Future in Mind

Barnsley

Transformation Plan

For
Children and Young People's
Mental Health and Emotional Well Being

2015 – 2020

REFRESH

OCTOBER 2019

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1. EXECUTIVE SUMMARY

CAMHS (Child and Adolescent Mental Health Services) is a term used for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing. Many mental health conditions in adulthood show their first signs in childhood, and, left untreated, can develop into conditions which need regular care.

In previous years, all too often children and young people's emotional wellbeing and mental health has not been given the attention it needs. The 'Future in Mind' report of the Children and Young People's Mental Health Task Force, published in 2015, highlighted the significant changes needed to improve our children's emotional health and wellbeing and focused our attention on adopting a whole child, whole family approach, promoting good mental health from the earliest ages.

This third, and potentially final, refresh of Barnsley's Local Transformation Plan has been developed with contributions from all partners via Barnsley's Future in Mind Stakeholder Engagement Group, supported by Barnsley's Children and Young People's Trust. In particular, Barnsley's young people are greatly influencing service transformation in Barnsley through our Young Commissioners, OASIS (Opening up Awareness and Support and Influencing Services) and Barnsley College Peer Mentors, both groups facilitated by a local charitable organisation, Chilypep (Children and Young People's Empowerment Project).

Since the publication of the 'Future in Mind' Report (March 2015), partners within Barnsley have been collaborating closely to transform services utilising the recurrent transformation funding from NHS England (Appendix 1 – Finance Schedule) to deliver the recommendations contained within the report. These recommendations were grouped under five key themes, these being:

- 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

These themes sit at the core of our Local Transformation Plan and Barnsley's wide range of partners work tirelessly together with passion, enthusiasm, commitment and dedication to deliver the entire ethos behind 'Future in Mind'.

Over the past four years we have seen a significant transformation of the services in Barnsley that support the emotional health and wellbeing of our children and young people. This transformation has enabled consistent, positive changes to the lives of the children and young people and their families who access these services.

We are immensely proud of the service transformation within Barnsley which includes the development of a Mental Health Support Team, MindSpace (pre the publication of the Green Paper 'Transforming children and young people's mental health provision' (https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper) which is accessible by all pupils in each of our 10 Secondary schools; the Public Health led initiative to implement the THRIVE approach in as many of our primary schools as is appropriate; the development of our Young Commissioners, OASIS and the challenge and influence they are bringing to our transformation of services; and the development of a new CAMHS Service Specification, co-produced with the young people of Barnsley and our partners, which moves us away from the traditional tiered medical model to a social model supported by a whole system approach.

A key focus of Barnsley's transformation of services will continue to be to provide support to children and young people at the earliest possible time to prevent escalation of their problem(s) and to support their emotional health and wellbeing throughout their childhood and adolescence. The Health Foundation noted in their report 'A healthy foundation for the future' (2019) that the Future in Mind report (2015) recognised the importance of addressing mental and emotional wellbeing issues in schools, whilst in November 2015, the National Institute of Clinical Excellence (NICE) report on children's attachment, made a specific recommendation that research be undertaken into effective school-based strategies. This is further supported by the Green Paper, transforming children and young people's mental health provision, recommending the development of mental health support teams (MHST) in schools.

Acknowledging the importance of these recommendations Barnsley CCG are committed to developing a second school-led emotional health and wellbeing support service, in addition to MindSpace (this will not be funded as part of the national Trailblazer programme since neither of Barnsley's applications have been supported by NHS England). This second mental health support team will focus on supporting the more vulnerable, primary school-aged children, in particular children in care, children with special educational needs and disabilities, children who are educated at home and those children who identify with the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) community.

Services are being planned and provided in a multidisciplinary way with all partners involved in the care pathways, therefore we will continue to widen the delivery of mental health training to universal services (e.g. Health Visitors, Public Health Nurses, GP's) and early help practitioners to enable more appropriate, timely interventions to occur.

Outcomes, in terms of our children and young people's emotional resilience and that they are effectively supported in order to reduce the prevalence of escalation of any mental health issues they may have, will continue to be improved and delivered by the continued implementation of this refreshed

Local Transformation Plan, driven by Barnsley's Children and Young People's Trust. However, on those occasions where children and young people are unfortunate enough to experience mental health crisis, we will, through implementation of this plan, continue to improve the crisis support offered to the children and young people to ensure that a timely and appropriate response is provided.

This transformation plan acknowledges that there remain a number of key challenges, especially in terms of current and future workforce capacity and skill mix, but also in terms of financial pressures, data capture and utilisation. These challenges remain the potential destabilisers to delivering the ambitions and aspirations of the NHS Long Term Plan but we are working closely with our partners (including NHS England / Improvement) to mitigate these risks wherever possible. It is recognised however that the enhancement of the key prevention work and early years support that will continue to be delivered through the implementation of this transformation plan is fundamental in successfully supporting specialist services by enabling a sustainable reduction in demand, creating capacity and capability within the whole system.

2. STRATEGIC CONTEXT

Children and young people's mental health forms an essential part of Barnsley's Health and Social Care priorities and has also been identified as one of the key areas of focus of the South Yorkshire and Bassetlaw Integrated care System (SY&B ICS).

