervention
- out-of-hours children’s mental health services
- crisis management to prevent escalation to Tier 4
- focus on looked after children, young offenders, learning disabilities, young carers and other priority groups
- the management of transition cases between children’s and adults’ services
- engagement with children
- online training to increase workforce capacity
- knowledge and confidence of GPs, school staff and other referrers
- targeted training aimed at parents and carers
- commissioning.

6.2 Eating disorders services

The NELFT eating disorders service (EDS) offers specialist assessment and treatment to people aged eight and above (adults, adolescents and children). The service works with individuals and their families to support them in their recovery.

Services provided by EDS include:
- psychological treatments delivered on an individual basis, to families and in groups
- dietetic input and nutritional support
- medical and nursing assessment and intervention.

The decision to offer a service will be based on the individual’s ability to benefit from treatments for an eating disorder. The EDS team includes a consultant psychiatrist, specialist adult and CAMHS nurses, CBT therapists, family therapists, dieticians and psychologists.

NELFT children’s eating disorders service (CEDS) is an integrated lifespan service. This service delivery model helps avoid well documented issues of transition that are both damaging and costly. Given the severe medical risks and associated mortality rates in eating disorders resources are targeted at those most at risk, such as low weight patients. In most cases the triage system will review the referral the same day, the patient will be assessed within one week and begin treatment immediately.

In order to maintain this care pathway resources are often redirected from the adult arm of the service. Consequently, for patients less at risk there is a delay in accessing treatment; however, following assessment all clients will receive immediate specialist nurse monitoring and be invited to a pre-therapy group. The use of trainee psychologists and assistant psychologists also helps to minimise the waiting time. There is no waiting list to see the dietician as this service is only on offer to high risk clients.

Resources for this part of the service are extremely limited therefore robust case management systems are in place to support case closure. Treatment is evidence based and time limited and there are routine outcome measures from the beginning to end of treatment.
Activity/performance 2014/15 for Havering eating disorders service:

<table>
<thead>
<tr>
<th>Activity/Performance</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>New referrals</td>
<td>62</td>
</tr>
<tr>
<td>Closures</td>
<td>63</td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>601</td>
</tr>
<tr>
<td>Telephone contacts</td>
<td>45</td>
</tr>
<tr>
<td>Total contacts</td>
<td>646</td>
</tr>
<tr>
<td>Average active caseload for team</td>
<td>79</td>
</tr>
<tr>
<td>Average number on waiting list (individual therapy)</td>
<td>2</td>
</tr>
<tr>
<td>Current waiting time for individual therapy</td>
<td>Approximately 12 to 16 weeks for non-urgent cases</td>
</tr>
</tbody>
</table>

NHSE commissioned the National Collaborating Centre for Mental Health to develop a new model of care for a children and young people's community eating disorder service (CYP CEDS). This was published within the commissioning guidelines in August 2015. In addition to developing a new service model the guidelines include access and waiting time targets, workforce, training, and good practice.

### 6.3 Community eating disorder service delivery

NHSE has provided each CCG with additional funding, for five years from September 2015, to transform community eating disorders services for children and young people.

### Additional funding per CCG, 2015/16:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>£111,350</td>
</tr>
<tr>
<td>Havering</td>
<td>£144,659</td>
</tr>
<tr>
<td>Redbridge</td>
<td>£146,066</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>£148,850</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£552,925</strong></td>
</tr>
</tbody>
</table>

The transformation is to be achieved by developing a specialist service with rapid and easy access to evidence-based, high quality care and support. This will lead to improved recovery rates, fewer relapses and reduced inpatient treatment. The multidisciplinary eating disorder team should have knowledge of the epidemiology of eating disorders, risk factors for developing the illness, the physiological effects of malnutrition, physical and medical risks of starvation, and of nutrition. The team should also understand that eating disorders often coexist with a range of mental and physical health problems, there is a high risk of self-harm, and the needs of children and young people with an eating disorder, and their families and carers, vary considerably.

Furthermore, research has shown that this service needs to be separate from general CAMHS.

### 6.3.1 Needs assessment

CCGs are required to work collaboratively to commission a community eating disorder service for children and young people, which needs to cover a population of a minimum 500,000 (all ages).
Current estimated population of Havering and neighbour CCG areas:

<table>
<thead>
<tr>
<th>CCG Area</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>187,029</td>
</tr>
<tr>
<td>Havering</td>
<td>237,232</td>
</tr>
<tr>
<td>Redbridge</td>
<td>293,000</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>265,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>983,061</strong></td>
</tr>
</tbody>
</table>

Prevalence

In 2009, the incidence of eating disorders among UK males aged 10 to 19 years was 31 per 100,000. For females in the same age group it was 120 per 100,000\(^{23}\). This incidence would equate to a total of 14,851 affected children and young people in Havering and its neighbour CCG areas, as set out in the table below.

