LONDON BOROUGH OF RICHMOND UPON THAMES

NHS Richmond Clinical Commissioning Group

Richmond Transformation Plan for Children and Young People's Mental Health and Wellbeing

2015 – 2020

Richmond Transformation Plan for Children and Young People's Mental Health and Wellbeing 2015-17

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Foreword

This is Richmond's transformation plan for children and young people's mental health and wellbeing. It sets out our rationale and key proposals for bringing about the transformative change required across the whole children's mental health system, in line with the government policy *Future in Mind* and NHS England guidance.

For Richmond, *Future in Mind* could not have arrived at a better time. In 2012 we developed our three year emotional wellbeing and mental health strategy and have been working hard on its implementation ever since. It is time for a new strategy to galvanise and co-ordinate a renewed approach and an even greater level of ambition for whole system transformation.

This plan is a living document and primarily focused on the first year of a five year journey. In a relatively short time we have prepared a plan which picks up on some of the most immediate and pressing needs. However, it is just the start and we aim to use this first year to not only implement the actions against which we have identified funding for 2015/16 but also to plan more thoroughly for transformation.

Future in Mind has arrived at a challenging time with financial constraints and a complex commissioning landscape with responsibilities spread between schools, Clinical Commissioning Groups (CCGs), local authorities including Public Health and specialised commissioning. Locally, Richmond upon Thames and Kingston councils have merged children's services and formed Achieving for Children - a community interest company that delivers and commissions children's services on their behalf. Richmond Council has agreed shared staffing arrangements with Wandsworth Council (excluding children services but including Public Health). Collaborative commissioning also takes place at a sector-wide level across south west London alongside NHSE specialised commissioning. Richmond Clinical Commissioning Group (CCG) has also embarked upon a programme of outcome based commissioning that includes adult mental health services in its second phase. This will no doubt have implications for the model of service delivery of child and adolescent mental health services in Richmond.

However, our partnership commitment to children and young people in Richmond is that we will not allow structural barriers between services, funding streams and different settings to get in the way. We aim to drive change across the whole system through building preventative approaches and earlier access into our everyday business and to develop joined up pathways of care which leaves no child falling through gaps.

1. Part one: Introduction

1.1 Setting the context

Over the last three years, since our last partnership strategy was written, we have developed a range of new and improved services including better organisation of resources and greater access through a Single Point of Access (SPA). We have brought together professionals and schools, and engaged with children, young people and parent/carers, as part of our ongoing commitment to involve the people best placed to guide our developments.

Future in Mind and our own needs assessment reminds us that there is still much more to do and provides a framework for this activity, which we welcome. The national picture

of mental health needs, the state of service access and lack of coordinated approaches to prevention and earlier intervention, particularly in schools, is echoed locally. However, some of our challenges are specific to Richmond.

Richmond is a borough of relative affluence, so responding to the challenges of inequalities caused by increases in vulnerable groups, such as unaccompanied asylum seekers amongst our looked after children; increasing self-harm presentations in A&E and comparatively higher rates of alcohol related admissions, paint a picture of increased need and risk that will need to be effectively addressed.

1.2 National policy context

The Government's Mental Health Strategy (2011), 'No Health without Mental Health', vowed to provide early support for mental health problems. The Department of Health Strategy 'Closing the Gap: priorities for essential change in mental health' (2014), also set out to improve access to psychological therapies for children and young people.

In 2014 the Department of Health and NHS England established the Children and Young People's Mental Health and Wellbeing Taskforce to consider ways to make it easier for children, young people, parents and carers, to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

The Taskforce published its findings in March 2015. The report, '*Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing'*, sets out a clear and powerful direction and key principles for whole system transformation. The key themes are:

- promoting resilience, prevention and early intervention;
- improving access to effective support – a system without tiers;
- care for the most vulnerable;
- accountability and transparency;
- developing the workforce.

In the Autumn Statement (December 2014) and the Budget (March 2015), the Government announced extra funding to transform services and enable local areas to move forward with delivering tangible improvements.

1.3 Future in Mind - key principles for local transformation

Future in Mind describes an integrated whole system approach to driving further improvements in children and young people's mental health outcomes. This requires the NHS, Public Health, voluntary and community services, local authority children's services, education and youth justice to work together to:

- place the emphasis on building resilience, promoting good mental health and wellbeing, prevention and early intervention;

- deliver a step change in how care is provided – moving away from a system defined in terms of the services that organisations provide towards one built around the needs of children, young people and their families;

- improve access so that children and young people have easy access to the right support from the right service at the right time and as close to home as possible. This includes implementing clear evidence-based pathways for community-based care to avoid unnecessary admissions to inpatient care;

- deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable;

- sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience;

- improve transparency and accountability across the whole system. Being clear about how resources are being used in each area and providing evidence to support collaborative decision making;

- build on the learning from our local ambitious programme of outcome based commissioning to transform adult community services for physical health and mental health services.

1.4 The importance of engagement, involvement and partnership working

This plan builds on the previous Emotional Wellbeing and Mental Health Strategy 2012-15 which was developed through extensive consultation and engagement with stakeholders including children and young people. The implementation plan is still live and governed by a partnership Emotional Wellbeing Board which reports to the Health and Wellbeing Board (see 5.2 for more detail on partnership governance).

The strategy has influenced by and is aligned with the work of a number of broader partnerships, including the Health and Wellbeing Board, the Local Safeguarding Children Board and the Richmond Partnership, (a multi-agency partnership group working in the best interests of the borough and its residents).

In order to refresh and update the information on which this transformation plan is based, and because of our ongoing commitment to engagement and involvement, we developed an engagement programme which included the following activities during September:

- A baseline assessment against the Future in Mind recommendations that was completed by a broad range of stakeholders including parent/carers and voluntary organisations

- Consultation and engagement events

  – A Health and Wellbeing Board listening event held on 14 September 2015

  – Young people focus groups carried out in five secondary schools and with young people from a CYP community counselling voluntary organisation

  – A Children and Adolescent Mental Health Service (CAMHS) Transformation Planning workshop involving a range of stakeholders

  – With young people who have special educational needs and disability (SEND) and those using tier 3 CAMHS

- Questionnaires circulated to SENCOs in order to ascertain the key issues for schools in the borough

- Feedback from the National Autistic Society local branch on parent experience and views

- GP follow-up poll to previous survey on CAMHS in 2013

1.5 Legislative context and drivers

This plan was developed within the national context set by the following key policy and guidance documents;

- Future in Mind NHS England (NHS and Department of Health (DH), 2015. Promoting, protecting and improving our children and young people's mental health and wellbeing
- The Public Sector Equality Duty – the Equality Act 2010
- Reducing health inequalities – the Health and Social Care Act 2012
- The Children and Families Act 2014
- Crisis Care Concordat (DH & signatories, 2014) - provision of crisis services and appropriate places of safety
- Five Year Forward View (NHS-E, 2014) – prevention; engaging communities, empowering patients
- The Forward View into Action- invest in community services for economic benefit (NHS-E, 2014)
- Closing the Gap: priorities for essential change in mental health (DH 2014)
- Ofsted CIF (updates Sep' 2015)- personal development, behaviour and welfare outcomes to be measured
- Mental health & behaviour in schools (DfE, 2015)
- SEND Code of Practice (DfE, 2015)
- Counselling in schools- a blueprint for the future (DfE, 2015)
- Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3) (NHS-E, 2014)
- Model Specification for Transitions from Child and Adolescent Mental Health Services (NHSE 2015)
- Transforming Care for People with Learning Disabilities – Next Steps. (NHSE and signatories 2015)

1.6 The Richmond context

Richmond is a prosperous, safe and healthy borough with a population of 193,600 according to the 2014 Office for National Statistics Mid-Year Estimates. The 0-19 children and young people (CYP) population makes up nearly a quarter (47,117) of the total population of Richmond of which 50.8% is male and 49.2% female. The largest age group is young children aged 0-4 which makes up 7.5% of the total population of the borough and 31% of the 0-19 population. 70% of the population is white British, whilst 11% are classified as 'white other' and 19% from black and minority ethnic communities.

The resident population of children and young people is very different to the school population. The 2015 Spring School Census identified that black and ethnic communities make up 16% of primary schools, 24% of secondary schools and 35% of special schools population. This diversity arises from children and young people travelling into the borough to attend Richmond schools.

Most children and young people living in Richmond are healthy and have a good start in life. Many of the outcomes for the Richmond borough are better than the average for London and England. However, not all children and young people enjoy similar positive outcomes and consequently have the same chances of good health as adults. This includes those with additional educational needs and those with disabilities.

'School readiness' is a key measure of a child's developmental progress at five years of age. Richmond had a low ranking in London and England in 2012/13. It is likely that this ranking reflects inconsistencies in applying the new assessment processes (recently introduced) in different areas. In 2014 there was significant improvement, with 64% of children securing a good level of development which was above the national average (60%). Nevertheless, there is clear variation in this outcome measure among children in Richmond, with children from poorer social backgrounds doing less well.

Although levels of childhood poverty and rates of children in care are lower in Richmond compared to other local authorities, these children are at higher risk of experiencing poor outcomes throughout their lives. For a relatively affluent borough, this also means a higher level of inequality in terms of the gap between the wealthiest and the poorest. There are an estimated 3,500 children under the age of 16 who are living in poverty in the borough.

We know that children in care are particularly vulnerable and generally do worse than their peers in terms of their physical and mental health, and also their education. Over the past five years there has been a significant increase in Looked after Children (LAC) in Richmond from 77 in March 2012 to 101 in January 2015. The increase relates to the local children's services decision in 2014 that Unaccompanied Asylum Seeking Children (UASC) aged 16-18, arriving in the UK, will be classified as LAC.

In 2015 the Youth Accommodation Needs Assessment, carried out by Achieving for Children, highlighted further information on the needs of care leavers. Of the 155 young people known to the leaving care team their legal status was as follows; LAC aged 16/17 13.5%; YP 18+ in leaving care team 69%; and UASC 17.4%. Given the increased prevalence of mental disorders amongst children in the care system, plus the likely high levels of mental health needs amongst UASC, this has significant implications for the

management of both appropriate access to support and treatment now but also for transition to support from adult mental health services.

Other vulnerable groups in Richmond include :

- young people who have offended
- young people leaving care
- children and young people at risk of sexual exploitation
- young people not in education, employment or training
- children affected by domestic violence and anti-social behaviour
- children affected by parental mental health issues, substance misuse
- children in need
- families who are participating in our Strengthening Families programme.

Amongst children and young people who are classified as having a special educational need and a statement, the most common needs identified are autistic spectrum disorders. (See 4.1 for more details on all vulnerable groups).

Levels of overweight and obesity among primary school aged children in Richmond are significantly lower than nationally. Nevertheless, approximately 3,000 primary school aged children are overweight or obese. In addition, between reception and year 6, levels of obesity double in Richmond (which reflects national trends). Children who are overweight and obese are also more likely to have emotional and social problems.

Alcohol and drug misuse are markers of risky behaviours and vulnerability among young people. The rate of hospital admissions for substance misuse among young people is lower than rates for London and England. However, the Richmond rate of hospital admission due to alcohol-specific conditions (39 per 100,000 of under 18 year olds) was sixth highest among London councils. While actual numbers of alcohol and drug related admissions are small, such admissions are avoidable.

In 2012/13 the Richmond rate of hospital admissions for self-harm in young people was the fourth highest among London councils. There were 222 admissions for self-harm over a three-year period.

There are almost 7,000 A&E attendances in children under age 5 per year. Despite a comparatively positive ranking and improvement from the previous year, these attendances are often avoidable and many could have been treated in primary care.

The ChiMat (Oct 2015) data estimates that the number of children and young people in the Richmond borough who may experience mental health problems and the appropriate tier of response needed is as follows:

Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
6,775	3,165	840	35

Data on actual activity is contained in section 7.1 and shows discrepancies between estimated need and actual access to services particularly at tier 2. This is consistent with the national picture (between 25-35% with a diagnosable condition access support. 2005 ONS).

1.7 Our vision and aims

Emotional wellbeing and mental health (EWMH):

"Every child and young person is supported to develop strong emotional health, psychological wellbeing and mental resilience."
(EWMH strategy, 2012)

The transformation plan for Richmond aims to deliver outcomes consistent with a coherent whole system approach to children and young people's mental health across services, communities and schools. We will work towards outcomes which will drive system wide transformation and for which we will need to work together in partnership as system leaders, commissioners and providers.

Through engagement of children, young people, families and professionals, we have identified the following priority outcomes on which our transformation plan is based.

Children, young people and families in Richmond will:

- Be resilient and have better coping skills to increase capacity for self-care
- Feel that parents are adequately supported to promote their children's mental health
- Know where to go for help
- Have timely access to supportive and effective multi-agency services which are co-ordinated to provide a team around the family
- Understand how to improve their mental health and manage it well
- Experience services which are sensitive and appropriate to culture, needs and circumstances
- Be involved in all aspects of planning, care and feedback on services

This plan fits within the *Children and Young People's Plan for Richmond 2013-17*. The vision for this overarching plan is to tackle inequality and create opportunity for children, young people and their families. This also includes promoting resilience and improving mental health.

Tackling inequality: we know that behind the story of our success there are inequalities between the relatively wealthy and poor areas of our borough, and between vulnerable children and their peers. Our vision is to target those children and young people most in need of support, so that every child in every part of our borough has the chance to reach their full potential. CYP Plan 2013-17. p.9

1.8 Our values

As a partnership we share an overarching vision and have agreed that the following values and beliefs will underpin our approach to addressing the emotional health and wellbeing of Richmond children and young people.