Mental Health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour which places demands on social services, schools and the youth justice system. If mental health problems are left untreated, it can create distress in the children and young people, as well as their families and carers, continuing into adult life and affecting the next generation.

Mental health problems are widespread. National figures show:

- One in four adults experience at least one diagnosable mental health problem in any given year;
- Over half of all mental illness starts before the age of 14 and 75% starts before the age of 18;
- One in 10 children aged 5 – 16 years has a diagnosable problem such as conduct disorder (6%), anxiety disorder (3%), attention deficit hyperactivity disorder (ADHD) (2%) or depression;
- Children from low income families are at the highest risk;
- One in five mothers suffer from depression, anxiety or in some cases psychosis, during pregnancy or in the first year after childbirth.

In December 2017 the Department of Education published its Green Paper 'Transforming children and young people's mental health provision

There are three key elements to the Green Paper's ambitions:

1. To incentivise and support all schools to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff deliver whole school approaches to promoting better mental health.
2. To fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide a specific extra capacity for early intervention and ongoing help within a school and college setting.
3. As the new Support Teams are rolled out, NHS England will trial a four week waiting time pilot (these are currently in operation in a number of areas throughout the UK) for access to specialist NHS children and young people's mental health services. This builds on the expansion of specialist NHS services already underway.

In addition, the Green Paper consultations covered several other issues, including how schools can provide enough information on mental health support to parents and carers and how to take forward work to enable schools and colleges to measure the impact of what they do to support children and young people's mental wellbeing.

On two occasions to date, NHS England have sought expressions from CCG's, working collaboratively with partners, to create new, local Mental Health Support Teams (MHST) as part of a Trailblazer programme. The aim of the MHST's are to:

- Deliver evidence-based interventions in or close to schools and colleges for those with mild to moderate mental health issues
- Help children and young people with more severe needs to access the right support
- Work with and within schools and colleges, providing a link to specialist NHS services
- Build on and increase support already in place, not replace it.

Unfortunately Barnsley's bids to be a Trailblazer site were unsuccessful on both occasions. However, the CCG and partners, understanding the importance of developing mental health support in schools, committed funding, prior to the publication of the Green Paper to develop a mental health support team accessible by each of our 10 Secondary schools and which the whole of Barnsley know as MindSpace. In addition, seeing the positive impact that this team is having on the wellbeing of Secondary school pupils, the CCG have committed additional funding in 2020 to develop a second mental health support team to better support the emotional wellbeing of our Primary school-aged children, especially the most vulnerable.

The Health Foundation found that young people are facing challenges that are different from those faced by their parents and grandparents. In a world where information is readily available, they lack the guides to help them navigate the increasingly different world they face. The levels of insecurity that young people report – in housing, in work, in education – defines a life marked by precariousness and uncertainty. There are young people who find it hard to think ahead and envisage a life where they could genuinely flourish. In essence, many young people lack the basic foundations that are essential for a safe, secure transition to adulthood.

The transition to adulthood is a critical stage in life. It is a time of moving from education to work, becoming independent, leaving home, and forging key relationships and lifelong connections. These milestones have been largely the same across recent generations. But todays young people face unique opportunities and challenges compared to their parents and carers.

Having a place to call home, secure and rewarding work, and supportive relationships with friends, family and community are the building blocks of a healthy life. There is strong evidence that health inequalities are largely determined by inequalities in these areas – the wider determinants of health.

Young people are growing up in an environment that makes securing these vital building blocks more difficult than it was for previous generations. Todays young people face a more precarious labour market and a more challenging

housing market, and they are reporting higher levels of loneliness and poor mental health than any other generation.

If young people are unable to create and maintain meaningful and supportive relationships, this may predispose them to illness later in life. Unfortunately, young people between the ages of 1 and 24 report feeling lonely more often than any other age groups (The Health Foundation, 2019). Many of the challenges encountered by young people in other areas of their lives are acting as barriers to these kinds of relationships.

Having a trusted adult or service in the community that the young person feels able to open up to can make a difference. Young people and those working in the sector report that having authentic and personalised support can be transformational in building confidence and enabling young people to take positive steps in areas such as work, housing and relationships (The Health Foundation, 2019).

When young people are limited by public transport and lack of mobility, it becomes more difficult to maintain relationships, and this may deepen feelings of isolation. It can also limit access to locally available youth services that could make a difference to a young person's life.

In 2018 the Children's Commission Office published their report 'Children's Voices: The wellbeing of children with mental health needs in England', in which they examined the wellbeing of vulnerable groups of children in England and their relationship with mental health services. Qualitative research explores the limited awareness of mental health issues in young people, focusing on their perception of mental health.

The key findings of the 2018 publication were that children appeared to have highly negative and stereotyped ideas about mental health illness; there is lack of awareness of the types of services and support available for children experiencing mental health problems; children and families delayed or avoided treatment due to anxiety and uncertainty around accessing services. Fear of being seen accessing services and insecurity about the confidentiality of the service also emerged as important barriers to young people's ability to address and overcome mental health needs.

There is an interrelationship between physical and mental health. Mental health problems are much more common in people who have long term physical illnesses.