Estimated numbers of young people aged 10 to 19 years with eating disorders:

<table>
<thead>
<tr>
<th>CCG area</th>
<th>Females (10-19)</th>
<th>Males (10-19)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>2,244</td>
<td>580</td>
<td>2,824</td>
</tr>
<tr>
<td>Havering</td>
<td>2,864</td>
<td>735</td>
<td>3,599</td>
</tr>
<tr>
<td>Redbridge</td>
<td>3,516</td>
<td>908</td>
<td>4,424</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>3,180</td>
<td>824</td>
<td>4,004</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,804</strong></td>
<td><strong>3047</strong></td>
<td><strong>14,851</strong></td>
</tr>
</tbody>
</table>

6.3.2 Current service model

The NELFT team is based in a health centre in Dagenham and works with patients with an eating disorder from the age of eight, with no upper age limit. Being based in a health centre allows the team to access physical health tests, as well as being based in a location that is not mental health-specific or likely to carry any stigma.

The team currently works with the most high risk children and young people with an eating disorder, predominantly anorexia nervosa. They are able to deliver some physical health interventions, being co-located in a health centre. Because the team has no upper age limit there are no issues regarding transition unless the person has co-morbidity or is an inpatient.

All therapy staff are trained in core treatment models such as CBT and systemic therapy. However, not all staff are trained in eating disorder-specific models such CBT-E for eating disorders and the Maudsley Model of family therapy for eating disorders. Not all staff have received children and young people’s IAPT core and specialist eating disorders training, with only two team members trained to offer IAPT supervision (four hours per week). Not all staff are trained in alternative evidence-based treatments for eating disorders such as MANTRA and specialist supportive clinical management.

A fuller description of the service and a breakdown of its activity for last year can be found in section 3.2.2. of this report.

\(^{23}\) Micali et. al. 2013 [http://bmjopen.bmj.com/content/3/5/e002646.full](http://bmjopen.bmj.com/content/3/5/e002646.full)
Access targets
All patients are triaged immediately for risk and given an appointment for the weekly eating disorders clinic. The patient then receives a multidisciplinary team assessment including an echocardiogram and blood tests, and they leave with a care plan.

Current staffing:

<table>
<thead>
<tr>
<th>Role</th>
<th>Full Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service manager Band 8b</td>
<td>0.5</td>
</tr>
<tr>
<td>Consultant psychiatrist</td>
<td>0.5</td>
</tr>
<tr>
<td>Nurse</td>
<td>0.5</td>
</tr>
<tr>
<td>Dietician</td>
<td>0.5</td>
</tr>
<tr>
<td>Psychologist/CBT therapist</td>
<td>0.5</td>
</tr>
<tr>
<td>Family therapist Band 8b</td>
<td>0.5</td>
</tr>
<tr>
<td>Family therapist</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.5</strong></td>
</tr>
</tbody>
</table>

Gaps
The current service is unable to deliver:
- education programmes for schools, colleges and GPs
- early interventions
- lower intensity specialist eating disorders services
- outreach and satellite services
- consistent input from paediatricians
- work with atypical eating disorders – one of the most common presentations in young people
- intensive therapy
- CBT for all patients and multi-systemic family therapy for any patient, both are which are indicated by NICE as effective interventions
- a greater than limited input from dieticians
- a seven day service which is required to meet new standards
- supervised meal times
- daily/intensive support
- home visits.

Conclusion
The service only works with patients who have an eating disorder and has therefore developed the skills to undertake this work. However there is a limited number of staff in the team, so it only works with high risk patients. Furthermore, being based in Dagenham means the distance by public transport makes the service inaccessible for many in Havering, and somewhat impractical for the provision of outpatient treatments.

Even with the additional funding the service will not be able to deliver all the requirements of the new model of care.

The new funding must support the new access and waiting time targets for assessment and treatment. Currently the service can meet the access time targets but not the NICE treatment time targets. The majority of resources are dedicated to the most high risk service users.
The additional funding will be spent on the workforce and must include a paediatrician and more therapists to deliver the NICE-compliant treatment. The issue is largely where these health professionals work, the range of eating disorders they will work with and how much early intervention and education and training the team will undertake.

6.3.3 New service model

Access and waiting time targets:

Emergency
Support received within 24 hours, to include NICE concordant treatment to be received within a maximum of 24 hours from first contact with a designated healthcare professional.