- The delivery of emotional wellbeing and mental health is everybody's responsibility and we will work in partnership to improve it
- We will take account of equality and diversity issues and ensure equal and fair access for all
- The foundations for positive emotional wellbeing and mental health are laid in the early years of life and we will support parents and carers from pre-birth onwards to support their child's emotional development
- We will prioritise prevention and earlier intervention and wherever possible deliver services in community based settings
- We will promote choice wherever possible and provide flexible provision appropriate to a wide range of needs and accessible to the broad diversity of the population
- Good information and communication is key - we will improve pathways between and within services, and provide clear information about service criteria
- Focusing on outcomes – doing what works to improve emotional wellbeing
- We will enable children, young people and parents to develop skills to increase their own capacity as well as improve and maintain their mental health and wellbeing
- Children, young people and families will actively participate in developing solutions to their own needs and in decisions around service planning and development
- Holistic approach –we will look at the needs of the whole family, adults services and the needs of the child, within the community
- A well trained and informed workforce underpins any good service. We will ensure that the workforce has the opportunity to develop skills and knowledge in this area
- We will make effective use of resources and remain focused on monitoring performance and ensuring better outcomes for children and young people
- Social health approach – working together to be inclusive and address the health and social needs of the whole community

2. Part Two: Improving access to effective support

2.1 The importance of improving access and support

The *Future in Mind* report acknowledges that the current tiered system of CAMHS creates barriers and fragmentation of care, often resulting in children and young people, "falling in gaps between tiers and experiencing poor transitions between different services."

There is a strong evidence base that access to early intervention services is effective in helping children, young people and their parents/carers, to overcome the problem for which were referred.

Timely access to the right help, at the right time and place, can prevent short-term problems turning into longer-term ones.

Talking directly over the phone with children, young people and their parent(s)/carer(s) is improving the accuracy of decisions made by the SPA (Single Point of Access) about where they can access help.

A 'collaborative approach' (between children, young people and their parents and professionals offering help) is achieving better outcomes than a service or professionally led approach.

Establishing a whole system approach to delivering help (including the voluntary and community sector and possibly also the private sector as equal 'help partners') makes it more likely to achieve a balance between 'demand for help' and 'capacity to deliver help and advice'.

2.2 Current position

In 2014 South West London and St Georges Mental Health Trust completed a transformation programme of community CAMH services.

- The programme led to the introduction of a Single Point of Access (SPA) for community CAMHS in October 2014 to make it easier for primary care professionals and schools to refer children and young people with a problem that might require (specialist) help to tier 2 and 3 CAMHS professionals

- Richmond has also developed five diagnostic pathways covering self-harm, eating disorders, ADHD, ASD, depression and a general information pathway about how to access services through the SPA.

Current issues in the local system:

- Joined up working with schools is inconsistent due to a lack of a standard universal offer to schools

- Our local offer is unclear. Professionals, parents and carers highlight the lack of available information and support at the pre-SPA referral stage, during the referral waiting time and post-diagnostic stage in our pathways

- There has been inconsistent monitoring of specialist CAMH services and inadequate activity data. However, the introduction of CYP IAPT locally has begun to partially address this issue

- For children and young people who deliberately self-harm, access to support before, during and after crisis, is a significant issue. We have a significantly higher rate of admissions than the London average and need to improve our arrangements for a hospital paediatric psychiatric liaison service. There is no dedicated Richmond psychiatric liaison service so when children and young people present at Kingston Hospital they are seen by the on-site psychiatric liaison nurse. There is no on-site provision at West Middlesex University Hospital, so children and young people living in Richmond are seen by our tier 3 CAMHS service

- Transition to adult services can be a time of great anxiety, confusion and uncertainty for young people with disabilities and additional needs, as they move from familiar arrangements, services and people who have provided support. In Richmond, we have an established governance framework that aims to ensure improved shared working arrangements, oversight and scrutiny. We also deliver a robust professional service to young people moving to adulthood. This framework consists of :

- Transition management board - a senior, multi-agency board with a strategic oversight to ensure that a high quality transition service and clear pathways are in place
- Transition Management Group - a multi-agency panel that has representation from adult services, disabled children's team, SEN and health who ensure that appropriate transition arrangements are in place for individuals
- Virtual transitions team **-** a virtual group of professionals who operationally plan, oversee and deliver the transitions arrangements for individuals

- The work of the board and the management group is facilitated by the maintenance of a comprehensive tracking list that is used to record young people within the wider SEN population who are likely to need health or social care support as adults. Therefore, we are able to identify all year 9 young people who are likely to require support as adults across social care and health. This enables the timely referral of young people to adult services but also provides the opportunity to use the tracking list as a strategic planning tool to identify future need in key areas such as housing and education.

- For children living with an autism spectrum disorder and other communication and sensory needs, local non-statutory services such as Action-Attainment have developed tools that support children with social communication difficulties, parents and schools to manage the learning environment more effectively. The local branch of the National Autistic Society (NAS) offer parents access to post-diagnosis support and provide behaviour management skills and advice. NAS also provide parents with a much welcomed opportunity to get together and share experiences.

- Eating disorders - In 2014 a community eating disorder service was established. Assessment, treatment and liaison work with the paediatric ward has improved as a result and there has been a reduction in some admissions to paediatric wards. However, the service is overstretched, and coverage, though more consistent, is incomplete and access is inadequate.

2.3 Evidence for change

What children, young people, parents and carers in Richmond say

In 2015 Health Watch and SEND Family Voice, a Department for Education (DfE) funded official parent engagement organisation for Richmond, undertook a survey to collect the opinions of parents and schools on services they have received from the Child and Adolescent Mental Health Service (CAMHS) in Richmond.

Key issues highlighted through the survey about the experience of mental health services, particularly from specialist CAMHS (South West London and St. George's Mental Health NHS Trust), included:

- Reception areas could be improved

- Waiting times and referral issues including lack of support between appointments for some children (support is often sought from the voluntary sector during long gaps)

- Poor prescription processes

- Whilst individual staff were often praised for their excellent care there were generally complaints about insufficient communication between the service and parent/carers

- Poor links between CAMHS, parents and schools including information sharing and planning

For each of the themes raised through the survey, there has been a response from South West London and St George's Mental Health NHS Trust and Achieving for Children, which provides the Emotional Health Service (EHS) about action already taken and further action planned. Some of the plans will also be supported through the transformation fund.

Data and feedback from the Single Point of Access (SPA)

- The general children services SPA has been in operation for more than three years. It also contains the multi-agency safeguarding hub (MASH) where police data also comes into the SPA (e.g. for children missing from home and child sexual exploitation etc). The addition of mental health screening has been operating in the SPA for a year. A review of data and information from the service highlighted the following:

- **Data –** over a 6 month period (1 January – 30 June 2015), the referral data shows that out of a total of 563 referrals received by the SPA, GPs made:

    - 45% of all referrals (254). This is twice as many referrals than schools (128), the second largest referrer

    Further analysis of the age of the young people referred to EHS highlights that the largest proportion of referrals (38%) were for 10 – 14-year-olds and for tier 3, 40% were for 15 -19-year-olds. In total, 51% of the referrals to EHS were for males and 49% for females. For tier 3, referrals for males were 47% and females 53%

- **Clarity of initial referral decision making -** a lack of time and capacity for the children services SPA staff to carry out a 'telephone triage' to identify concern thus directing majority of referrals to the tier 2 Emotional Health Service (EHS)

- **Waiting times -**. increases in waiting times for initial 'choice' meetings (from 2 weeks to 3 - 4 months) and for start of 'partnership' interventions (from 4-6 weeks to 4-6 months)

- **Staffing capacity –** current staffing capacity across tiers 2 and tier 3 is inadequate to meet service demand. The current CAMHS SPA service model does not provide the opportunity to fully assess complex cases and determine the best referral option

- **Information and support -** inability to redirect referrals to the voluntary sector because of lack of information about local services and a lack of capacity of child and young people specific counselling services

For parents of **children living with an autistic spectrum disorder** the support of the voluntary sector and of other parents can be invaluable. The particular stresses were summarised by the National Autistic Society local branch as:

- When accessing CAMHS there is no immediate support pre-diagnosis or post-diagnosis
- The lack of 'ongoing behaviour support' which is not the focus of mental health services and yet for very challenging behaviours in families this can often lead to family breakdown and the child requiring to be placed in some sort of residential setting
- There is a need for a more holistic approach to the family including considering the effect on siblings
- Better coordination of the different pathways e.g. when a young person presents with a dual diagnosis e.g. ASD and ADHD or ASD and depression

Summary of evidence for change

The engagement work and surveys in Richmond (GP surveys; schools focus groups; stakeholder workshops; parent and carer and schools surveys) indicate a very similar picture to that highlighted through *Future in Mind*. The traditional model of CAMHS needs to change in order to ensure that children and young people do not experience long waits and have to retell their story as they move between tiers, teams and different professionals.

Our key issues in relation to access can be summarised as follows:

- Improved communication about children and young people between CAMH services, GPs, schools and families
- Engagement of children, young people and families in their own care and in service improvement
- Demand for 'tier 2 CAMHS', including the Emotional Health Service and voluntary sector services such as Off the Record, outweighs supply and is reducing access
- Despite our new SPA access to the full range of services, it is still fragmented and needs to be redesigned to include the voluntary sector
- Support to children and families during waiting times or in gaps between appointments
- Referrers, schools and service users would like services to be community-based in or near community settings
- The particular needs of families coping with complexity arising from learning disability, developmental disorders and any other special or complex needs. These are often co-morbid with mental health problems and challenging behaviour and are not being met. This means families do not feel adequately supported by the system

We need more information and further development in relation to:

- The experience of crisis care in Richmond and how well we are meeting the Crisis Care Concordat in line with the London crisis care declaration and national guidance
- Scoping how and where we can best provide a named point of contact for every school and GP in Richmond to improve communication for those referred and accessing services
- How we better utilise and integrate digitally enabled support for young people as part of service information and engagement
- Scope for peer support or mentoring as part of service improvements
- How we can develop a non-tiered approach which works for Richmond. For example, through exploring the implementation of the 'Thrive model' (Anna Freud Centre & Tavistock Jan 2015) as an alternative model of care locally and across the South West London Collaborative. (South West London (SWL) commissioners have submitted an expression of interest to become an accelerator site using the Thrive model for CAMHS.)

2.4 Where we want to get to

Our overall aim for transforming services in Richmond is to make the system work better together through joined up assessment and provision; and co-operation and collaboration between referrers, schools, providers and service users.

We aim to reduce demands on costly specialist services and improve mental health through developing more responsive services closer to home, easily accessible, high quality and wide ranging in choice. We will expect greater engagement of children, young people and their families in their own care, and in the development of all our plans and of all services.

We want to ensure that:

- Children and young people and their parents/carers have timely access to the right help when they are in need of it. This includes improved capacity and functioning of the SPA
- We offer a range of options on how young people and families can access information and advice on self-help whilst waiting for assessment or commencement of treatment
- We offer additional brief assessment/intervention appointments in community-based settings staffed by tiers 2 and 3 (EHS/CAMHS) clinicians
- We improve the availability of information about our local offer and provide better support based on utilising parents/carers and the voluntary/community sector
- Children and young people in crisis get access to appropriate and timely care by professionals in the community and receive access to support and training

- Our targeted and specialised community-based provision particularly for self- harm and eating disorders is effective at preventing the need for inpatient beds.

- We will increase the capacity of our eating disorder service and meet the new NICE clinical guidelines for eating disorder management and treatment in young people, published in summer 2015

2.5 Key actions

In order to stem the demand for more costly specialist services, we will increase access to a timely assessment and treatment at an earlier stage. Specifically we will:

- Increase capacity in the emotional health service in order to reduce waiting times from 3 months to 2 months for CAMHS tier 2 Access Service

- Increase access to telephone advice

- We will introduce a number of pilot projects such as;

    - 'Joint drop in clinics'

    - A rolling group programme for those who fall into the most frequently referred categories in order to expand access to services

- We will explore the impact of CAMHS outreach clinics in community settings through a pilot approach

- Increase tier 3/specialist CAMHS capacity in SPA in order to improve triage /initial risk assessment and onward referral to SWLSTGs

- Include multi-disciplinary team triage that will include a focus on risk taking and prioritise safeguarding

- Ensure greater access to the voluntary sector through formal engagement of services in the SPA

- We will increase post-diagnostic support for families of children who have neuro-developmental disorders

- Develop a local conversation with and between children and young people to consider campaigns, digital technology and peer support

- Increase access to psychological therapy as part of the expansion of our CYP IAPT

- We will enable parents/carers and voluntary organisations to engage better in the development of community-based support from pre-SPA referral to post diagnosis

- We will use some of our resilience funding to commission a Richmond specific deliberate self-harm nurse

- We will invest in the community eating disorder service in order to deliver against the best practice model outlined in the new joint commissioning guidance from

NHSE and NCCMH (2015) and ensure compliance with the national waiting time standards by 2020; specifically to:

- Improve access and wait-times
- Deliver evidence-based treatments for the whole range of eating disorders
- Offer a range of treatment for all co-morbidities within the team with evidence-based treatments
- Enable a fully integrated physical health management service
- Establish ongoing training and development to the required standard

2.6 Transformation funding priorities 2015/16

Transformation monies will be used to address the following service priorities:

- Increase staffing capacity in the CAMHS tier 2 Single Point of Access to clear waiting lists and expand service offer **(Ref IA1 – page 42)**
- Increase staffing capacity in the CAMHS tier 3 Single Point of Access to improve triage, initial risk assessment and joint working **(Ref IA2 – page 42)**
- Expand voluntary sector counselling for children and young people **(Ref IA3 – page 44)**
- Increase the capacity of the SWL designated eating disorder service to meet new access and waiting times Guidance **(Ref IA4 – page 45)**

3. Part Three: promoting resilience, prevention and early help

3.1 The importance of promoting resilience, prevention and early help

The *Future in Mind* Task Force Report highlights that there is a strong evidence base that supporting families, including building resilience from childhood through to adulthood and supporting self-care, reduces the burden of mental and physical health over the whole life-course and reduces the cost of future interventions.