Compared to the general population, people with diabetes, hypertension and coronary heart disease have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease (CVD) and other chronic conditions, have triple the rate. People with severe mental health disorders, such as schizophrenia and bipolar disorders and depression are more likely to develop long term conditions such as diabetes or CVD.

Due to high levels of deprivation and higher levels of risk factors for long term conditions (such as high rates of smoking and obesity levels and low levels of physical activity) it is likely that the levels of many long term conditions will be higher in Barnsley than nationally.

Building resilience within our children and young people to enable them to enjoy robust mental health and wellbeing or to intervene early to prevent escalation of mental ill health remain at the core of Barnsley's Local Transformation Plan. The cost benefit of early intervention, particularly early in an infant and parent relationship, is obvious, and although it takes time, is a focal point of our plan.

3. EVIDENCE OF NEED – LOCAL CONTEXT

The sources used to analyse local need are primarily the Barnsley Joint Strategic Needs Assessment 2019, Barnsley's Mental Health Profile, Child Health Profiles and CAMHS (Children and Adolescent Mental Health Services) intelligence.

Barnsley Councils Corporate Plan 2017 – 2020 focuses on achieving three key priorities:

- Thriving and vibrant economy
- People achieving their potential
- Strong and resilient community

These priorities reflect the strongly shared vision of Barnsley's Health and Wellbeing Board which is to ensure that the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and linger lives, in safer and stronger communities, regardless of who they are and where they live.

Demographics

Population (ONS 2017 Mid-Year Estimates)

0 - 18	19 - 64	65+ years	TOTAL
52,858	143,951	46,532	243,341

Using the 2017 mid-year population projections (and if recent trends of births, deaths and migration continue), Barnsley's resident population is predicted to reach 257,000 by 2025 and 263,500 by 2030.

Barnsley's population is ageing and the number of residents aged 65+ is projected to reach 60,800, a change of 33% from 2017.

Ethnic breakdown

	WHITE BRITISH	BAME
BARNSLEY	96.1%	3.9%
YORKSHIRE AND HUMBER	85.8%	14.2%
ENGLAND	79.8%	20.2%

Since the 2011 Census, the number of residents that identified their country of birth as part of the European Union (excluding United Kingdom and Ireland) has increased due to the number of migrants from mainly Romania and Poland.

In July 2016 the Gypsy, Roma and Traveller Census that took place showed there were 130 adults and 89 children (aged under 16 years) who are known

to Barnsley council currently living within a small group of static and mobile encampments within the Barnsley Borough. Although there has been no more recent Census it is not thought that the current numbers of Gypsy, Roma and Traveller people living in Barnsley would have changed significantly in number from the 2016 Census.

There are however, groups within the population for whom we do not have accurate and up-to-date information.

The number of Lesbian, Gay, Bisexual, Transgender and Queer / Questioning (LGBTQ+) residents in Barnsley is unknown and very difficult to estimate, not least because there are no agreed definitions or mechanisms for routinely gathering this information.

Estimated of the size of the LGBTQ+ population vary, but national surveys designed to capture sexual orientation and behaviour show 5% - 7% of the population is LGBTQ+ (Department of Trade and Industry (DoTI), 2014), which is the figure the Government uses when undertaking equality impact assessments.

Taking 6% as the mid-point we can reasonably estimate that Barnsley's LGBTQ+ population is approximately 14,600.

What are the issues that cause poor health and wellbeing within Barnsley?

The health and wellbeing of the local population cannot be examined in isolation from the influences that also need to be improved in order to make any sustainable improvements. Dahlgren (1995) developed a model showing the various determinants of health at different levels and these range from general socio-economic, cultural and environmental conditions to age, sex and hereditary factors.

Research shows that social disadvantage factors create the circumstances in which people's health experience is adversely affected. Such factors are known as determinants of health, many of which are distributed unevenly within the population.

Life expectancy at birth for males born in Barnsley is currently 78.1 years compared with 74.6 years in 2001 – 2003. The difference in life expectancy at birth for males born in Barnsley and those in the rest of England is 1.5 years.

Life expectancy for females born in Barnsley is currently 81.9 years compared with 79.6 years in 2001 – 2003. The difference in life expectancy at birth for females born in Barnsley and those in the rest of England is 1.2 years.