Urgent
NICE concordant treatment to be received within a maximum of one week from first contact with a designated healthcare professional.

Routine
NICE concordant treatment to be received within a maximum of four weeks from first contact with a designated healthcare professional.

Treatment
Treatment for an eating disorder needs simultaneously to address a number of areas of development and functioning. In a similar way to the assessment, multidisciplinary input is required to ensure treatment is integrated, person-centred, reflects the principles of participation and joined decision making, and remains outcome and goals focused, comprehensively managing all relevant problem areas.

The areas covered within an individual’s treatment might include:

- monitoring and management of the child or young person’s physical/medical state and functioning, overseen by medical staff (a paediatrician or GP with specific expertise in eating disorders) or appropriately-trained nursing staff
- monitoring and management of the child or young person’s general mental state, overseen by a psychologist or psychiatrist
- nutritional rehabilitation overseen by a dietician
- individual psychological interventions provided by psychologists, nurse therapists or other appropriately trained and qualified therapists
- family interventions (to include multi-family group interventions), provided by family therapists, psychologists, nurse therapists or other appropriately trained and qualified therapists
- group interventions and other psychosocial interventions, provided by psychologists, nurses or occupational therapists
- home treatment and mealtime support, provided by nursing and support staff
- management of psychotropic medication where prescribed, including for any coexisting mental health problems (for example, depression and anxiety), overseen by a psychiatrist.

Psychological treatment therapies to be available

- family interventions are to be a core component of treatment required for eating disorders in children and young people
• CBT and enhanced CBT (CBT-E) in the treatment of anorexia nervosa, bulimia nervosa and related adolescent presentations.

Required changes to the workforce:

Numbers
The number of professionals within the team will depend on the anticipated needs of children and young people, and their families or carers, within the geographical area served by the team. The table below outlines the staffing levels the commissioning guidelines suggest to deal with 150 CAMHS referrals. In 2014/15 there were 176 referrals.

Recommended staffing levels for 150 CAMHS referrals into eating disorders service:

<table>
<thead>
<tr>
<th>Role</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of service (psychiatrist/psychologist)</td>
<td>1.8</td>
</tr>
<tr>
<td>Paediatric consultant</td>
<td>0.3</td>
</tr>
<tr>
<td>Speciality registrar (psychiatrists)</td>
<td>2.4</td>
</tr>
<tr>
<td>Senior clinical staff Band 8A/8B</td>
<td>2.5</td>
</tr>
<tr>
<td>Therapists Band 7</td>
<td>10.1</td>
</tr>
<tr>
<td>Home treatment specialists</td>
<td>3.8</td>
</tr>
<tr>
<td>Dieticians</td>
<td>2.3</td>
</tr>
<tr>
<td>Support staff Band 4</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25.9</strong></td>
</tr>
</tbody>
</table>

The commissioning guidelines also estimate recurrent cost for CYP CEDS, based on 150 referrals to be £2,336,367. The cost for referrals is calculated not by cost for a single patient, but including a share of the steady caseload for the service.

Skill mix
The following areas of expertise must be provided within the eating disorders service team:
• psychiatric assessment for children and young people
• medical assessment and monitoring
• rapid response to referrals as outlined in the care pathway
• staff trained to supervisory level for evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)
• staff trained in the delivery of evidence based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)
• relevant experience to enable the team to provide home treatment and family support
• acute service and paediatric support: support should be provided to these services seven days a week
• ability to provide care and response over a seven day week
• the team should have sufficient staff to provide administrative and management support. Support staff must be experienced and have adequate training in relevant areas including data entry.

6.4 Self-harm

The rate of hospital admissions for self-harm or mental health disorders can be an indication of the effectiveness of local CAMHS provision. Hospital admissions for self-harm in children have
increased in recent years, with admissions for young women being much higher than admissions for young men.

In 2011/12, Havering’s rate of admissions for mental health disorders per 100,000 residents from birth to age 17 was lower than the England rate. The borough was in the second quintile of performance (lower is better) for admissions due to self-harm, compared with all local authority areas in England. For 2012/13, the rate of admissions for children and young people up to age 17 with general mental health concerns was estimated to be around 40 individuals per 100,000.

Between 2010/11 and 2012/13, hospital admission for self-harm among children and young people aged 10 to 24 was estimated at 279 individuals per 100,000. This local data also correlates with the national picture. Research conducted by Young Minds shows that one in 15 young people self-harm, leading to a 68% increase in young people admitted to hospital due to self-harm injuries in the last 10 years.

Havering is investing in this area by providing school outreach on prevention and resilience building, to help students manage life events and to provide them with positive coping strategies.