Parental bonding and infant attachment is a key predictor of early cognitive development and later educational attainment, as well as related health and social outcomes.

Evidence shows a strong link between poor maternal mental health and poor outcomes for children and young people, including emotional and behavioural problems. The costs of not addressing perinatal mental health are significant.

Whole school approaches that combine universal and targeted elements are shown to be effective in building resilience and improving mental health of children and young people. In terms of educational outcomes for children the links between emotional wellbeing and academic attainment are clear (Hornby and Atkinson 2003). Resilience is also highly correlated with academic achievement and educational success (Werner and Smith 1992).

Children and young people can benefit greatly from the support and activities provided by voluntary and community organisations, as they can provide environments that help to reduce the stigma surrounding mental health.

3.2 Current position

- Richmond is currently preparing a new early years development plan to achieve a more integrated approach to delivery of prevention and early intervention services (including health visiting, children centres and early years services, maternity and primary care)

- We have commissioned a community paediatric service for children and young people aged 0–19/ flexibly to 25 years in order to respond to the SEND requirements of the Children and Families Act 2014. The service is delivered by a consultant-led team of paediatricians based in the community in an integrated child development team offering assessment, diagnosis and ongoing management of a wide variety of complex health needs/conditions. This service is particularly key for younger children and a paediatrician with a speciality in ADHD was recently appointed. Our designated doctor for SEN provides valuable assessment, opinion and management strategies, in relation to complex cases with neuro-developmental delay/disorder requiring therapeutic intervention

- Health visitors follow the 4-5-6 model; this includes the high impact actions of perinatal mental health and postnatal, antenatal contact and transition to parenthood and breastfeeding

- Richmond has a range of universal and targeted parenting programmes available to families

- There are a range of good examples of whole school approaches and initiatives to emotional wellbeing including SEAL. A range of counselling services are commissioned by individual schools. However, school approaches are inconsistent in the borough

- The promotion of emotional wellbeing and mental health is a priority for the newly commissioned school nursing service

- Strong community and voluntary agencies are well-placed to support families to develop resilience and signpost to early help and specialist services. However, information about them is not always widely available

We have a range of examples of good practice as follows:

- A collaboration between national MIND and Richmond Homestart to develop a product to support pregnant women and new mothers

- Health visitors promote health and development in the six high impact areas for early years. This includes the transition to parenthood and the early weeks and maternal mental health. A 6-8 week maternal mood assessment in clinics will also be undertaken. The parent/carer will also be encouraged to access further support via the baby buddy app that creates a virtual friend

- Evidence based parenting programmes and groups that covers all levels of need from positive start, family links nurturing programme, Triple P Teen to Early Bird, Early Bird Plus and Cygnet are delivered in children centres
- Richmond Borough MIND deliver MIND KIT peer-to-peer support and mental health first aid training to enable volunteers to deliver mental health wellbeing sessions in a variety of locations, including schools and youth settings
- Educational psychologists deliver a range of programmes including mindfulness in secondary schools and group CBT interventions in schools

3.3 Evidence for change

What children and young people in Richmond say

Key findings from the Richmond Young People's Survey 2014 (carried out every two years in schools);

- 63% of year 10 pupils worry about exams and tests
- Around half of year 10 girls worry about the way they look, their weight and what others think of them
- Self-esteem amongst pupils reduces with age. This is the opposite to the national trend

The key issues raised by young people in focus groups:

Stigma – we want to talk more about mental health; have discussions earlier in school and for this to be routine (if not compulsory) within PSHE

Information – we want to know more about resilience and mental health and how to look after ourselves and each other

Access – we want to know where we can go, when and how – both through online sources and staff in schools

Earlier intervention – we want this to be more of a priority than it currently is

Involvement – we want help from each other and our parents through mentoring/buddying, and parent workshops

Choice – we want high quality services including counselling at early stages when problems emerge

Whole school and family approaches – we want the people around us to know how to help us

Children and young people in Richmond have made it clear that they want us to prioritise resilience, prevention and earlier intervention. They don't just want help from services; they also want more help from each other, schools and from their families.

What schools, GPs and other stakeholders say:

GP feedback

Our data shows that GPs are the main referrers to CAMHS and often a first 'port of call' for concerned parents. The GP survey on CYP Mental health services 2013 highlighted the following key issues:

- Access issues with high specialist CAMHS thresholds
- Availability of counselling and psychological services similar to IAPT for adults
- Help with bereavement
- Help for parents in relation to behavioural issues

Community paediatrics feedback

Community paediatricians identified the following key issues:

- The support of educational psychologists in the pre-school social communication pathway although intermittent is of great value
- Attendance of CAMHS SPA staff at the child development bi-monthly meeting would enhance multi-disciplinary team working
- The need for better transition care for children with ADHD and ASD who have just turned 5 years old and started school
- The need for behavioural support /assessment by CAMHS team for children with mild to moderate/severity remains a significant gap. The Early Bird programmes are not sufficient to meet current needs
- Liaison systems with tier 3 CAMHS needs to improve to prevent premature closure of referrals

Head teacher and schools feedback

Schools are the second main referrer to CAMHS according to our data. Feedback from ongoing engagement with schools and the last Kingston/Richmond head teachers forum meeting identified that they wanted:

- Visibility and ease of access particularly with tier 2 services
- Community clinics and appointments
- Fast feedback on referral outcomes

- Joint appointments that include schools in order to achieve an holistic assessment
- Champions and experts in schools to manage low level issues

Other stakeholder feedback

A transformation planning workshop was held to explore current provision in the borough and identify gaps and priorities for action. The key messages coming from the workshop are summarised below:

Gaps – for parents

- An established families programme and parenting (e.g. programme like FAST in Westminster)
- Parenting and child support for more affluent families including issues such as academic pressure
- Parenting in early years and support for dealing with behavioural issues
- Perinatal care for those hard to reach groups

Gaps for universal services

- Supervision and support of professionals
- Good understanding of the local offer from the voluntary sector
- Post adoption trauma therapy/theraplay
- Drop-in for staff
- Pre-SPA advice (before referral, consultation) and post-diagnosis support

Gaps for schools

- Improved access to tier 2 services
- Support for a whole school framework approach including training
- Influencing schools to recognise and resource resilience and earlier intervention
- Better access to the local voluntary sector offer
- Links between CAMHS, schools and colleges
- Peer support/mentoring in schools and youth centres

Staff in schools have told us repeatedly through forums and workshops that they are increasingly concerned about stress, anxiety and self-harm and are unsure how to help pupils and staff. Within more affluent families, schools report that there can be an enormous pressure on pupils with high attainment expectations. At the same time, we know from our needs assessment that not insignificant numbers of children have

parents with substance, alcohol or domestic abuse issues and that these family needs are often hidden.

At a multi-agency workshop on resilience earlier this year, attended by around 60 professionals including schools, there was a general consensus that structured approaches to help school staff build skills and understanding around what can help a child to be resilient would be useful.

The national service specification for health visiting implementation requires that a multi-agency perinatal maternal mental health pathway is in place. This is not yet fully agreed or developed including evidenced based interventions in early years settings.

3.4 Where we want to get to

Our five year aim for this theme is *whole system* transformation through partnership activity and joint commissioning. We want to drive investment in prevention across the system, including our schools in the process, through promoting resilience and demonstrating impact on a wide range of positive life outcomes for children and families.

Over the next two years we will facilitate professionals to act earlier to prevent poor mental health, by investing in early years, and building resilience from childhood through to adulthood. We will coordinate, support and better advertise existing services whilst building new approaches and provision in partnership where gaps have been identified.

In early years and parenting our priority aim is to support parents and carers to parent effectively:

This will be achieved through:

- early identification of maternal depression perinatally and post-natally with effective implementation of a robust pathway
- implementing our evidence-based parenting support and group work programmes;
- continue embedding the team around the child model and the family e-CAF
- improving our triage for emotional and mental health issues through the SPA

For schools our priority aim is to support consistent, high quality approaches to building resilience and promoting emotional wellbeing based on whole school approach

This will be achieved through:

- Providing comprehensive evidence-based training
- Testing approaches to building resilience in schools
- Support to address stigma
- Focusing on disadvantaged families; and those where pressure to attain is an issue
- Better links between schools and external resources including mental health services and the voluntary sector

For universal services our priority aim is to build the capacity of professionals wherever they are in the system. We will also promote resilience and offer support earlier when it is needed

This will be achieved through:

- More multi-agency staff training and forums
- Access to earlier advice and consultation from the SPA prior to referral
- Providing easier access to information and advice, including online

3.5 Key actions

- We will develop, agree and implement a robust perinatal and postnatal pathway; and ensure that health visitors provide appropriate support as part of implementation of the new health visitor service requirements

- We will expand community counselling services for children and young people, accessible through the local voluntary sector

- We will empower children and young people to develop projects, campaigns, conversations, digital tools that enable the de-stigmatisation of mental health and increase peer support

- We will develop the role of the new school nursing service in promoting emotional wellbeing and mental health. This will include effective PSHE. It will also include providing advice and support through confidential drop-in sessions, group sessions and telephone and online communications

- We will work in partnership with schools to develop an extensive joint training programme procured across south west London. The programme will enable schools to better protect and promote mental health and emotional wellbeing. The programme will work with designated leads for mental health in each school

- We will develop a model of joint working between the emotional health service, school nursing (including a designated role) and education psychology to increase the capacity of schools to deliver universal and targeted interventions

- We will pilot the academic resilience approach within a cluster of schools. The pilot will support a cluster of schools to test the approach and established tools, and to share and embed learning within a community of practice across the cluster

- We will develop the named CAMHS lead for schools and GP practices

- We will explore how we build upon the national BOND (Better Outcomes, New Delivery) DfE funded programme to build capacity of, and access to, community and voluntary sector services. This could include better integration of information to schools and support for access through existing channels such as the SPA similar to the reach partnership model established in Middlesbrough

3.6 Transformation funding priorities 2015/16

Transformation monies will be used to address the following service priorities:

- Empower children and young people to de-stigmatise mental health, access help quickly, help themselves and help others **(Ref PR1 – page 46)**

- SWL mental health training for school leads **(Ref PR2 – page 47)**

- Schools Pilot Academic Resilience Project **(Ref PR3 – page 48)**

4. Part Four: Care for the most vulnerable

4.1 The importance of care for the most vulnerable

The *Future in Mind* report highlighted that there are groups of children and young people who are more at risk of developing mental health problems and may find it harder to access help. In order to ensure that this group of children and young people feel safe and are resilient, services need to be coordinated, flexible, multi-agency focused and integrated. Staff who work with this group of children and young people need to have access to high quality mental health advice and support.

Evidence indicates that children and young people are often vulnerable for a range of reasons including poverty, disability, substance misuse, physical or mental illness, or because of other problems within the family home.

In Richmond our vulnerable children and young people are defined as:

- **looked after children (LAC**)
  On 31st March 2015, there were 96 LAC in Richmond, showing an increase of 13% from 85 in 2014. When using the strengths and difficulties questionnaire to measure wellbeing, children in care have an average wellbeing score of 13.1 compared to a 13.4 London and 14.0 for England. Significantly, there has been an increase in unaccompanied asylum seeking young people looked after by Richmond. As such, Richmond looked after 19 unaccompanied children in 2014-2015, increasing from, less than 5 in 2013-4.

- **Children subject to child protection plans (CPP)**
  The number of children subject to CPPs within Richmond has risen by 28% from 2014 to 2015 (90 rising to 115).

- **Young people who have offended**
  At the end of 2014-15 there were approximately 243 children known to the youth offending service in Richmond. There has been a reduction from 2013 to 2015 of 27% with 34 young people entering the system in 2014-15.

- **Young people leaving care**
  An assessment in 2015 found that the leaving care team are currently working with 155 children young people.

- **Children and young people at risk of sexual exploitation**
  An analysis of police data by Richmond Council identified that from 1 April 2014 to 31 March 2015, there were 40 allegations of CSE of 149 sexual offences (27%). All victims were under 17 years old and white. CSE primarily affects girls and young women and it is primarily a risk to young people aged between 14 and 17.

- **Young people not in education, employment or training**

In 2014, 4.3% of 16-18 years olds were NEET. This was slightly lower than the national average of 4.67% and greater than the London average of 3.4%. The proportion of 16-18 year olds 'not known' (8.7%) but lower than the London (10.4%) and national (9%) averages.

- **Children affected by domestic violence and anti-social behaviour**
  The number of cases referred to MARAC has fallen slightly since 2012/13 from 229 to 214 in 2014/15, there has been a significant increase in the rate of children per case between 2012/13 and 2014/15. The provisional data for 2014-15 suggests that 206 children have been affected by domestic violence within the cases reviewed by MARAC. Domestic abuse is also a factor in a high proportion of cases where children are the subject of a child protection plan. Of 69 children considered at ICPC in the first six months of 2013, 58 (84%) had domestic abuse as a factor either currently or previously.

- **Children affected by parental mental health issues and substance misuse**
  The children and young people needs assessment (2014) identified that nationally, 20% of births are to women with mental disorders with varying degrees of severity. When using local prevalence rates for expectant mothers at risk of mental disorders, it is estimated that this equates to 585 mothers who have a mental disorder in Richmond.