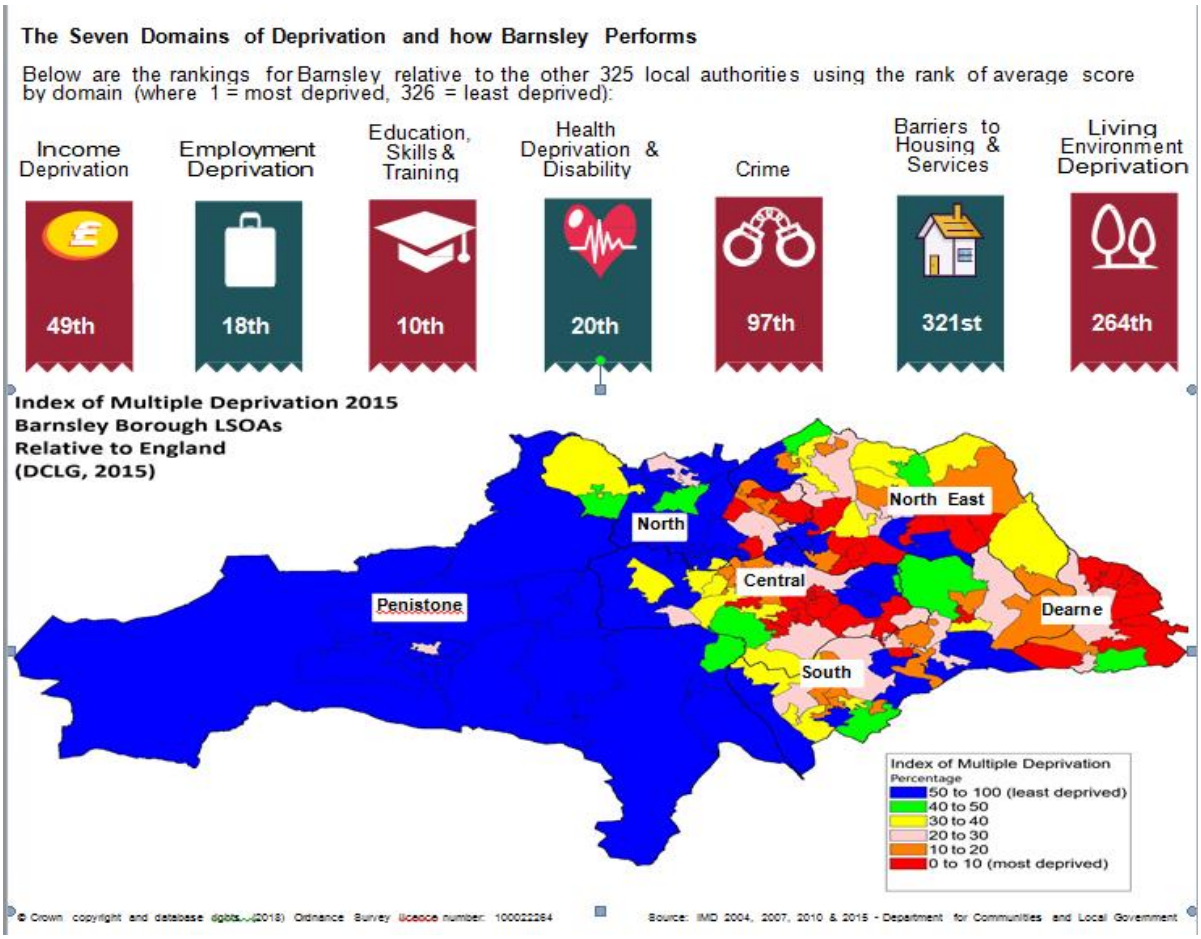
More noticeably however, healthy life expectancy at birth for males in Barnsley is only 59.7, although this does represent an increase of 2 years since 2012 – 14. The healthy life expectancy at birth for females in Barnsley

has seen an increase of 4.5 years since 2012 – 14 to reach a level of 61, only 0.5 lower than the Yorkshire and Humber average.

Indices of Multiple Deprivation

Calculated using the rank of average score measure, Barnsley is the 39th most deprived local authority of the 326 local authorities in England. The table below shows the rankings for Barnsley relative to the other 325 local authorities using the rank of average score by domain (where 1 = most deprived, 326 = least deprived)

Income Deprivation	Employment Deprivation	Education, Skills and Training	Health Deprivation and Disability	Crime	Barriers to Housing and Services	Living Environment Deprivation
49th	18th	10th	20th	97th	321st	264th



Determinants of health that may impact on the emotional health and wellbeing of children (or be affected by mental health).

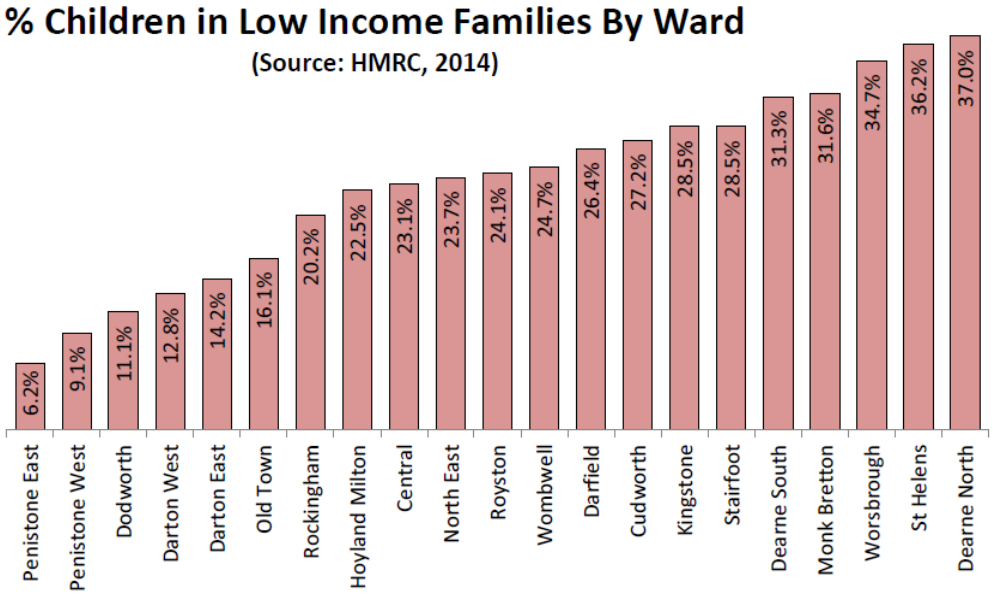
Poverty is a relative concept which applies to people who are considerably poorer than mainstream society, with resources well below those of the average individual or family which excludes them from ordinary aspects of life which are the norm for the majority (Joseph Rowntree Foundation 2010).