6.5 Perinatal services

This service is commissioned across four CCGs – Havering, Barking and Dagenham, Redbridge and Waltham Forest. It works closely with the Primary Infant Mental Health Service and aims to reduce the impact of maternal mental health upon children, by ensuring early diagnosis and better intervention and support. The service does not operate a waiting list, but has allocated emergency clinic space for priority patients.

**Havering perinatal service usage 2014/15:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>New referrals</td>
<td>251</td>
</tr>
<tr>
<td>Face to face contacts</td>
<td>842</td>
</tr>
<tr>
<td>Telephone contacts</td>
<td>207</td>
</tr>
<tr>
<td>Average caseload for team</td>
<td>92</td>
</tr>
<tr>
<td>Average waiting time (days)</td>
<td>0</td>
</tr>
</tbody>
</table>

6.6 Children and young people’s IAPT

In August 2015, Havering’s CAMHS partnership was allocated funding for a children and young people’s Improved Access to Psychological Treatments (IAPT) service. A number of staff have already been identified as key roles who will participate in training.

The key aim of the IAPT programme is to transform existing services for children and young people, adopting elements of the IAPT programme which will help to improve outcomes for children, young people and their families by providing treatment that is based on best evidence, and is outcome focused and client centred.

6.7 Key performance indicators (KPIs)

Specific KPIs have been agreed and detailed for year one of the plan and have been correlated to the arrangements set out in the finance tracker. For the second phase onward we will work across
the local partnership to develop a joint performance framework which will include an outcome indicator set to measure how well we are achieving these outcomes.

Plans will also be supported with measurable and ambitious KPIs to ensure the plan is delivering the required improvements. This work will be developed in more detail as part of the joint governance arrangements which will include a joint CAMHS implementation group.

7. Evidence of co-production

7.1 Collaboration with our commissioning partners

7.1.1 NHSE specialised commissioning

NHSE has been engaged in development of the plan through the BHR Integrated Care Steering Group. Requirements for a transformation plan were discussed at the meeting held in September 2015.

Joint commissioners attended an NHSE-hosted transformation planning workshop on 2 October 2015 to discuss requirements and progress, and to discuss the plans in detail with other commissioners.

Further plans to work with NHSE to co-commission local services include integrated pathways from inpatient to the community, and discharge and community planning. As a borough we are aware of our population of young people currently accessing Tier 3 services who are at risk of needing to access Tier 4 in future. We aim to develop clear pathways with colleagues in specialised commissioning to provide seamless transitions between specialist and community services for children and young people. This work will also include addressing residential and school placement breakdowns which can occur.

7.1.2 Youth justice

Havering is committed to developing a health and justice pathway for young people accessing the youth offending service to address not only the mental but also the physical healthcare needs of offenders. The CCG is a statutory and active member of the borough’s Youth Offending Service (YOS), which meets quarterly. The borough has seen increasing youth offending and gang activity as borough demographics change (see section 3.2.2 of this report for a full analysis) and there is a clear association with mental health problems. This joint meeting provides evidence of the health contribution to the YOS.

In relation to custody, Havering currently has two young people in secure training centres and two in young offenders’ institutes, equating to four young people – lower than neighbours Redbridge (five), and Barking and Dagenham (13). Despite this we are keen to ensure that all young offenders, especially those with learning difficulties, have better access to continuity of care and integrated delivery of services in both the community and secure estate.

Havering YOS's dedicated CAMHS and the borough’s CAMHS looked after care workers both contributed to this plan.
In July 2015 Her Majesty’s Inspectorate of Probation inspected Havering YOS. The inspection lasted several days and was part of the Short Quality Screening Inspections Programme. It focused on three areas:

- the start of any court order, including assessments and planning
- outcomes of intervention
- management oversight of all cases.

Case managers were interviewed and required to give detailed feedback on areas such as supervision, auditing and support. The lead inspector found that, overall, the service provided good assessments of offending behaviour and public protection arrangements and these had improved significantly since the last inspection. The full inspection report can be read on the inspectorate website.

Havering is not currently a member of the North East London Resettlement Consortium and we are looking into joining this group. We will apply to work with them to develop a local integrated health and justice pathway. This will include integrating young offenders into the vulnerable group pathway enabling prioritised access and tailored support delivered by professionals who are experienced in dealing with youth offending mental health problems. We will prioritise further pathway development work and support to offenders in crisis, for example outreach support in police stations.

By investing in the physical and mental health of young people accessing the YOS, we aim to build on an existing model of good practice that is being delivered and ensure all children have support from the right services at the right time.