  Two hundred and thirteen (27%) clients in treatment for substance misuse in Richmond live with children. 41 young people were in contact with the Richmond Young People Substance Misuse Service. Of those, 80% had wider vulnerabilities recorded, in addition to their substance misuse. Mental health problems (37%) and self-harm (30%) were among the top five wider vulnerabilities recorded for service users.

- **Children in Need (CiN)**
  Provisional data is showing that there has been a 15% increase in the number of CiN from 788 in 2014 to 909 in 2015. In 2014, 277 of the 788 CiN were recorded as having a disability (28.5%) compared to London's (12.6%) and England (13.2%). The most common disability amongst CiN was a learning disability (51%). Autism and Asperger's Syndrome also account for 34% of the CiN in 2014.

  However, there are other vulnerable groups with mental health needs that are of great concern and these are children and young people with learning disabilities, special educational needs and those in transition.

- **Children and young people with learning disabilities**
  The CHiMat report (Oct 2015) states that people with learning disabilities are more likely to experience mental health problems (Emerson E. et al 2008). Emerson et al 2004 calculated prevalence in children and young people with learning disabilities for different age groups and when applied to Richmond, the result is as follows:

5 – 9 years	10-14 years	15-19 years
135	255	275

- The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with learning disability. When applied to Richmond:

5-9 years	10-14 years	15-19 years
55	105	110

Service provision for this group of children and young people needs to be highly individualised so that their particular needs can be met within a community setting in order to prevent unnecessary hospital admission. The national Transforming Care Programme provides a framework and guidance that outlines responsibilities for local partners in conjunction with the NHSE tier 4 specialised commissioning team for this group of children and young people. In particular, those children and young people at the higher end of the needs spectrum and at risk of requiring a Tier 4 admission in an emergency will need to have receive regular reviews led by Health and social care clinical partners that focus on Positive Behaviour Support (PBS) interventions to mitigate behaviours that put the young person at risk. These reviews will form part of a pre-admission CTR risk assessment planning process in order to help prevent, manage and mitigate potential crises that could lead to a subsequent Tier 4 admission.

Implementing the requirement of the national transforming care programme is of particular importance in Richmond given the increasing numbers of children and young people who have neurological conditions and disorders with presenting challenging behaviours. This is borne out by a growing trend over the last three years for children and young people with these conditions who are both referred and subsequently meet the criteria for continuing healthcare and also require a learning disability CAMHS intervention. There were at least 20 children out of the continuing healthcare caseload of 29 children and young people during 2014/15 who have varying degrees of learning disabilities and challenging behaviour.

- **Children and young people with SEN**

The number of pupils with a statement maintained by the local authority has risen from 800 in 2010 to 1040 in 2015. Following the new statutory requirements from the Children and Families Act 2014, Richmond has finalised 90 education, health and care plans since September 2014 to June 2015, (53% relate to early years). SEN is far more prevalent in boys and this corresponds with national trends showing boys are around twice as likely to have SEN than girls, although this varies by type of need.

There has been a steady increase in children receiving a diagnosis of autism. Since 2012 the total number of pupils with a main presenting need of autistic spectrum disorder has increased by 45% in Richmond. Amongst pupils with statements/EHC plans, the most common need was ASD with 190 pupils in Richmond (24%). This is in line with national data where ASD was the largest identified need recorded with over 54,000 pupils (24.5%).

Around 415 of children and young people who live in Richmond with a statement/EHC plan are placed out of borough, 78% are at secondary level in Richmond. The largest numbers of pupils have ASD (24% in Richmond).

- **Young people in transition**
  There are a number of young people for whom the current transition and adult services' arrangements need improvement. These young people can reasonably be described as "potentially vulnerable adults" (PVA) or just "vulnerable adults" (PV) depending on their age. They are unlikely to meet the threshold for accessing support from continuing healthcare and adult social care under the Care Act 2014 but due to a range of factors are identified as PV/PVA and as such require some support to ensure a successful transition into adulthood.

- **Vulnerable families**
  Considering data on local need has enabled Richmond to identify key areas of concern for families being prioritised to participate in the national troubled families programme, known locally as Strengthening Families. A review of the families participating in the programme identified that parental mental health is a concern in 35.8% of families. Parental substance misuse accounts for 19.8% of families in the programme and is the fourth highest wider family concern. 4% of families were receiving treatment for alcohol dependency, a reflection of very severe alcohol problems.

  A survey of troubled family coordinators in 2014 cited the prevalence of domestic violence experienced by families as a major concern. It also showed that less than half of the cases that involved domestic violence were known about at the point of referral. Many of the families on the programme have a child with additional learning needs or a disability, who is being supported in school or by other providers.

  The data also shows that 6% of troubled families have children who are being looked after by the local authority. A significant proportion of families have been assessed by the key worker as having parenting problems.

  The Family Nurse Partnership (FNP) is a preventive programme for vulnerable first time mothers aged 19 or under and can achieve significant benefits for vulnerable young families across a wide range of outcomes. There are around 53 conceptions among under 19-year-olds in Richmond per year, with around 66% leading to abortion (compared to 62% in London and 49% in England). The relatively low rates of live births among under 19-year-olds did not qualify Richmond for national FNP funding. The future procurement and commissioning of the health visiting service offers the opportunity to work with Achieving for Children and the Richmond Clinical Commissioning Group (CCG) to identify how it can further strengthen the work with vulnerable groups.

Child sexual exploitation is a rising concern and in 2014/15 our Local Children Safeguarding Board made this one of its key priorities; providing guidance and support for agencies working with parents who have issues of substance misuse, mental health and/or domestic violence. This is supported by the findings from the *"Review of Child*

Sexual Assault Pathway for London" that mapped the pathway for children and young people following sexual abuse, pan-London and both in acute and historic cases. The findings included variation and significant gaps in medical aftercare and long-term emotional support (especially for those under 13 years), as well as issues with the prosecution process.

- Less than 1 in 12 children/young people that have been sexually abused access sexual assault or local paediatric services
- 35% of under 13 year olds from The Havens had aftercare with a local paediatrician
- 10% of children and young people had emotional support/therapy from CAMHS or tier II service, even though 90% were referred.

The recommendations include the establishment of five child houses in London and an enhanced paediatric service at The Havens (sexual assault referral centres). The child houses are a child friendly building where children and young people will be able to access medical examination, sexual health aftercare, counselling, therapy and advocacy.

Inequalities: Although factors which are strongly associated with increased vulnerability, such as childhood poverty and being in care, are at a relatively lower level in Richmond compared to other local authorities. This can mean that those children and young people who are more vulnerable can feel extremely isolated. Services and schools are not always practiced at differentiating responses to vulnerability and complexity. This is an added challenge for us to address as part of our local services transformation to ensure equity of provision for vulnerable groups.

4.2 Current position

- We have a number of posts that are embedded within services working with some of our most vulnerable groups. These areas include youth justice service, looked after children services, children social care and services for disabled children
- Early Years services include a range of parenting programmes for vulnerable families and access through children's centres to a range of specialist provision
- Hounslow and Richmond Community Healthcare NHS Trust (HRCH) offer a 0-19 specialist health visitor for children with special needs is being reviewed in the light of the transfer of responsibility for the health visiting service to the local authority
- We ran a pilot project that placed a health visitor in the SPA to identify at risk/vulnerable children, ensuring all information is shared in a timely manner
- Specialist health posts work with LAC services, youth offending, and teams who support children with disabilities. They also work closely with the emotional health service
- A new post has been funded to address the needs of children with challenging behaviour following a pilot project built around an integrated team
- We have a virtual transitions team that comprise adult and children services staff
- Young carers receive support commissioned from the voluntary sector

- All LAC have their health reviewed in-line with national standards. In 2014, 13.5% of LAC were identified as having a substance misuse issue compared to 6.1% in London and 3.5% nationally. However, new issues emerge and challenge services such as the increasing number of unaccompanied asylum seekers

- The school nursing service seeks to identify early children and young people with emotional difficulties through health assessments and reviews, including for those with long-term conditions and other vulnerable groups

- Our LAC CAMHS practitioner offers a monthly thinkspace supported by tier 3 clinicians. They can fast track more vulnerable or complex children requiring additional and/or psychiatric input into tier 3 CAMHS services

- Young people entering the criminal justice system in Richmond remain a priority for the mental health support team. The delivery of health and wellbeing provision for young offenders was redesigned and commissioned during 2014/15 in order to provide a more comprehensive health offer that includes internal consultancy as well as Tier 2 intervention work and brokering CAMHS provision for Tier 3 and above

- Health is represented on the YOS management board by Kingston Clinical Commissioning Group and forthcoming meetings will focus on the health provision for young offenders. We are not currently involved in the resettlement consortiums aimed at improving outcomes for young people leaving custody or working with NHSE health and justice commissioners

4.3 Evidence for change

- Data and feedback from service users in Richmond indicates that the prevalence of some vulnerable groups are increasing. For example, unaccompanied asylum seekers who are placed in our care; those who are at risk of sexual exploitation and those with a learning disability who are relatively unsupported between appointments with services

- We also know that self-harm and alcohol use which are indicators of risk and vulnerability are comparatively high in Richmond. (Rate of hospital admission due to alcohol-specific conditions is sixth highest among London councils; and fourth highest for self-harm)

- Whilst we have increased health input to the youth offending team, we need to monitor the impact of this service. The prevalence of significant mental health problems amongst young people under 18 is between 44% for those in contact with the criminal justice system to 85% of young people who are detained in youth offender institutions

- Our challenging behaviour pilot aimed to address the gaps in current service provision for children aged five and over with a learning disability who exhibited particularly challenging behaviours. This pilot project demonstrated the need for this group of children and young people to receive an integrated service offer, covering health, social care and education. It further highlighted the importance that Richmond Clinical Commissioning Group identifies and maintains a local risk register

of children and young people who have high levels of need, as required by the national transforming care programme.

Additional feedback from stakeholders:

- Adult services identified that there are a group of young people who are typically known to children's services through the SEN, looked after, leaving care or family support teams that require further support. They have a range of diagnosis including autism spectrum conditions, ADHD and learning difficulties

  The issues that lead to concerns about vulnerability are broad but include: risky or criminal behaviour, non-engagement with support services or education, unsupportive parents/carers, low self-esteem and mental health issues that are not significant enough to meet criteria for Community Mental Health Team (CMHT) involvement. This is highlighted as a concern

- Feedback from social care services indicates a need for better engagement with, and consultation from, tier 3 CAMHS clinicians

- Children placed out of borough often can suffer delay in accessing CAMHS provision

We need to improve the CAMHS offer for children who experience sexual abuse and those who may experience trauma, such as unaccompanied asylum seeking children.

4.4 Where we want to get to

- We will ensure that vulnerable young people accessing the system in crisis through turning up in A&E having self-harmed, are appropriately assessed and enabled to access relevant services

- We want to improve joint working between tier 3 CAMHS and social care so that staff receive expert advice and support. This will include access to early trauma assessments for those who have experience of supporting children and young people who have been sexually abused

- We want to further develop our emotional health internal consultancy offer to support staff working with vulnerable groups and include specialist provision for children with disabilities. This includes a particular focus on challenging behaviour in the home and family breakdown as well as the mental health needs of non-verbal children

- We want a SWL service developed around the child house model for those children and young people experiencing child sexual abuse and trauma

- We want to ensure that all staff working within the youth offending service have a thorough understanding of the impact of trauma, abuse and neglect on mental health, so that these individuals can be identified and supported early to prevent them developing chronic long-term mental health problems. This inadvertently impacts on offending/reoffending behaviour

- We want to ensure we have clear pathways into specialist health services to ensure effective interventions are provided to all young people

- We will better support the voluntary sector as an appropriate and accessible doorway to the system for many vulnerable young people by integrating access through a clearer local offer and increased access through the SPA

We will explore how we could participate in future opportunities such as the resettlement consortiums for young people leaving custody. We will also work more closely with NHSE health and justice commissioners to better understand the needs of this group and to improve local pathways with partners.

We will improve relationships with NHSE specialised commissioning team to improve monitoring of Tier 4 inpatient admissions, and collaboratively plan to provide care closer to home; prevent unnecessary in-patient admissions and ensure there is effective discharge planning in the community. This will enable us to meet the requirements of the national transforming care programme, including prioritising the implementation of CTRs that include local pre-admission CTRs discharge meetings involving all partners and users/carers to design and commission individualised packages of care and support.

4.5 Key actions

- Recruit specific deliberate self-harm nurse to see Richmond cases presenting at A&E and ensure better information sharing and co-ordination of onward access to appropriate services
- Increase support for victims of child sexual abuse through supporting the proposed development across SWL of a child sexual assault hub and an enhanced paediatric service at The Havens (sexual assault referral centre)
- Development of the Single Point of Access (detailed in the Access section) to include:
    - Integration of health referrals
    - Improved multi-disciplinary team triage /initial risk assessment
    - Increased access to telephone advice for those working with vulnerable groups in other parts of the system
    - Ensuring accurate assessment within the SPA of cases presenting with mental health and safeguarding concerns to ensure the referral is right first time
- The plan for CAMHS outreach clinics in community settings through a pilot approach will include monitoring levels of access by vulnerable groups
- Increase access to community and voluntary sector services including counselling. This will include existing channels such as the SPA and building on previous work led through the BOND (Better Outcomes, New Delivery) pilot
- Richmond Clinical Commissioning Group will develop joint working arrangements with the NHSE specialised commissioning team over the next few months by

organising regular joint meetings to review and develop the information provided for commissioners in Tier 4 CAMHS inpatient services. This will also include an invite to attend our Joint Agency Panel and the Emotional Wellbeing Board to ensure that partners are fully aware of the transforming care programme and the need to develop community-based services.