A lack of financial resources severely limits the opportunities available to people and the life outcomes they can expect. Social mobility is difficult and most people born into poverty stay there. (JRF 2016).

Poverty limits the ability of people to participate in society, change their lifestyles and determine their own destiny. This results in fuel poverty, poor diet, unhealthy lifestyles, low aspirations and dependency, (JRF 2016).

Child poverty is an issue that occurs throughout the borough, but with large differences between communities. The likelihood of a child living in poverty is up to 6 times higher in some parts of the borough than in others; in Penistone East Ward it is 6.2% and in Dearne North Ward it is 37.0% (HMRC 2014, released 2016).

The England rate of children living in low-income families was 19.9% in 2014 compared to the regional rate of 22.2% for South Yorkshire and an overall rate of 23.8% for Barnsley. This has risen 1 percentage point since 2012. The England rate rose by 1.9 percentage points in the same period, so the gap is narrowing.



Child poverty and deprivation is one of the most important factors determining health inequalities in childhood and throughout life. Research demonstrates that a child's physical, social and cognitive development during the early years strongly influences their school readiness and educational attainment, their employment chances and general health and wellbeing outcomes through to adulthood and older age.

There is often a complex/cyclical relationship between determinants of health and mental health with exposure to adverse environmental, social and educational conditions leading to increased risk of emotional and wellbeing issues but also that mental health problems can in themselves lead to subsequent deterioration of a person's social, educational, employment and housing conditions.

For children and young people the health and social wellbeing of parents and the family as a whole may impact on a child's or young person's emotional health and wellbeing.

Employment

The table below show the percentage of Barnsley's Working Age Population compared to the Yorkshire and Humber and the England figures:

Year	BARNSLEY	Y & H	ENGLAND
2013	71.1%	69.7%	71.5%
2014	72.6%	70.6%	72.5%
2015	72.8%	72.5%	73.8%
2016	70.9%	72.5%	74.2%
2017	70.8%	73.4%	75.1%
2018	71.1%	73.6%	75.4%

The trends show that Barnsley continues to have a lower number of working age residents in employment than both the regional and national rates and, more noticeably, that in recent years, the gap between England and Barnsley has widened.

The percentage of people in Barnsley aged 16 – 64 years old who are economically active and unemployed is 5%. Since 2013 the percentage of working age residents that are unemployed has declined and this trend mirrors both the national and regional figures.

The percentage of people aged 16 – 64 years od in Barnsley who are economically inactive is 24 – 25%. Whilst the trends show that the rate of people of working age and economically inactive in Barnsley has reduced the rate continues to be higher than both the regional and national averages.

At 11.9% Barnsley has a higher proportion of the population claiming out of work benefits when compared to England (8.1%) and regional (9.5%) rates. Whilst the numbers are declining locally and nationally these figures do not include those claiming universal credit. When we look at claimants of universal credit the figures show that Barnsley has a significantly higher proportion of claimants than there are regionally and nationally (Barnsley 7.8%, Y & H 4.6%, England 4.5%).

Basic Digital Skills

There are five categories of 'Essential Digital' skills for life and work:

- Communicating
- Handling information and context
- Transacting
- Problem solving
- Being safe and legal online

76% of adults in Barnsley have all five Basic Digital Skills.

Housing

The quality of housing has a direct impact on health, educational attainment, economic prosperity and community safety, all of which are important to the success and wellbeing of Barnsley communities.

The growing and ageing population of Barnsley not only adds pressure on housing supply in the borough, but also presents new challenges in providing suitable housing options to meet different needs. As the population ages, the demand for housing will change, moving away from family homes and towards smaller and more specialised homes for people with care needs. The composition of households will also change, with more people living alone. Good housing and support services for vulnerable people can assist the to live healthy, independent lives and reduce the pressure on families and carers.

People who live in clean, dry, warm, secure and affordable homes are less likely to experience poor health as a consequence of their housing conditions. Also, those living close to areas of green space including parks, woodland and other open spaces, tend to experience improved health and a greater sense of wellbeing (Shelter, 2013).

The health effects of poor housing disproportionately affect vulnerable people: older people living isolated lives, the young, those without a support network and adults with disabilities (Kings Fund, 2015).

Evidence from Shelter (2013) suggests, in relation to children, that bad housing could lead to:

- Up to 25% higher risk of severe ill-health and disability during childhood and early adulthood
- Increased risk of Meningitis, Asthma and slow growth, which is linked to Coronary Heart Disease;
- A greater chance of suffering mental ill health and problems with behaviour;
- Lower educational attainment, greater likelihood of unemployment and poverty;
- Bad housing is linked to debilitating (and even fatal) illnesses and accidents;
- There is a direct link between childhood Tuberculosis (TB) and overcrowding;

- Almost half of all childhood accidents are associated with physical conditions in the home. Families living in properties that are in poor conditions are more likely to experience domestic fire.