7.1.3 Community engagement with children and families

We have incorporated findings from the Havering emotional health and wellbeing review of children’s services 2015-18, when children were able to feedback on how they felt about existing service provision and what they would like to see. The CCG also delivered a paediatric roadshow event across the borough to find out about community health services and the views of their service users. One of the surveys conducted looked at the top 10 avoidable hospital admissions for children and young people, and the third highest was behavioural and emotional mental health issues in children. This was further supported by consultation with schools who admitted that the challenges in knowing what pathways to follow meant they would often refer to A&E. We have since provided feedback sessions to ensure we are listening to what parents, families and young people are saying.

Engagement has included the following groups:

- Positive Parents (support group for parents of children with additional needs)
- Us Mums (peer support for parents of children with additional needs)
- Add+Up (local ADHD support charity)
- First Steps Parents Group
- Havering Foster Carers Group
- parents of primary and secondary school children
- children accessing short break provisions
- children attending afterschool clubs
- all parents and children who attended the paediatric roadshows.
7.2 Services designed and built around needs of children, young people and families

Our understanding of the needs of children, young people and their families is built upon both the Havering JSNA and the extensive work we do across all agencies to obtain the views, experiences and input of children and young people. There are a number of mechanisms in place to engage directly with young people and their families, including children with vulnerabilities such as looked after children and those with special educational needs or disabilities.

The transformation plan has been informed by the views and needs of children and young people that have been routinely captured as part of business as usual, and through the engagement work described in section 7.1.3 above. In addition we have rolled out GP master classes to ensure family doctors are trained on emerging children’s issues locally, of which mental health is one.

A specific review of CAMHS was conducted throughout 2014/15 and sought to identify if services are:

- suitable for those who need them
- available and accessible to all children and young people who require them
- able to produce evidence of appropriate outcomes
- able to facilitate partnership working with other agencies
- including families in the process where appropriate
- effective pathways for young people making transitions with links to relevant partnership agencies.

Key messages and concerns from children and young people and their families were:

- A need for clarity regarding services that are provided locally as knowledge of services in Havering is limited.
- Mental health providers including the voluntary sector should work in conjunction to develop a suite of targeted training, aimed at parents and carers of children and young people with special educational needs and learning disabilities, as this is a current gap.
- Parents would like to be trained on how they can resolve conflict as most of the time they feel unequipped to offer support to their child.
- Children and young people wanted to access support through a wider variety of locations, not just traditional mental health services—which often have stigma attached to them.
- Parents also wanted access to advice and guidance on how to support the wider family at times of distress, including siblings with no mental health concerns.

7.3 Effective joint working

Our engagement in this process has been robust and wide; we have engaged with individuals and services including GPs, public health, children and adults’ social care, mental health providers, education, special educational need and disability (SEND) services and the voluntary sector. Key elements of the engagement process to ensure multi-agency and senior management input into the plan included:

- joint stakeholder engagement event on 24 September, to share the proposed model and obtain feedback
- the findings from the Havering CAMHS service review 2015 were used to inform this transformation plan. This consultation included the views of parents and carers, schools,
GPs, hospitals, mental health providers, Havering’s parent forums, and youth services including the YOS. The full recommendations from this are enclosed at Appendix C

- attendance at Havering Joint Transformation Planning Group, which has met monthly since July to provide joint coordination of the process between the local authority and CCG
- sharing our proposed plans for transformation with lead GPs and clinical directors of paediatric and mental health services throughout the process.

There is already good progress in joint working and commissioning arrangements across local agencies, cemented recently by the introduction of the SEND reforms of the Children and Families Act 2014. The local authority and CCG have appointed a joint children’s commissioner to lead and develop arrangements for more integrated education, health and social care services for children and young people. A joint commissioning strategy for SEND is currently in production following the recently launched SEND strategy.

7.4 Alignment to SEND reforms, Crisis Care Concordat, CPEN

Havering, Barking and Dagenham, and Redbridge (BHR) CCGs are committed to working in partnership to continue to improve crisis care for adults, children and young people with mental health needs in the boroughs.

The Mental Health Crisis Care Concordat24 is warmly welcomed by BHR CCGs and their partners, and builds on work that is already under way across the area. An action plan has been developed in response to the Concordat by the CCGs, local authorities and physical and mental health care providers. The action plan is also supported by the Metropolitan Police Service, London Ambulance Service NHS Trust and the community and voluntary sector.

Havering has an action plan to drive and deliver local improvements to crisis care. The plan aligns with the local transformation plan as it consists of overarching commissioning and partnership responsibilities as well as actions to improve prevention, access, treatment and recovery. The plan includes shared actions across BHR CCGs, reflecting the commitment of partners and agencies across the boroughs.