4.6 Transformation funding priorities 2015/16

Transformation monies will be used to address the following service priorities:

- Improve the hospital paediatric service by recruiting a Richmond deliberate self-harm nurse **(Ref CV1 – page 49)**

- Contribute to funding a SWL child sexual abuse worker **(Ref CV2 – page 49)**

5. Part Five: engagement, accountability, transparency and partnership working

5.1 Our commitment to engagement, accountability, transparency and partnership working

Our last three year CAMHS strategy, 2012-15, promoted a whole system approach and has helped us to drive integration in practice throughout many areas of the system. The action planning and delivery, galvanised partnership working across Richmond between providers and commissioners and with neighbouring boroughs.

Our commitment to continue to pursue a whole system that works better for children and young people's mental health and wellbeing is based on our success so far as a partnership approaching this together. Since 2012 our engagement, accountability, transparency and partnership approaches have led to numerous improvements in Richmond including multi-agency teams; a new emotional health service; a Single Point of Access; a schools and multi-agency services forum; a VCS information to schools project; the development of multi-agency care pathways; and much more.

We have also developed a range of planning processes and engagement activities from surveys, focus groups, an established schools and multi-agency forum. We have also commissioned consultation with specific groups such as parent/carers of CAMHS service users. We remain committed to this engagement activity and recognise the importance of building our coproduction skills and capacity as part of the transformation process.

Our opportunity with *Future in Mind* is to expand and improve upon our experience so far and begin to address the more challenging and systemic issues which have not yet been effectively addressed in partnership.

5.2 Our governance arrangements

The *Future in Mind* report highlights that there needs to be strong leadership locally across the whole system in order to ensure that the commissioning of CAMHS can deliver better service models of care and improved evidenced-based outcomes. The

report advises that the governance frameworks, underpinning CAMHS commissioning locally, need to be reviewed in order that:

- There is a lead accountable commissioning body
- The roles and responsibilities of local authorities can be clarified
- A single identifiable budget for CAMHS can be established; and
- A local CAMHS plan can be agreed.

Our Emotional Wellbeing Board was established in 2012 to drive the implementation of our then newly developed CAMHS strategy. The membership of the board comprises representation from health and local authority commissioners, NHS providers, public health, the voluntary sector and schools.

The board has clear terms of reference and is accountable to senior management teams across health and the local authority and ultimately to the Health and Wellbeing Board (HWB). The Emotional Wellbeing Board also supports an emotional wellbeing forum that consists of wider representation from the voluntary and community sector that provides opportunities for shared learning and networking across the children's partnership.

The LSCB Quality Assurance Sub Group also has a role in testing and assessing services in relation to safeguarding and child protection the results of which feed into service improvement. The SPA Mental Health Triage, CAMH services for children and young people with SEND, and teenage relationship abuse have all been scrutinised by this subgroup.

Given that we are about to update our local CAMHS strategy, this transformation plan contains actions primarily focused on year one of the five year process of transformation. Our last strategy was whole system focused from prevention to acute services and we need time to develop an equally ambitious and comprehensive next step strategy.

The governance for our new CAMHS transformation planning process has been reviewed. The Emotional Wellbeing board will report via the Clinical Commissioning Group, Public Health and AfC management teams to the Strategic Partnership Group (CCG and Council chief Officers) and Health & Wellbeing Board, Richmond's Council Cabinet and the Clinical Commissioning Group Governing Body through quarterly progress reporting. The membership of the Emotional Wellbeing Board will now include Health Watch as a full member of the board and other stakeholders from NHS England, such as the specialised commissioning team and the Health in Justice Team, as associate members.

Associate membership will ensure that the NHS England teams have the opportunity to actively participate in the business of the Emotional Wellbeing board by having an open invitation to attend specific board meetings. We have also created sub-groups covering the five key areas of Future in Mind in order to ensure operational delivery and development of our CAMHS transformation plan. These sub- groups will have wide stakeholder involvement and will need to demonstrate robust engagement with children

and young people. Appendix 12.1 provides further detail about our new governance framework.

Outcome Based Commissioning (OBC)

Richmond CCG is the local system leader for commissioning CAMHS. However, the adoption of an OBC approach to commissioning adult community services will have implications for the commissioning of CAMHS locally. OBC is a new form of contract that aims to deliver improved outcomes for patients and provide greater financial stability for the health economy. OBC puts patients and what matters to them at the heart of everything we do. By adopting OBC, the success of healthcare provision will be measured by results that matter to the patient and not by numbers of patients seen.

Patients will have more influence over how their healthcare is delivered by helping to shape the outcomes that are included in community service provider contracts and by making informed decisions about how their care is delivered.

The scope of the first phase of the OBC programme is focusing on the provision of community services for physical health i.e. adult out of hospital health and social care services. The second phase of our OBC programme covers community services for mental health that will enable people to be supported in their community and avoid unnecessary hospital admission. This includes services such as the Community Mental Health Teams (CMHT), Improving Access to Psychological Therapies (IAPT) and voluntary sector services.

5.3 Engagement, involvement and partnership working

Since 2012, as part of our previous strategy implementation, we have established a network of practitioners and schools which comes together in regular forums to learn, share and coproduce plans with us. We have held multi-agency workshops covering a wide range of themes from development of pathways to the Single Point of Access. The evaluations have been excellent and the workshops have been much appreciated as a valuable opportunity to contribute, network and plan local services.

We will utilise this existing multi-agency network to continue to engage with schools, frontline practitioners and clinicians, to contribute to our understanding of the local system, challenges and needs; and to coproduce solutions – building our strategy and plans for a further four years of system-wide transformation.

Richmond received ministerial commendation for its engagement and involvement of children and young people in relation to the implementation of the SEND reforms. We continue to mobilise children, young people, parents, carers and partners through direct support and commission survey, consultation and engagement activities in the borough. However, we recognise that we can always do more. We will therefore work closely with the SEND participation and engagement officer for CYP with disabilities, the CYP youth engagement officer, the recently appointed Tier 3 CAMHS participation worker as well as the children, young people and parents engaged in all our services and schools to identify more robust ongoing mechanisms for participation and coproduction.

We know from our experience of engagement that we have parents/carers who are active, organised and willing to challenge and advocate for change to our CAMHS and

other services. We will enable local parent voice groups, Richmond Clinical Commissioning Group (CCG) community involvement group, patient participation groups and GP practices to feed into SWL Commissioning Collaborative to strengthen and enhance our services locally and at a sector wide level as part of our governance and service improvement processes.

5.4 Where we want to get to

We want to:

- Ensure that children and young people, their families/carers, are at the heart of all the work of the Emotional Wellbeing Board and are central to services that are relevant for their identified need
- Develop a joint commissioning plan and arrangements collaboratively with Kingston Council and the Richmond Clinical Commissioning Group (CCG) so that we can commission services at all levels of CAMH interventions supported by a joint Richmond/Kingston commissioning board and pooled budget arrangements
- Actively monitor our CAMH services through the use of robust local data so that we can be confident that we know what good looks like and take action when services are of low quality
- Disseminate and promote evidenced based practice, pathways and information across the children's partnership
- Ensure that the needs of vulnerable groups are addressed as an integral part of the work of the Emotional Wellbeing Board
- Develop more effective data collection systems and engagement processes in order to identify gaps and understand the needs of underrepresented children and young people, groups and carers and reflect this in our monitoring and cycle of improvement

5.5 Key actions

We will:

- Review our membership and governance structure to create sub-groups covering each of the key areas of the *Future in Mind* task force recommendations to monitor the implementation and delivery of our transformation plan
- We will publish our transformation plan, tracker and declaration on the website of the CCG, local authority and any other local partners
- We will produce and publish an annual report based on our action plan and programme of transformation that will go to the Children's Strategic Partnership, Local Safeguarding Children Board and Health and Wellbeing Board and we will publish this with our local offer for our service users and parents/carers
- We will update our local strategic plan to ensure the priorities and aspirations of *Future in Mind* and the 2020 vision are captured and aligned against our medium and longer term action plans for Richmond
- We will develop and implement a local monitoring framework and assess performance to ensure that we can demonstrate impact and evidence improvement in outcomes

6. Part Six: Developing the workforce

6.1 The importance of workforce development

The *Future in Mind* report highlights the importance of a workforce that has the, "right mix of skills, competencies and experience". It further outlines the importance of access to training appropriate to their setting. A workforce that is not equipped with the basic knowledge, skills and competencies cannot identify when families, children and young people require help or support to deal with emerging emotional or mental health issues.

6.2 Current position

- We are shaping our local approach to workforce development and planning between the local authority and the NHS in the light of the transfer of commissioning responsibilities for health visiting and school nursing through Richmond Public Health leadership of the London-wide strategic approach
- We need more information about the skills, expertise and qualifications of our wider workforce in order to plan and deliver appropriate training and development activities
- We know that the service offer/post diagnostic support for children and young people diagnosed or showing traits of ADHD is poor because there are not enough trained staff to work with this group of children, young people and parents (see Access chapter)
- The workforce in Richmond includes a large number of committed parents and carers who require peer support and training, including options for self-care
- We have a comprehensive programme of professional training available to staff but need to attract the tier 3 CAMHS workforce to attend our programmes
- The multi-agency nature of the workforce, and our belief that prevention and early intervention is facilitated by a team around the child, will require the development of new roles and responsibilities. This will in turn lead to the need for our workforce to acquire additional skills to work effectively
- Richmond is committed to train its workforce in the principles of IAPT. The EHS is part of London and Reading collaborative. Richmond is linked to the UCL and Kings London Collaborative and has been using IAPT measures since January 2014. To date, 7 EHS staff have undertaken IAPT training. Currently, 4 staff in Early Help and Protection service are doing a Postgraduate Certificate in Enhanced Evidence Based Practice (EEBP) at Reading University. A further 3 members of staff will be attending training next year from the Richmond partnership

6.3 Evidence for change

There is a growing evidence-base of interventions that have a positive effect on mental health outcomes for children and young people. Staff will need a variety of therapeutic skills including behavioural, cognitive, interpersonal, psychodynamic, pharmacological and systemic approaches to deliver evidenced-based interventions.

There were a number of key messages that emerged from the transformation consultation and engagement process:

- Professionals in the wider workforce wanted timely access to CAMHS clinicians for consultation and advice to support decision making about referrals and interventions
- Professionals wanted opportunities to undertake joint training with CAMHS clinicians

- Professionals valued opportunities for shared learning as evidenced through our successful programme of research seminars

- Through our focus groups with young people they told us that school staff do not have the expertise to provide support/advice and the knowledge and skills to signpost effectively.

6.4 Where we want to get to

- A workforce with the capacity and skills to meet the needs of children and young people at universal, targeted and specialist levels of intervention

- An agreed evidenced-based training programme that matches the identified training needs of our professionals across all tiers and sectors

- CYP IAPT principles to be embedded across our CAMH continuum to improve participation by CYP and their families in service delivery and design, and to carry out session-by-session routine outcome measures (ROM) ensuring goal focused outcomes

- A workforce that is appropriately supported by tier 3 CAMHS clinicians to both understand and manage emerging complex disorders such as self-harm and eating disorders

- Children and young people, parents and carers to have confidence in our workforce to respond appropriately and sensitively to their needs

6.5 Key actions

We will:

- Review our current mental health training programme to ensure that we are effectively targeting our training offer

- Commission a workforce audit and develop a workforce strategy to support professionals and volunteers at universal, targeted and specialist levels of training

- Continue our programme of research seminars promoting evidenced-based practice

- We will ensure that CAMHS practitioners are trained in the CYP IAPT evidence based interventions as part of a rolling programme of training

- We will introduce clear links to specialist CAMH services for GP practices and Schools in Richmond including continuing to work with CAMHS tier 3 and CEPN to coordinate education for GPs

- We will expand our training offer to upskill professionals and parents that address areas of specific need identified by parents/families such as ASD/ADHD.

6.6 Transformation funding priorities 2015/16

Transformation monies will be used to address the following service priorities:

- Commission a workforce audit and develop a workforce strategy (**Ref DW 1 – page 50)**
- Commission 'Why Try' an ADHD training programme (**Ref DW2 – page 51**)

7. Part Seven: commissioning

7.1 Finance and workforce

7.1.1. Finance

The Richmond CAMHS transformation plan priorities were based on feedback from the consultation and engagement events that were held during August and September 2015. This included:

- A baseline assessment template questionnaire covering the five key areas from *Future in Mind* that was sent to a wide range of stakeholders during August and September
- A Health and Wellbeing Board Children and young people listening event held on the on 14 September 2015 attended by 65 participants (see appendix 12.2)
- A CAMHS transformation planning workshop held on 22 September involving 30 attendees from a range of stakeholders (see appendix 12.3)
- Young people focus groups carried out in five secondary schools and with young people from a CYP community counselling voluntary organisation (see appendix 12.4)
- A meeting with the Youth Council on 24 September 2015 to obtain their feedback

The outputs from these key events confirmed existing stakeholder feedback and intelligence about the priorities and service responses required to address issues of children and young people's emotional wellbeing and mental health needs.

The analysis of feedback and prioritisation was undertaken by Richmond Clinical Commissioning Group (CCG) Children's commissioners (Children's GP clinical leads and the Children's Health Commissioning Manager). The prioritisation process was informed by the following criteria:

- The results of a baseline assessment against five outcome areas identified in *Future in Mind* :
  - Promoting resilience, prevention and early intervention
  - Improving access to effective support
  - Ensuring care for the most vulnerable
  - Ensure accountability and transparency
  - Developing the workforce
- Outcomes from the above mentioned engagement events
- National and SWL CAMHS priority areas
- Building on local approaches and enhancing existing local CAMH services
- Addressing short-term issues and piloting/testing new ways of working
- Addressing identified areas of clinical risk and safeguarding concerns

- Activities that seek to achieve clinical outcomes underpinned by a recognised clinical evidence base
- Gaps in service provision
- A demonstration that CAMHS transformation funding could be fully spent in financial year 2015/16.