Lifestyle

Lifestyle choices impact upon the health needs of a community and the following statistics reflect the lifestyle choices of Barnsley residents:

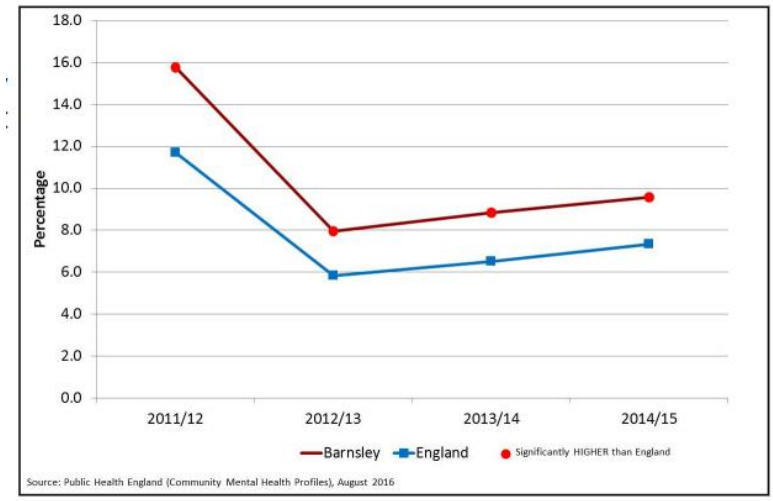
Smoking: Although the prevalence of smoking in Barnsley has reduced from the high of 24.4% in 2012 to 18.2% it still continues to be above the rate for England of 14.9%. This is reflected in the rate of smoking-related deaths for people aged 35+ in Barnsley which is now 333.9 (related deaths per 100,000), significantly worse than the England rate of 262.6 (related deaths per 100,000).

Alcohol

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

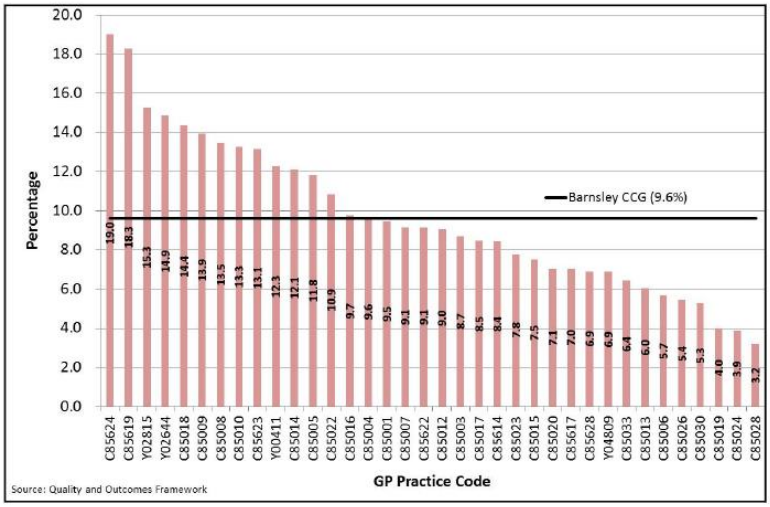
The Government has said that everyone has a role to play in reducing the harmful use of alcohol – this indicator is one of the key contributions of the Government (and Department of Health) to promote measurable, evidence-based, prevention activities at a local level, and supports the national ambitions to reduce harm. Alcohol related hospital admissions can be reduced through local intervention to reduce alcohol misuse and harm. In May 2018 the Government announced its intention of developing a new national strategy for Alcohol.

The trend data (see graph below) shows that the rates for admissions for mental and behavioural disorders due to use of alcohol for men, women and persons in Barnsley are significantly higher than the England average.



Mental Health Profile

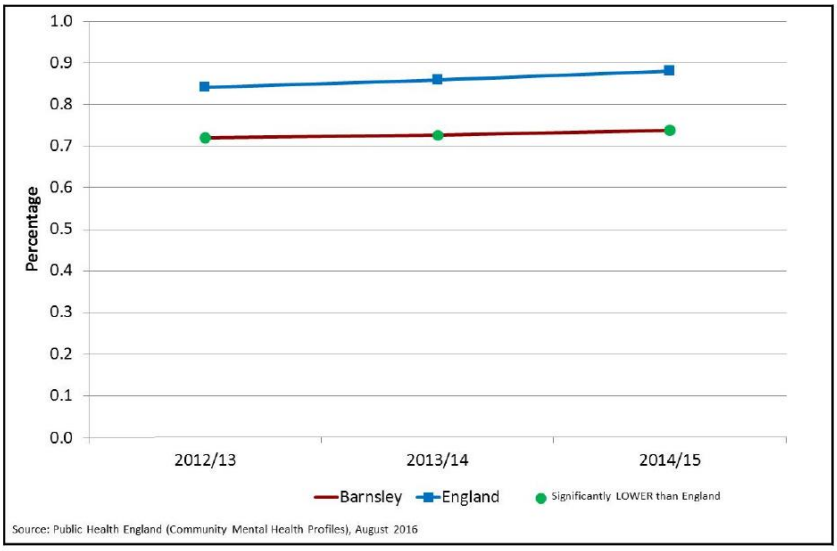
Barnsley's rates of depression prevalence have been significantly higher than the rates for England for each year between 2011 and 2015.