As part of the 2014 SEND reforms the mental health of children with additional needs has been high on the agenda in Havering. As part of this plan we seek to address the gap in transition pathways for children and young people with learning difficulties who are moving onto adult services. Our engagement activity highlighted that better links need to be made from children’s services, so that adults services are more aware of the young people they will be working with prior to their arrival, to enable better planning and coordination. Often there is confusion about where the responsibility lies and how this is taken forward. To address this, we envision that the transformation plan will include developing a transition liaison role, which will sit in children’s services and identify those who will need transition to adult services within the next few years.

24 http://www.crisiscareconcordat.org.uk/about/
8. Finances

8.1 Current investment

Havering CCG and the local authority contribute substantial funding to commissioning mental health services for children and young people. Funding is as follows:

- CCG funding – NELFT: £2,128,000
- Local authority funding – NELFT: £165,265; Relate: £71,097; Havering Mind: £35,000.

8.2 Future investment

The financial table in Appendix B details the future investment in CAMHS provision for the remainder of the current year and the whole of next year. Havering CCG has been allocated an indicative amount of an additional £506,755 per year to spend on supporting the implementation of this transformation plan. Of this, £144,649 per year has been specifically allocated by the government for eating disorder services. The remaining £362,096 of the allocation is for local discretion.

9. Governance, transparency and implementation plan

We are establishing a time-limited Mental Health of Children and Young People Implementation Group which will merge with the Adult Mental Health Partnership Board at a later date to ensure all needs including transition are addressed. This group will have responsibility for delivering this plan and will be chaired by a clinical director of the CCG.

We have budgeted for support staff to ensure evidence-based programme delivery which will also help us to cement our plans for future years. Governance arrangements have been agreed by the Health and Wellbeing Board and Havering CCG’s governing body. Quarterly updates will be presented at both boards and they will act as governance and assurance against the plan. The implementation group brings together partners from education, health, public health, social care, and the voluntary and community sectors to understand mental health needs and oversee the development and delivery of the local Mental Health of Children and Young People Strategy.

**Governance structure:**

- Havering CCG Governing Body
- Health and Wellbeing Board
- Clinical director-chaired CAMHS Implementation Group
10. Measuring outcomes

10.1 Evidence based and outcome focused

We have worked closely with our main provider of CAMHS services to review and better understand the extent to which current services are delivering evidence based interventions. Our CAMHS provider is part of the national children and young people’s IAPT (CYP-IAPT) programme and staff continue to receive specialist training to ensure that the interventions delivered are evidence based. During the transformation planning process our CAMHS provider has, however, highlighted a number of skills and training deficits, particularly in relation to eating disorders.

Investment in the eating disorders service will enable all staff within it to be trained in eating disorder-specific models; this will include specialist training in CBT-E for eating disorders and the Maudsley Model of family therapy for eating disorders. All staff will receive CYP IAPT core and specialist eating disorder training and will also be trained in alternative evidence based treatments for eating disorders such as MANTRA and Specialist Supportive Clinical Management.

Additional resources would enable the use of early interventions such as FREED (first episode and rapid early intervention for eating disorders) and to offer treatment for atypical eating disorders such as ARFID (Avoidant/Restrictive Food Intake Disorder).

There is an expectation that additional investment will also enable the provider to meet the new access and waiting time standards for eating disorders, improving outcomes for children and young people.

As part of our ongoing development and implementation of the transformation plan we will be undertaking more detailed work over the coming months to review all pathways with our provider against relevant NICE and Scottish Intercollegiate Guideline Network (SIGN) guidance, these will include:

- Antisocial behaviour and conduct disorders in children and young people (NICE)
- Depression in Children and Young People (NICE)
- Alcohol Use Disorders (NICE)
- Attention Deficit and Hyperkinetic Disorders in Children and Young People (selective update) (SIGN)
- Attention Deficit Hyperactivity Disorder (ADHD) (NICE)
- Autism Spectrum Disorders in Children and Young People: Recognition, Referral and Diagnosis (NICE)
- Autism Spectrum Disorders (SIGN)
- Bipolar Disorder (NICE)
- Borderline Personality Disorder (NICE)
- Depression in Children and Young People (NICE)
- Post-Traumatic Stress Disorder (NICE)
- Psychosis with Coexisting Substance Misuse (NICE)
- Self-Harm: Longer-Term Management (NICE)
- Self-harm: Short-term Physical and Psychological Management (NICE).
10.2 Designing our outcomes