The allocation of funds was based on the production of business cases for each priority that contained actual project costs where potential providers were identified. In the absence of an identified provider, costs were estimated based on previous experience of similar projects.

All key partners through the Strategic Partnership Group (CCG, Council AfC and Public Health) have given in principle agreement and sign off of the Richmond CAMHS transformation plan. The transformation plan has also been signed off by the Director of Public Health in consultation with the chair of the HWB and the chair of the CCG's Finance and Performance Committee. The Richmond CAMHS transformation Plan will be formally considered by the Council's Cabinet Committee, the Richmond Clinical Commissioning Group (CCG) Governing Body at its January 2016 meeting and the Health and Wellbeing Board meeting.

7.1.2 The table below outlines the investment proposals for 2015/16 Richmond CAMHS transformational plan

Transformation plan priority areas	**Richmond CAMHS Priorities**	**Cost**
Improving access to effective support	Increase staffing capacity in the CAMHS tier 2 Single Point of Access to clear waiting lists and expand service offer **(Ref IA1) page 42 (tracker local priority 1)**	£64,028
	Increase staffing capacity in the CAMHS tier 3 Single Point of Access to improve triage, initial risk assessment and joint working **(Ref IA2) page 42 (tracker local priority 2)**	£68,000
	Expand voluntary sector counselling for children and young people **(Ref IA3) page 44 (tracker local priority 3)**	£12,000
	Increase the capacity of the SWL designated eating disorder service to meet new access and waiting times guidance **(Ref IA4) page 45 (tracker local priority 4)**	£97,490
Promoting Resilience, Prevention and early intervention	Empower children and young people to de-stigmatise mental health, access help quickly, help themselves and help others **(Ref PR1) page 46(tracker local priority 5)**	£20,000
	SWL mental health training for school leads **(Ref PR2) page 47(tracker local priority 6)**	£20,000
	Schools Pilot Academic Resilience Project **(Ref PR3) page 48(tracker local priority 7)**	£10,000

Care for the vulnerable	Improve hospital paediatric service by recruiting a Richmond Deliberate self-harm nurse **(Ref CV1) page 49(tracker local priority 8)** Contribute to funding a SWL Child Sexual Abuse worker **(Ref CV2) page 49 (tracker local priority 9)**	£20,000 £10,000
Developing the workforce	Commission a workforce audit and develop a workforce strategy **(Ref DW1) page 50 (tracker local priority 10)** Commission 'Why Try' an ADHD training programme (**Ref DW2) page 51 (tracker local priority 11)**	£10,000 £10,000
Total		**£341,519**

7.13 **Details of 2015/16 CAMHS transformation investment proposals**

Project Title Ref IA1	**Increase staffing capacity in the CAMHS tier 2 Single Point of Access to clear waiting lists and expand service offer (tracker local priority 1**	
Transformation Project description	The CAMHS Single Point of Access has been in operation for just over a year. In recent months the level of referrals to tier 2 have risen resulting in increased waiting times for initial choice meetings (from 2 weeks to 3-4 months) and for partnership interventions (from 4-6 weeks to 4-6 months). Tier 2 CAMHS received 132 referrals as at March 2015 Transformation monies will be used for 6 month pilot (Jan – Jun16 The project aims to reduce waiting times by offering: - A telephone consultation to all referred clients and their parents - Community clinics (brief face-to-face assessments) at least one morning and one afternoon per week in order to listen, establish the problem and provide information and advice - Increase clinical specialists sessions to shorten waiting times to commencement of 'partnership' (brief intervention/psychological treatment)	
KPI	**Main KPI**	a) Improvement in waiting times from referral to initial assessment/face-to-face contact and telephone consultation b) % increase in paired measures score (IAPT ROM)
	Baseline	a) initial appointment 12 weeks waiting time b) 7% paired measures
	Target	a) 100% referrals assessed in eight weeks a) 50% referrals received offer telephone consultation within four weeks of referral b) 15% paired measures March 2016; **Q4**
Outcome	Reduced waiting list Improved waiting time between initial assessment and commencement of treatment	
Project Costs	3FTE 8a Clinical Psychologists **£64,028 recurrent (Q4 2015-16 & Q1 2016-17)**	
Baseline Investment	£549,000 - EHS	
Evidence based	*Future in Mind* strongly advocates a single point of Access	

Project Title Ref IA2	**Increase staffing capacity in the CAMHS tier 3 Single Point of Access to improve triage, initial risk assessment and joint working (tracker local priority 2)**
Transformation Project description	The current Richmond CAMHS tier 3 single point access (SPA) provides a limited service delivered by 0.5 wte clinical psychologist (supported by 0.5 admin) who will triage referrals or enquiries within one working day on the appropriate next steps Transformation monies will be used to pilot six month pilot project (Jan –

<table>
<tr><td></td><td colspan="2">Jun16) aimed at enhancing the current tier 3 CAMHS SPA service in order to provide:

• Management of clinical responsibility
• Specialist mental health full screening
• Multi-disciplinary triage and clinical decision
• Integration with an existing MASH becomes a possibility
• Assessment, brief treatment and consultancy to other professions (assessments, case discussion and early intervention in alliance with social workers)
• Compliance with children's and young person's improving access to mental health
• Central service user tracking and data collection for wellbeing and mental health
• Training of assessment skills to allied professionals

This will increase SPA CAMHS tier 3 capacity to improve access to expert assessment, enable better integration with tier 2 CAMHS, and improve performance/collection of outcomes data</td></tr>
<tr><td rowspan="2">KPI</td><td>Main KPI</td><td>(a) Time between referral received and screening
(b) Assertive signposted
(c) Assessment/consultation
(d) % referrals screened
(e) % increase in paired measures score (IAPT ROM)</td></tr>
<tr><td>Baseline</td><td>(e)6.5% paired measures</td></tr>
<tr><td></td><td>Target</td><td>(a) 24 hours
(b) 48 hours
(c) 10 working days
(d) 100%
(e) 15% paired measures March 2016;
Q4</td></tr>
<tr><td>Outcome</td><td colspan="2">Multi-disciplinary triage of referrals resulting in better clinical decision making and appropriate onward referral
Reduction in waiting times
Provision of an initial rapid crisis response to referrals, for example:
• Direct from A&E
• If psychosis is mentioned in the referral
• Where suicidal thoughts/serious self-harm are mentioned
• Safeguarding is raised</td></tr>
<tr><td>Project Costs</td><td colspan="2">Transformation monies will be used to fund the following posts:
0.3 wte Consultant Psychiatrist
0.5 wte Clinical Psychologist (Band 8a)
1.4 wte Mental Health Therapist (Band 7)
1.0 wte Office Manager
0.5 wte Admin
£68k recurrent Q4 2015-16 & Q1 2016-17)</td></tr>
<tr><td>Baseline Investment</td><td colspan="2">SWLStGs - £63k to fund 0.5 wte clinical psychologist supported by 0.5 admin</td></tr>
<tr><td>Evidence based</td><td colspan="2">NCCMH NHS England guidelines 2015
Future in Mind DOH 2015 strongly advocates a single point of access for CAMHS</td></tr>
</table>

<table>
<tr><td>Project title
Ref IA3</td><td colspan="2">Expand voluntary sector counselling for children and young people (tracker local priority 3)</td></tr>
<tr><td>Transformation Project description</td><td colspan="2">There is only one local voluntary sector provider that offers a free information, advice and counselling service solely for young people (aged 11-18 years). The service practices:
A confidential service to young people
A tier 1 & 2 service
Signposting to sexual health information
A counselling service which will support the emotional health and wellbeing of young people
A responsive drop-in service for young people which provides advice and information when they need it.
Transformation monies will be used for 6 month pilot (Jan – Jun16

This projects aims to:
Increase counselling capacity in this service in order that a counsellor can participate in the Single Point of Access (SPA) service for one morning a week
Expanding the existing counselling service to include two mornings a week in order to create a greater capacity for additional client referral via the SPA. In addition to the increased hours, SPA client referrals will also be able to access the service at any of its opening times throughout the week
Engage with schools by offering specialist counsellors who can provide lessons on aspects of mental health, including anxiety, depression and other areas
Undertake a review to identify suitable venues in the borough for counselling. This will be done with a view to expanding mental health counselling into areas with inadequate services, currently failing to reach those particularly in need</td></tr>
<tr><td rowspan="3">KPI</td><td>Main KPI</td><td>a) Improvement in waiting times from referral to service
b) Reduction in core outcomes score</td></tr>
<tr><td>Baseline</td><td>a) Eight weeks waiting time
b) Clinical score for severity of symptoms from a service average of 17 points at start of counselling</td></tr>
<tr><td>Target</td><td>a) Six weeks
b) 10 points
Q4</td></tr>
<tr><td>Outcome</td><td colspan="2">Children and young people have increased access to information, advice and counselling
Reduction in severity of symptoms (a reduction of 5-7 points shows a clinically significant improvement)</td></tr>
<tr><td>Project costs</td><td colspan="2">£12,000 recurrent Q4 2015-16 & Q1 2016-17)</td></tr>
<tr><td>Baseline investment</td><td colspan="2">Off the Record Counselling £50k (specifically for children and young people)
Catholic Children's Society £58k
Refuge £40k
Richmond Carers Centre £30k</td></tr>
</table>

	• Richmond Homestart £160k • Domestic Violence Intervention Project £29k • Barnardo's £50k	
Evidence based	There is recent evidence to suggest counselling to be equally as effective as cognitive behavioural therapy (CBT) with approximately 40% of people in Increasing Access to Psychological Therapies (IAPT) services moving to recovery for both interventions (Glover, Webb & Evison, 2010). A number of review papers have been conducted, providing evidence that counselling is clinically effective; it has been reported than person-centred counselling is effective for clients with common mental health problems such as anxiety and depression (e.g., Bower et al., 2000; Cape et al., 2010; King et al.) Studies using routine outcome measures, such as clinical outcomes for routine evaluation (CORE) have reported reliable improvement pre- and post intervention for counselling for three quarters of clients (Mellor-Clark et al., 2001).	
Project Title Ref IA4)	**Increase the capacity of the SWL designated eating disorder service to meet new access and waiting times guidance (tracker local priority 4)**	
Transformation Project description	Transformation monies to be used to increase funding to the jointly commissioned SWL eating disorder service in order to develop an eating disorder service model that complies with the new guidance on access and waiting time standard. Specifically, the service will increase clinical capacity to achieve: • Expanded range to include all eating disorders without weight thresholds, to include feeding disorders • Expanded referral routes to include self-referral and referrals from schools • Delivery individual cognitive behavioural therapy to a greater number of young people treating all common co-morbidities within the dedicated team, treating all cases of feeding disorders • Start-up of a day-patient provision that will work together with the outpatient provision, working as a single unified community team, with links with our inpatient team that is separately funded • Increased staffing as detailed in the guidance to deliver on this model • Employment of more therapists who are eligible to do the systemic family therapy / eating disorders training in this current round. **The business case for the south west London designated CAMHS eating disorder service. The preferred option is the silver option: this has been commissioned but details to confirm benefits realisation are still being confirmed**	
KPI	**Main KPI**	(a) ED referrals seen by the community ED team not Specialist team (b) Children start treatment in four weeks

		(c) Children have outcomes recorded (d) Children have their views of the service recorded
	Baseline	96.4% (27/28) of children referred to CAMHS dedicated service for a routine appointment were assessed within 8 weeks of referral
	Targets	(a) 100% (b) 90% (c) 100% (d) 80% **Q4**
Outcome	• Compliance to access and wait time standards • Increased numbers of patients receiving the appropriate evidence-based treatment will aid recovery • All patients with an eating disorder will receive a service from the dedicated service • Reduction in the number and length of in-patient admissions, depending on option chosen	
Project Costs	**£97,490 recurrent**	
Baseline Investment	Current service costs to be confirmed	
Evidence based	Future in Mind strongly advocates investment in eating disorder services	
	See appendix 12.5	

Project Title Ref PR1	**Empower children and young people to de-stigmatise mental health, access help quickly, help themselves and help others (Tracker local priority 5)**
Transformation Project description	Transformation monies to be used to increase engagement and empower children and young people to get help from each other, schools and families. This project is built around the four common themes identified by children and young people: **De-stigmatise mental health** • Organise focus groups to be held in youth clubs, schools, Children in Care Council, YOS Youth Board, with SEND champions, in PRU, with LBGT Youth Group • Develop borough wide mental health campaign to include development of Flash-mob to introduce campaign, commissioning of forum theatre piece for Schools and Youth clubs. The entire project will be captured on film. This can then be used as a resource for schools and youth clubs. • Organise an event for youth clubs as part of youth service summer programme **Access help when needed quickly** • Drop-in support sessions with mental health workers on the YES bus (outside schools and Richmond quadrant) and in youth clubs **CYP would like to help themselves** • Review existing web platforms accessed by young people (e.g. school website, Off the Record website etc.) to provide advice and information to ensure children and young people have access/signposted to the help and support they need