Diagnosed Mental Health Prevalence

Obtaining an accurate diagnosis for a mental illness is not easy. Often a period of time for careful assessment is necessary to ensure a correct and accurate diagnosis is made. A diagnosis can be useful in helping an individual to understand their own condition and access appropriate support, such as social care. It can also be helpful for health professionals to access the appropriate guidance for a particular condition, e.g. National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia (Public Health England, 2016).

Barnsley's rates for the prevalence of mental health conditions have been significantly lower than the rates for England for each year between 2011 and 2015.



Barnsley's 2014/15 rate for the proportion of patients self-reporting that they had a long term mental health problem (6.3%) is significantly higher than the rate for England |(5.1%).

IAPT (Increasing Access to Psychological Therapies)

The IAPT programme supports the frontline NHS in implementing NICE (National Institute for Health and Care Excellence) guidelines for people suffering from depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication, which traditionally had been the only treatment available. When the programme was first implemented in 2008 it was targeted at people of working age, but in 2010 was opened to adults of all ages. Barnsley's service accepts people from 16 years old.

In spring 2018 the Barnsley IAPT service was competitively tendered using a revised, more ambitious, service specification based on NHS England's IAPT Manual. The new IAPT service has been delivered from 1 September 2018 and is consistently achieving the nationally recommended targets. Barnsley's IAPT service also supports Young People in Post 16 Education at Barnsley College with a Wellbeing practitioner on site one day per week.

Child Health

The health and wellbeing of children in Barnsley is generally worse than the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is worse than the England average with 23.8% of children aged under 16 years living in poverty.

In 2017/18, 70% of five year olds in Barnsley achieved a good level of development at the end of Reception, which is in line with the England rate of 71.5%.

In Barnsley the rate of women smoking at the time of delivery has decreased since 2010 – 11 when it was 22%, however, the rate remains significantly above the England rate.

Just over half (55.5%) of mothers in Barnsley in 2016/17 gave their babies breast milk in the first 48 hours after delivery, which falls far short of the England rate of 74.5%.

Around only a third of mothers in Barnsley (32.9% -provisional data for Q1, 2019) continued to breastfeed their babies at 6 – 8 weeks after birth.

More than one in five (21.3%) of Barnsley's 4–5 years old population were overweight or obese in 2018/19, which reflects the England rate of 22.6%.

More than one in 3 (34.9%) of Barnsley's 10-11 year olds were overweight or obese in 2018/19 which again, is reflective of the England rate of 34.3%.

The levels of underweight children in Barnsley have fluctuated in both age groups (4-5 and 10-11) over the years. Currently there are more children who are underweight in Barnsley than either regionally or nationally for both age groups (Barnsley 1.7%, Y & H 0.9% and England 1.0%)

Barnsley's 2017 rate for under 18 conceptions is 29.1% per 1,000. Whilst this is a reduction on previous years it remains significantly higher than the regional and national rates of 20.6% and 17.8% respectively.

The total number of children on the current Special Educational Needs and Disabilities (SEND) register in Barnsley is 4,945, approximately 15% of all pupils. The most common primary diagnosis of the type of SEND are moderate learning difficulty (MLD) followed by social, emotional and mental health (SEMH), speech and language and communication(SLCN) and autistic spectrum condition (ASC).

The proportion of Barnsley's 16 – 17 year old cohort who are NEET (Not in Education, Employment or Training) or are Not Known (NK) is 4.9% (December, January and February 2018/19). This represents a notable improvement when compared to performance last year of 5.6%

Caring for children

The rate of Children in Need (rate per 10,000 population aged under 18 years) in Barnsley has historically been much lower than comparators but it did increase in 2014/15 to go above the regional and national rates. However, since 2015 the rate for Barnsley has fallen for three consecutive years, whilst comparators have steadily increased. The current rates are Barnsley 301.3, Y&H 363.5 and England 341.0.

Barnsley's rates of referrals to Social Care (rate per 10,000 population aged under 18 years) remains below our regional and national comparators (Barnsley 491.4, Y&H 621.6, England 552.5). This positive picture reflects a robust and integrated 'front door' process which is embedded, whereby the vast majority of referrals then proceed to 'assessment' to ensure that every child receives the appropriate course of action.

After increasing significantly in 2014/15, the rate of children in Barnsley with a Child Protection Plan (rate per 10,000 population aged under 18 years) has since returned to previous levels, falling below regional and national comparators in 2017/18. The rates for comparison are Barnsley 37.7, Y&H 46.1, England 45.3). It is felt that the decline in numbers n Barnsley is due to improved management oversight and scrutiny of cases, confident decision making and improves step-down pathways.

The number of our Children in Care (Looked After Children) is closely monitored. There is no definitive good performance, but it is important to be confident that the right children are being looked after at the right time. There were 310 looked after children at the end of 2018, which is a rate of 62.0 per

10,000. The rate remains below both the regional and national comparators of 71.0 and 64.0 respectively.