The following outcomes to guide the transformation plan are proposed. These will be developed into an outcome set by the newly established Local Transformation Plan Steering Group:

- more new parents are supported, from the birth of their child, in communication and parenting skills to provide them with confidence and local networks
- children, young people and their families acquire, develop and sustain resilience skills which help them deal with challenges and adversity
- children, young people, their families and professionals know where and how to ask for help
- children and young people with early identified needs are supported in community settings, particularly schools, reducing the need for access to more specialist mental health services
- children and young people with additional needs, requiring additional targeted support, are able to access the right support at the right time
- vulnerable children and young people are supported and prioritised, and care is provided which recognises and supports their specific needs
- local services meet the needs of children, young people and their families in terms of service quality and experience and meeting personal outcomes
- children and young people receive high quality specialist services which are outcome focused and evidence based.

10.3 KPIs identified

A detailed summary of KPIs and associated spend is enclosed in the finance tracker at Appendix A.

In order to establish the baseline for the range of KPIs detailed in the tracker and introduce robust data collection, we would undertake the following tasks:

- use the implementation group to steer the development of the KPIs including baseline measures
- build on existing models of engagement such as the continued engagement with parenting networks Positive Parents and Parents in Partnership. In addition we will incorporate the views of children and young people via roadshows, surveys and engagement with schools
- agree our KPI measures with providers using population level data from the JSNA and local service reviews
- use local and routine data sources to collect data for performance monitoring from the provider database Rio. This may involve adding new fields and negotiating new targets
- work with our digital provider to ensure we collect the right data to inform coverage across Havering
- ensure data quality and manage the data returns quarterly (to be done by NEL Commissioning Support Unit)
- develop a dashboard that displays all the data for the transformation programme, which can be easily checked for governance and assurance purposes.

In addition, we are already in the process of collecting data for our baseline KPIs and have built them into our contract negotiations with providers. These have been accepted. We have established quarterly performance monitoring meetings with providers and these will be reviewed at the CAMHS Implementation Group.
CYP-IAPT KPIs
We have been formally accepted as part of the CYP-IAPT programme and are working with NHS England to agree our KPIs and baseline data. We will ensure that services participating in CYP IAPT will provide monitoring data to NHS England via the learning collaborative, to enable reporting on progress toward agreed milestones. Havering CCG will ensure robust planning processes and governance are in place to sustain the service transformation, and will ensure alignment with local transformation plans at Health and Wellbeing Board Level, and at programme level within all partner organisations.

Eating disorder service KPIs
The KPIs have been agreed at sector level and include recruitment of staff to clear backlog, improvement in waiting times and access, improved outcomes, and reduced admissions to Tier 4.
Appendix A – Model of care

See separate document

Appendix B – Finance tracker for in-year spend 2015/16, plus 2016/17 forecast

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Service description</th>
<th>15/16 Q3-4 spend</th>
<th>2016/17 spend</th>
<th>Relevant KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eating Disorders (ED)</strong></td>
<td>Supplement existing ED team to become evidence compliant, meet new access and waiting time standards to treatment. Focus on reducing waiting times and increasing access into the service</td>
<td>£111,358</td>
<td>£111,358</td>
<td>To record percentage of cases that received NICE concordant treatment within the standard's timeframes</td>
</tr>
<tr>
<td>Resource specialist ED services to meet national standards</td>
<td>Offering step up and step down support to students in need of eating disorders support. Based in schools and working closely with the ED team. Outreach role in schools</td>
<td>£33,301</td>
<td>£33,301</td>
<td>Number of students seen in school and managed in school setting and numbers referred into and out of service</td>
</tr>
<tr>
<td><strong>ED Total spend</strong></td>
<td></td>
<td>£144,659</td>
<td>£144,659</td>
<td></td>
</tr>
<tr>
<td><strong>CAMHS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing Hub</td>
<td>Additional staff to support crisis and extended hours (8am to 8pm): three Band 6 early intervention CAMHS coordinators</td>
<td>£82,500</td>
<td>£165,000</td>
<td>Number of service users seen with additional needs via wellbeing hub</td>
</tr>
<tr>
<td>Resilience building</td>
<td>Training for education providers to build resilience of whole school population</td>
<td>£50,000</td>
<td>£0</td>
<td>Training delivered to 100 professionals working with children in universal services</td>
</tr>
<tr>
<td>Training and support for parents and carers of children with emotional</td>
<td></td>
<td>£15,000</td>
<td>£20,000</td>
<td>Resilience building training delivered to 100</td>
</tr>
<tr>
<td>Programme management</td>
<td>Programme lead and admin support</td>
<td>£76,013</td>
<td>£72,096</td>
<td>Successful implementation of transformation plans</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>--------</td>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Enhanced support to high risk young people (young offenders, pupil referral unit clients, looked after children and those with behaviour and communication problems)</td>
<td>Additional sessions with appropriate professionals such as speech and language therapists, paediatricians. Support CAMHS to design a pathway for vulnerable children</td>
<td>£25,000</td>
<td>£105,000</td>
<td>The number of vulnerable children receiving enhanced support</td>
</tr>
<tr>
<td>Developing digital models of support</td>
<td>Developing easier access to self-directed support</td>
<td>£38,548</td>
<td>£0</td>
<td>The number of young people accessing self-directed support</td>
</tr>
<tr>
<td>CAMHS and schools link pilot</td>
<td>Targeted training programme for teaching staff in primary and secondary schools</td>
<td>£50,000</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Perinatal mental health</td>
<td>Additional universal community support such as baby massage and attachment parenting courses</td>
<td>£25,000</td>
<td>£0</td>
<td>The number of parents supported in universal settings and referrals made into and out of perinatal service</td>
</tr>
</tbody>
</table>