	CYP would like to help others • Establish peer mentoring programme for schools to enable young people and education professionals to design an education teaching resource pack for schools • Production of a toolkit (hard copy and online) by young people to support their peers. It will also include capacity building of RYC and area based teams of young people in peer facilitation skills • Enable young people to access training to become peer mentors, exploring qualification (AQA) in mental health first aid • Launch a buddy system for young people entering the tier 3 specialist CAMH service-they are matched with a trained and supported young person who has 'been there' and can reduce anxieties around accessing CAMHS These proposals will be further refined by organising a steering group with representation from service providers, schools, and Richmond Youth Council with the aim of developing and managing all projects.	
KPI	**Main KPI**	a) % of schools engaged
	Baseline	• 82 schools in Richmond • Further development of baselines to be undertaken by steering group by January 2016
	Target	a) 60% of schools **Q4**
Outcome	Children and young people have greater awareness of mental health. They feel empowered and better able to support each other. They are able to access mental health support when they need it.	
Project Costs	**£20K non-recurrent**	
Baseline Investment	• Youth Service - £1.8m (service integrated across Richmond and Kingston) • 2.5 Participation Officers covering SEND and youth service	
Evidence based	• Future in Mind • NICE (2009) social and emotional wellbeing in secondary education	

Project Title **Ref PR2**	**SWL mental health training for school leads** **(Tracker local priority 6)**
Transformation Project description	Transformation monies will be used to roll-out the NHSE/DfE CAMHS and Schools link pilot scheme to 20 schools in Richmond as part of a SWL collaborative approach. The School Link scheme aims to support the establishment of a named point of contact within CAMHS and a named lead within each of the 20 selected schools. The named lead in schools will be responsible for mental health, developing closer relationships with CAMHS in support of timely and appropriate referrals to services. The aims of the training are to: • raise awareness and improve knowledge of mental health issues amongst school staff; • improve CAMHS understanding of specific mental health and

	wellbeing issues within schools; and • support more effective joint working between schools and CAMHS.	
KPI	**Main KPI**	a) Number of school leads trained b) Increased staff confidence in managing mental health issues
	Baseline	To be established using pre-training questionnaire March 2016
	Target	a) 20 b) 95% **Q4**
Outcome	• Improved awareness and knowledge of mental health issues amongst school staff. • Improved CAMHS understanding of specific mental health and well-being issues within schools. • More effective joint working between schools and CAMHS.	
Project Costs	**£20k non-recurrent**	
Baseline Investment	• Percentage of the £549k EHS budget • AFC workforce development budget: emotional wellbeing and mental health training	
Evidence based	NICE (2009) social and emotional wellbeing in secondary education NICE (2008) social and emotional wellbeing in primary school education Future in Mind	

Project Title Ref PR3	**Schools pilot academic resilience project (Tracker local priority 7)**	
Transformation Project description	This project will offer training, consultancy and support to five schools to transform their approach to vulnerable and disadvantaged pupils through developing academic resilience approaches which involve the whole school community. The capacity of school staff and the commitment of school leaders and other key stakeholders in a local cluster will be developed through the following activities: • Helping schools explore, test and measure the impact of resilience approaches in the school setting • Helping schools to self-audit and plan for improvements against the evidence base for individual and organisational approaches to resilience • Through better use, and improvement of, existing resources e.g. pupil data and information; environmental resources; parents and pupil engagement • Share practice and promote integrated approaches though a Community of Practice involving local school leads and service providers	
KPI	**Main KPI**	Increased staff confidence in using approaches to build resilience (validated tool to be agreed)
	Baseline	To be developed with agreed schools by using questionnaire to measure confidence pre-consultancy support in January 2016
	Target	95% **Q4**

Outcome	• Increased identification of pupils at risk of poorer outcomes including mental health in participating schools • Improved capacity, understanding, confidence, skills amongst staff to increase resilience in vulnerable pupils • Improved attendance and attainment in vulnerable pupils at participating schools • Improved engagement in school • Improved capacity, understanding, confidence, skills in staff
Project costs	**£10k non-recurrent**
Baseline Investment	Elements of different services contribute to this agenda: 'Healthy Schools' and school nursing service
Evidence based	Social and emotional wellbeing in primary education. NICE guidelines [PH12] Published date: March 2008 Social and emotional wellbeing in secondary education. NICE guidelines [PH20] Published date: September 2009 The guidance complements and supports NICE guidance on and parent training and education in the | management of children with conduct disorders

Project Title Ref CV1	**Improve hospital paediatric service by recruiting a Richmond deliberate self-harm nurse (tracker local priority 8)**	
Transformation Project description	The proposal is use transformation monies to improve the CAMHS paediatric liaison service at West Middlesex University Hospital for those children and young people who present at A&E following acts of deliberate self-harm, by funding 0.5 CAMHS paediatric liaison nurse. Currently tier 3 staff cancel pre-booked clinics with young people and their families in order to attend as required at West Middlesex A&E.	
KPI	**Main KPI**	CYP presenting with self- harm or crisis to be seen within two hours
	Baseline	To be developed following audit of cases in A&E by February 2016
	Target	100% **Q4**
Outcome	• Reduction in self harm admissions and A&E presentation • Reduction in tier 4 admissions	
Project Costs	0.5 wte Psychiatric liaison nurse band 7 (Agency CAMHS paediatric nurse will be recruited to deliver service from January 2015) **£20,000 – recurrent 2015/16** **£31,000 – recurrent 2016/17**	
Baseline Investment	Tier 3 CAMHS – approximately £155k across South West London	
Evidence based	Joint Commissioning Panel for Mental Health (2012). Crisis Care Concordat (DH & signatories, 2014) - provision of crisis services and appropriate places of safety	
	See appendix 12.6	

Project Title Ref CV2	**Contribute to funding a SWL child sexual abuse worker (Tracker local priority 9)**
Transformation	This proposal is to contribute to funding a child sexual abuse worker post

Project description	to work across SWL on child sexual abuse referrals, undertake assessments, carry out a brief intervention and onward referral into appropriate services. All victims of child sexual abuse will be offered:
	• Assessment of emotional needs and risk
	• Brief intervention and family support
	• Targeted referral to either:
	  • CAMHS Tier II
	  • CAMHS Tier III
	  • In house intervention programme
	  • School counselling/nurse - with support from experts	

KPI	**Main KPI**	a) Percentage of strategy meetings for suspected CSA b) Waiting time for emotional health and wellbeing c) Assessment waiting time for local emotional support and therapy
	Baseline	six cases per year assessed at the Havens (2004-2014) three to five new CSA cases per year paediatric clinic (2014)
	Target	a) 100% b) Two weeks c) Six weeks **Q4**
Outcome	• CYP achieve therapeutic and risk management goals • CYP have reduced long term mental health morbidity e.g. self-harm, anxiety (at 12 months) • CYP returning to education/employment after CSA (after 6 months) • CYP in recovery from trauma	
Project Costs	% cost of wte SWL child sexual abuse post **£10k recurrent cost**	
Baseline Investment	• Domestic violence intervention project £29k • Barnardo's £50k	
Evidence based	Review of child sexual assault pathway for London	

Project Title Ref DW1	**Commission a workforce audit and develop a workforce strategy (Tracker local priority 10)**
Transformation Project description	Our transformation plan identifies that there are capacity, skills and knowledge gaps in the local workforce, including parents and carers who require peer support and training in order to respond to the emotional wellbeing and mental health needs of children and young people at universal, targeted and specialist levels of intervention. The project aims to commission a workforce audit and develop a workforce strategy to: • Identify gaps in capacity, skills, capabilities, age, gender, mix and knowledge • Understand the internal and external environment • Forecast future workforce skills, requirements, competencies • Agree a continuous professional development programme • Identify the evidenced-based training programmes that matches the identified training needs of our professionals across all tiers and sectors, as well as those of parents and carers • Identify capacity, skills and knowledge, as well as gaps in the local workforce. This will also include parents and carers who require

	peer support and training	
KPI	Main KPI	Workforce audit and strategy completed
	Baseline	Baseline position to be established following completion of the workforce audit by March 2016
	Target	Workforce audit completed March 2016 Workforce strategy completed by April 2016 **Q4**
Outcome	A workforce (including parents and carers requiring peer support and training) with the capacity and skills to meet the current and future needs of children and young people requiring CAMHS interventions in Richmond.	
Project costs	**£10k non-recurrent**	
Baseline Investment	Baseline investment to be established end of March 2016 following completion of the workforce audit.	
Evidence based	Future in Mind	

Project Title Ref DW2	**Commission 'Why Try' an ADHD training programme (Tracker local priority 11)**	
Transformation Project description	This project is to create a centre of excellence at a local secondary school to cascade-train staff in secondary schools, the youth offending service, youth clubs, colleges and parents to become facilitators and implement the 'WhyTry' programme locally. The 'WhyTry' programme is a strength-based approach to helping young people overcome their challenges and improve outcomes in the areas of truancy, behaviour, and academics. The programme is based on sound, empirical principals, including solution focused brief therapy, social and emotional intelligence, and multi-sensory learning. A key tenet is to build resiliency. The WhyTry programme is aimed at those at risk of exclusion and/or diagnosed or showing traits of ADHD. The 'Why Try' program is a strength-based approach to helping young people overcome their challenges and improve outcomes in the areas of truancy, behaviour, and academics.	
KPI	**Main KPI**	Numbers of facilitators trained Increased staff confidence
	Baseline	To be established using pre-training questionnaire by March 2016
	Target	95% **Q4**
Outcome	• Reduction in the level of exclusions • Improvement in attitude and motivation • Improved school attendance	
Project Costs	**£10k non recurrent**	
Baseline Investment	Family coaches £181,400k (of which a small proportion is focused on ADHD) Parenting courses	
Evidence based	Bird, Brandon. "Why Try Evaluation Report 2006-2010." Churchill County	

	Probation Report, Field Research (2010). Mortenson, Bruce, Ph.D. and Rush, Karena, Ph.D. "PRIDE: 28-day Summer Program for At-Risk Students." Research Committee at Townson University (Oct. 2007). Williams, Leigh. "Horizon Middle School Mental Health, Counselling, and PBS Effective Education, Recipe for Success." Field Research (2009). "Effectiveness of the Why Try Program in Working with Children with Conduct Disorders." Doctoral dissertation, Argosy University, Sarasota, FL (2009).

RICHMOND CAMHS TRANSFORMATION 2015/16 FINANCIAL MITIGATION STRATEGY

Risk Ref	Service Priority	Service Start Date	Description of Costs	Cost	Cost impact 15/16	Cost impact 16/17	Description of risk	Risk Type	Probability	Impact	Total Risk Score	Mitigating action
IA1	Increase staffing capacity in the CAMHS tier 2 Single Point of Access to clear waiting lists and expand service offer	Jan 2016	6 month pilot agency Staffing costs recurrent (Q4 & Q1 only)	£64,028 Budget based on actual cost	£64,028	£64,028	Risk of under/over spend due inability to recruit staff Delayed service start	Financial	2	3	6	Procure agency staff deploy existing staff and backfill posts Weekly monitoring of agency spend
IA2	Increase staffing capacity in the CAMHS tier 3 Single Point of Access to improve triage, initial risk assessment and joint working	Jan 2016	6 month pilot agency Staffing costs recurrent (Q4 & Q1 only)	£68,000 Budget based on actual cost	£68,000	£68,000	Risk of under/over spend due inability to recruit staff Delayed service start	Financial	2	3	6	Procure agency staff deploy existing staff and backfill posts Weekly monitoring of agency spend
IA3	Expand voluntary sector counselling for children and young people	Jan 2016	6 month pilot Agency Staffing costs recurrent (Q4 & Q1 only)	£12,000 Budget based on actual cost	£12,000	£12,000	Risk of under/over spend due inability to recruit staff Delayed service start	Financial	2	3	6	Procure agency staff deploy existing staff and backfill posts Pre-pay provider Weekly monitoring of agency spend
IA4	Increase the capacity of the SWL Designated Eating Disorder service to meet new Access and Waiting times Guidance	Jan 2016	Staffing costs recurrent	£97,490 Budget based on actual costs	£97,490	£97,490	Risk of under/over spend due inability to recruit staff Delayed service start	Financial	2	3	6	Procure agency staff deploy existing staff and backfill posts Weekly monitoring of agency spend

PR1	Empower children and young people to de-stigmatise mental health, access help quickly, help themselves and help others	Jan 2016	non-recurrent	£20,000 Budget based on estimated cost	£20,000	£0	Risk of under/over spend through failure lack of engagement by CYP and schools	Financial	2	1	2	Obtain quotation for actual cost Re-negotiate increase in service outputs to match budget Monthly monitoring of spend
PR2	Mental health training for School leads	Jan 2016	non-recurrent	£20,000 Budget based on estimated cost	£20,000	£0	 Risk of under/over spend through failure to procure a provider Tender price is lower than budget provision delayed service start	Financial	2	2	4	Obtain quotes from DfE approved list Re-negotiate increase in service outputs to match budget Identify participating schools from those that have expressed an interest Procure service for Richmond only and pre-pay provider Monthly monitoring of spend
PR3	Schools Pilot Academic Resilience Project	Jan 2016	non-recurrent	£10,000 Budget based on actual cost	£10,000	£0	Risk of under/over spend due to delayed service start	Financial	1	1	1	Identify participating schools from those that expressed an interest Pre-pay provider Monthly monitoring of spend
CV1	Improve hospital paediatric service by recruiting a Richmond Deliberate self-harm nurse	Jan 2016	Staffing costs recurrent	15/16 budget £20,000 based on estimated cost will need to finalise agency cost with provider. 16/17 full year cost of permanent post	£20,000	£30,000	Risk of under spend due to inability to recruit staff Delayed service start	Financial	3	3	9	Obtain quotation for actual cost before service commencement Procure agency staff Weekly monitoring of spend Deploy existing staff and backfill posts

CV2	Contribute to funding a SWL Child Sexual Abuse worker	Jan 2016	Staffing costs recurrent	£10,000 Budget based on estimated cost	£10,000	£10,000	Risk of under/over spend due to inability to recruit staff Delayed service start	Financial	2	2	4	Obtain quotation for actual cost before service commencement Procure agency staff Pre-pay provider Monthly monitoring of spend
DW 1	Commission a workforce audit and develop a workforce strategy	Jan 2016	non-recurrent	£10,000 Budget based on estimated cost	£10,000	£0	Risk of under/over spend through failure to procure a provider Tender price is lower than budget provision	Financial	2	1	2	Re-negotiate increase in service outputs to match budget Pre-pay provider Monthly monitoring of spend
DW2	Commission 'Why Try' an ADHD training programme	Jan 2016	non-recurrent	£10,000 Budget based on estimated cost	£10,000	£0	Risk of under/over spend through failure to procure a provider Tender price is lower than budget provision	Financial	2	1	2	Identify an alternative ADHD training programme Re-negotiate increase in service outputs to match budget Pre-pay provider Monthly monitoring of spend

Our overall strategy is to ensure that the Richmond CAMHS transformation plan priorities do not underspend. Where it has not been possible or appropriate to re-negotiate increase in service outputs to match budget, we will utilise and pool underspends to fund:

1. A clinical transformation manager post for a maximum of 3 months (Jan – Mar16) that has already been recruited by the CCG in order to lead the transformation change of three interrelated projects i.e. **IA1 – page 42; IA2 – page 42; IA3 – page 44** to improve our service offer through the CAMHS tier 2 and 3 SPA.

		Impact		
		Minor	Moderate	Major
Probability	Very Likely	3	6	9
	Possible	2	4	6
	Unlikely	1	2	3

Richmond CCG Commissioning spend – 2014/15

Service	Spend 2014/15	
Specialist Tier 3 – SWLSTGs	£1,148,121	SWL Block contract
CAMHS SPA Tier 3 SWLSTGs	£68,216	All CAMHS referrals to Tier 2 and Tier 3 CAMH Services are centrally handled at CAMHS Single Point of Access (SPA).
Targeted Tier 2 – Achieving for Children	£170,000	Primary Mental Health service
Other	£120,411	Specialist CAMHS Assessments

London Borough of Richmond/Achieving for Children spend – 2014/15

Service	Spend 2014/15	
EHS	£549,000	
IAPT	£80,000	
Voluntary Organisations		
Off the Record Counselling	£50,000	
Catholic Children's Society	£57,984	
Refuge	£40,000	
Richmond Carers Centre	£30,000	
Richmond Homestart	£160,000	
Domestic Violence Intervention Project	£29,000	
Barnardo's	£50,000	

NHSE specialised commissioning Tier 4 In-patient admissions – 2014/15

Tier 4/Inpatient	Cost	Activity
South London and Maudsley NHS Foundation Trust	82,652	72
South West London and St Georges Mental Health NHS Trust	279,699	715
Total	**£362,351**	**787**

This data has been disaggregated as follows

Ethnicity	Actual Cost	Actual Activity
White - Any other background	62,027	205
Black or Black British - British	7,423	14
White - British	192,191	450
Unknown	82,652	72
White - English	3,712	7
Any Other Group	14,347	39

Age	Sum of Actual Cost	Sum of Actual Activity
13	32,881	67
15	48,250	91
16	21,209	40
17	23,601	46

Unknown	236,411	543

Gender	Actual Cost	Actual Activity
M	135,455	286
F	226,896	501

Unit Type	Actual	Actual Activity
Non Eating Disorders	319,655	700
Eating Disorders	42,696	87

Length of Stay	80

Richmond CCG welcomes the receipt of this data from NHSE Specialised Commissioning. It is difficult to undertake meaningful analysis given the high level of the data. However, there are a number of conclusions that can be tentatively drawn and these are as follows:

- South West London and St Georges Mental Health NHS Trust is the main provider of Richmond's tier 4 in-patient admissions
- The total unit cost of in-patient admissions is £460.42
- The ethnicity profile of inpatient admissions being predominately white British and this reflects the ethnic profile of Richmond
- 15 years olds were largest age group of in-patient admissions
- The gender profile is predominately female
- The majority of in-patient admissions were for non- eating disorders
- The average length of an in-patient admission was 80 days.

7.13 Workforce

Tier 2 - Local authority/Achieving for Children

Tier 2 CAMHS provision is provided by Achieving for Children primarily through the Emotional Health Service. This is an integrated service with an integrated clinical leadership and management structure operating across Kingston and Richmond boroughs. The staff numbers (number of whole time equivalent posts) refer to the whole service establishment of 15.70 clinical staff.

Emotional Health Service	
Consultants	FTEs
Band 8	6.50
Band 7	6.70
Band 6	
Band 5	
Band 4	1.00
Management	1.50
Vacancies	3.00
Professional disciplines and therapeutic qualifications	FTEs

Clinical Psychologists	7.70
Counselling Psychologists	2.00
Systemic Psychotherapists	3.80
Art Psychotherapists	1.20
Assistant Psychologist	1.00

Tier 3 – South West London St Georges Mental Health Trust

Tier 3 provision is provided by South West London and St. George's Mental Health NHS Trust (SWLSTG). The current tier 3 CAMHS workforce for community CAMHS in Richmond is 10.1 whole time equivalent (WTE) staff. This includes a total clinical workforce of 7.1 WTE and 3.0 WTE non-clinical roles. The Trust's dedicated services, to which Richmond children and young people are referred, cover five boroughs and the staffing detailed in the table below is the total for that service. The tier 2 staffing provision (1.0 wte) relates to just the member of staff employed by SWLSTG. From May 1 2015, Trust staff working in external agencies providing tier 2 services now enter directly onto IAPTUS.

Richmond Staffing	**SPR**	**T3**	**T2**
	WTE	WTE	WTE
Medics		1.60	
Rotational ST1-3		1.80	
Psychologists / Psychotherapists / Family Therapists	0.50	1.20	1.00
PMHWs		2.00	
Nurses			
Office Managers			
Admin	0.50	2.00	
Management		0.50	
Dedicated Services (total for 5 London boroughs)	**ED**	**LD**	**Neuro**
	WTE	WTE	WTE
Medics	0.90	0.70	1.80
Rotational ST1-3			
Psychologists / Psychotherapists / Family Therapists	1.60	0.80	1.00
PMHWs	1.15	2.00	2.50
Nurses		1.00	
Assistant Psychologists	1.00		1.00
Office Managers			
Admin	1.00	1.00	0.80
Management	0.50		0.50

We have strong engagement with our wider workforce including community services, community paediatrics, primary care, social care, schools, youth justice team, early years and the community and voluntary sector. We will build on the capacity of the wider workforce by developing their knowledge through improved communication and training. We will also strengthen their work by undertaking a workforce audit and developing a strategy.

Activity data

Tier 2

There were 132 Richmond children and young people referred to tier 2 services from 1 January 2015 to 31 March 2015, with 131 referrals being accepted.

Referral Data	**Jan 2015 – March 2015***
Number of referrals	132
Number of referrals accepted	131
Waiting time to first appointment	12 weeks
Waiting time for choice appointment	16 weeks

*new service, no reliable data available before January 2015

Tier 3

There were 811 Richmond children and young people who were accepted into a service at tier 3 over the 2014/15 financial year. This compares with an estimated need of 840 children and young people at tier 3. SWLSTG established dedicated services for eating disorders and neurodevelopment as part of the CAMHS transformation. These services commenced in September 2014 therefore the data regarding referrals and referrals accepted, along with wait times, is for quarters 3 and 4 only. It is anticipated that the migration to IAPTUS will provide more robust data regarding tier 2 data in the future.

KPI Info	**14-15 Data**
Children accessing early intervention service (Single Point of Referral providing CAMHS triage only)	261 (Jan – March 2015 only)
Tier 3 - referrals	664
Tier 3 - referrals accepted	657
Access to information	
Dedicated LD Complex Needs – referrals	2
Dedicated LD Complex Needs - referrals accepted	2
Dedicated LD Complex Needs – waiting times	9.5 weeks
Dedicated Eating Disorders – referrals (only Q3/Q4 data)	23
Dedicated Eating Disorders - referrals accepted (only Q3/Q4 data)	15
Dedicated Eating Disorders - waiting times (only Q3/Q4 data)	2.0 weeks
Dedicated Neurodevelopmental – referrals (only Q3/Q4 data)	139
Dedicated Neurodevelopmental - referrals accepted (only Q3/Q4 data)	137
Dedicated Neurodevelopmental - waiting times (only Q3/Q4 data)	12.3 weeks

All CAMHS interventions are NICE compliant. Richmond CAMHS is a member of London and the South East CYP IAPT Collaborative. CYP IAPT principles are applied across all tier 3 services and outcome measures submitted to Meganexus as part of the national programme

7.2 South West London (SWL) model for CAMH services

Richmond CCG is working collaboratively with commissioners, South West London and St. Georges Mental Health Trust, NHS England and Achieving for Children to develop new models of care across south west London for mental health. Areas of focus include:

- CQUIN to implement the 'You're Welcome" quality criteria in all local CAMHS services/teams within the Trust to enable Trust Local
- CAMHS services/teams to become more 'young people friendly' and to work towards achieving 'You're Welcome' accreditation by the end of Q1, in 2016
- To develop a SWL service specification with refined KPI's and data requirement for specialist CAMHS services to ensure equity of access across boroughs and allow for greater monitoring and management of performance
- To develop the centralised eating disorder service to meet the requirements outlined in the national guidance on eating disorders and be compliant by 2020. This will include all eating disorder referrals being seen in the dedicated eating disorder service, meeting access targets, developing, a day service and self-referral
- To develop a model of care for paediatric liaison service across SWL to ensure that there is adequate provision for when children and young people are in crisis by March 2016
- To develop an ASD/ADHD pathway that includes post diagnosis management and support through the South West London Children and Adolescent Mental Health Network
- To review the pathways for child sexual assault services ensuring appropriate level of mental health interventions
- To review with partners a future commissioning model for the sustainability of multi systemic therapy going forward
- To review and develop a model of care to ensure children with SEN aged 18 – 25 receive an appropriate service
- To ensure effective step up and step down provision for those children and young people that require inpatient services, allowing care in the community to be closer to home and developing creative models and approaches such as Person-centred Care Planning to ensure the best possible outcomes for those individuals
- To develop the perinatal pathway following the publication of National Guidance and through the South West London Maternity Network increase capacity within the system to improve perinatal maternal health and improve out of hospital mental health support for women and families in the postnatal period and 1st year of life together with adult mental health

7.3 Future south west London commissioning intentions

Transformation plans

In August 2015 NHS England (in partnership with DOH, DfE, PHE and other national bodies) published guidance to support the development of local transformation plans for children and young people's mental health and wellbeing. The purpose of the document was to provide guidance to local areas on the development of local transformation plans to support improvements in children and young people's mental health and wellbeing. The document outlines a phased approach to securing locally driven sustainable service transformation and includes details of how the extra funding announced in the Autumn Statement (December 2014) and Budget (March 2015) will be used to support this work.

The guidance also outlines the assurance process and programme of support that will be available to local areas. A self-assessment checklist will be part of the assurance process and will support the allocation of additional funding, a tracking template will be required to monitor and review progress as well as a high-level summary of our transformation plans. This will all be populated from the action plan that forms part of this strategy. Our transformation plan will be required to be signed off by our Health and Well Being Board locally and by the NHS England Specialised Commissioning Team.

The overarching aim of transformation is that by 2020 we have laid the foundations for sustainable system-wide service transformation to improve the mental health and wellbeing of all our children and young people including those that are vulnerable.

Based on the guidance published and successful application of our transformation plans, Richmond has been allocated:

Service Area	**Funding 2015/16**
Initial allocation of funding for eating disorders and planning in 2015/16	£97,490
Additional funding available for 2015/16 when transformation plan is assured	£244,028
Minimum recurrent uplift for 2016/17 and beyond (if plans are assured)	**£341,519**

Key actions:

- We will develop our eating disorder service so that it is complaint with national waiting time standards and guidance by 2020

- We will ensure there is CAMH input into child sexual assault services for children and young people

- We will further develop relationships with NHSE to improve monitoring of inpatient admissions and collaboratively plan to provide care closer to home, preventing unnecessary inpatient admissions and ensuring there is effective discharge planning into the community. This will be through news approaches such as person-centred care planning

- We will develop an improved model of care for CYP aged 18- 25 with education health and care plans that require mental health interventions

- We will submit robust transformation plan based on the actions from this strategy, to ensure that we are able to access additional funding for our local implementation, seeking regular assurance through our Emotional Wellbeing Board, Children's Strategic Partnership, Local Safeguarding Children Board and Health and Well Being Board

- We will provide a regular update to the Emotional Wellbeing Board on south west London-wide commissioning actions. We will also ensure they dovetail with our own local actions, services and processes are seamless and transparent and are easily accessible for our children and young people

- We will work in partnership to continue to ensure that we are locally compliant with the Crisis Care Concordat especially in relation to serious self-harm, A&E attendance and avoidable hospital admissions (Section 2, Improving Access to Effective Support)

- We will forge stronger links with adult mental health services to promote the implementation of best practice during transition to adulthood (with a focus on care leavers)

8. Part Eight: Action Plan

8.1 Action plan

9. Annex 1: Summary: Richmond's Local Transformation Plan For Children and Young People's Mental Health

10. Annex 2: self-assessment checklist for the assurance process

11. CAMHS Transformation Plans Investment Priorities (Pages 40-52)

12. Appendices

12.1 **Emotional wellbeing board governance framework**

12.2 **Children and young people's listening event**

12.3 **CAMHS transformation planning workshop agenda and feedback**

12.4 **CAMHS focus groups**

12.5 **Business case – CAMHS eating disorders**

12.6 **Business case – CAMHS liaison nursing**

12.7 **Richmond CYP IAPT Baseline Data**