**CAMHS total spend**  
£362,061  
£362,096

**Total spend**  
£506,755  
£506,755

**Balance**  
£0  
£0

### Additional detail on spend against allocation

#### Digital development

As part of our plans to creatively engage children and young people, we will promote earlier intervention by developing digital models of Early Help (guided self-support). This will allow us to develop lower cost, high volume, evidence-based support. The scale of need across the borough is potentially quite considerable. National data suggests that one in seven children and young people report emotional difficulties, which would equate to more than 10,000 in Havering who may require additional help to meet their needs, but who may not require CAMHS intervention. Therefore it is imperative that our approach to meet these lower level emotional needs:
is innovative
makes the best use of technology
supports self-management approaches
achieves value for money
is wide reaching and high impact.

A fuller description of the additional methods for delivering low level support can be read at section 4.11 of this report.

The funding within our plans allocated to this for area is £38,548 which has been allocated within the spend for the current year. At this stage we are not able to be explicit about the exact type of self-directed support we will commission, however this will be further informed by work with clinicians to ensure solutions are safe, high quality, and evidence based. This will also require further market development work and review of best practice in this area. We know many NHS organisations and local authorities already have such schemes in place and we will work closely with them to develop our approach in this area.

**Eating Disorders Service**
We will increase staffing levels to the recommended levels for the service, as set out in the table on page 50 of this report. Increased staffing will account for 80% of the additional funds, increasing the team from 3.5 whole time equivalent posts to 25.9. The remaining 20% of the funding will be allocated to developing digital tools on body image for patients, for example an app.

**Schools healthy support service**
We will be offering step up and step down support to students in need of eating disorders support. This will be an outreach role based in schools, but working closely with the eating disorders team. This will be delivered during the third and fourth quarters of the next year.

**Resilience building training for staff**
This will be delivered to 100 professionals within schools and universal settings. This training will support teachers and professionals working with students to help young people build resilience and techniques to cope with life’s adverse events.

**Supporting vulnerable groups**
Within this plan we identified a number of vulnerable groups who will benefit from additional resource and investment. The Youth Offending Service (YOS) has been identified as having limited access to speech and language therapy despite an evidence base of need. The funding identified will be used to pay for a specific therapist who will work across both the YOS and pupil referral units, providing therapy for young offenders or those at risk of or offending. The aim of this is improving communication skills for young offenders in particular where there are strong links between mental health, ADHD and communication difficulties. The speech and language therapist will work with CAMHS workers in the YOS.

Within this we have also allocated resource for an overall programme manager who will lead on implementing the wider plan and service redesign. The role will map current provision and develop joint clinics for mental and physical health for young people attending the Youth Offending Service and other mainstream services where appropriate.
Training for parents and carers:
As part of the consultation for our recent CAMHS review as well as engagement events with parents and carers, the most common feedback received related to the lack of training available to them. We recognise that this gap contributes toward pressure on existing services, increased likelihood of crisis in the long run and a dependence on services for support. The resource allocated to training parents will lead to:

- earlier identification and access to services
- creation of an additional support network
- increased family empowerment
- less dependency on services
- a holistic approach to mental health, leading to better outcomes.

Perinatal
The allocation for perinatal mental health will be used to enhance existing children’s services to provide maternal support, which may include baby massage, attachment parenting courses and crèche facilities. By commissioning these services and promoting prevention and support for new parents we aim to see a better offer for all new mothers and their babies. In addition we will redesign the referral route for health visitors and other professionals who identify mental health issues in families.