Crisis Care

Crisis resolution teams treat people with serious mental health conditions when they experience an acute and severe psychiatric crisis. However, many crisis episodes result in contact with police services or attendance at hospital A & E Departments. Mental health problems are also associated with physical health problems, which may result in hospital visits. The impact of mental illness upon A&E Departments may be significant and the need for liaison psychiatric services substantial.

Barnsley has had a psychiatric liaison service at Barnsley Hospital A & E for some time but this service has previously excluded under 18's. However, additional funding has recently been agreed by Barnsley CCG's Governing Body which will enable the service to transform in to an all-age service and it will operate as such from January 2020. To compliment the all-age liaison service additional, recurrent funding has also been agreed by the CCG to enhance the CAMHS Intensive Home Based Treatment Team.

Emergency Admissions

The rates of emergency admissions for those under 18 years of age is lower in Barnsley than the rates for both England and Yorkshire and Humber and is the lowest it has been in Barnsley since 2010/11. However, hospital admissions as a result of self-harm in 10 – 24 year olds (rate per 100,000 population) has been consistently, significantly higher than England since 2013/14, the rates being Barnsley 695.2, Y&H 404.4, England 421.2. Work is being carried out to better understand why this rate is increasing and to identify the most appropriate support to provide to Barnsley's young people to prevent self-harm and to significantly reduce the number of emergency admissions of children and young people in Barnsley.

4. MINORITY GROUPS / VULNERABLE GROUPS

In 2016, official records highlighted that over 50,000 children were identified as needing protection from abuse in England, with abuse and neglect referrals accounting for 60% of the number of children taken into care. In addition, 51% of children in need had abuse or neglect identified as a primary need at assessment (NSPCC Report: 'Transforming the mental health services for children who have been abused' 2017)

There is extensive evidence that experience of childhood maltreatment can contribute to the development of a range of mental health disorder, as well as substance misuse, suicide attempts, sexually transmitted infections, risky sexual behaviour and criminality.

Insecure and disorganised attachments are also particularly common among children who have been abused and neglected, and this can contribute to the development of mental health problems.

There is also evidence that experience of maltreatment in childhood doubles the risk of depression, and this depression is more treatment-resistant that depression which occurs without experience of childhood maltreatment.

Effective mental health support for children can be crucial in making the difference between overcoming trauma and living a life shaped by abuse. Mental health support should not be limited to a medical model and should explore the full potential of family, schools and the wider community network as part of the mental health offer. Effective and early targeted intervention can help manage problems before they escalate.

Barnsley CCG, together with Barnsley Metropolitan Borough Council (BMBC) continue to jointly commission Barnsley Sexual Abuse and Rape Crisis Services (BSARCS) to ensure that the children involved in sexual exploitation receive specialist treatment necessary to enable them to reach full recovery.

Barnsley's Local Transformation Plan focuses on early intervention and support by enhancing early years support through family centres with the development of parenting programmes and wellbeing practitioners amongst its partners, with particular emphasis on 'attachment' issues.

School-led emotional health and wellbeing services are at the forefront of our transformation with the development of a mental health support team known as MindSpace, delivering emotional health and wellbeing support to pupils in each of Barnsley's 10 Secondary Schools. In addition Barnsley's Public Health Team have led the implementation of the THRIVE approach to approximately 50% of Barnsley's Primary School aged pupils. Unfortunately there is an ongoing cost to schools of implementing the THRIVE model which has led to a reduction in the number of Barnsley primary schools adopting this approach. A small working party has therefore been established to identify other resources that may be used / implemented by all of the Primary Schools

in Barnsley to better support the emotional health and wellbeing of our primary schooled-aged children.

We recognise that failure to provide high-quality, early support to those most likely to develop serious mental health problems will not only place considerable strain on acute services further down the line but more importantly, would mean that we had failed some of the most vulnerable children and young people of Barnsley.

Looked After Children

Outcomes for Looked After Children often fall behind that of other children and young people simply due to their life experiences which lead them to becoming looked after by the Local Authority. This inequity has been recognised and Barnsley CAMHS have reviewed their 'Children in Care' pathway (Appendix 2) to ensure that Looked After Children have priority access to CAMHS.

Work is also being progressed in terms of how the mental health and emotional wellbeing of Care Leavers can be better supported by services once they turn 18. As the Local Authority maintains Corporate Parenting responsibility for 'Care Leavers' until they reach 21 years of age (or until 25 years of age in some cases) mental health service providers are working with BMBC and the CCG to consider how Care Leavers may be identified within the system (providing consent is given) and to raise awareness among mental health staff of the unique experiences and vulnerability of these young people.

Training sessions are being delivered to our mental health practitioners by the Local Authority's Looked After Team to help them understand the particular vulnerabilities of Care Leavers to ensure that Care Leaver's needs are prioritised appropriately enabling them to access emotional health and wellbeing support in a timely manner.

BAME (Black Asian and Minority Ethnic)

Barnsley's BAME population remains less than 3% of its total population. However, it is well known that many BAME groups experience higher rates of poverty than white British in terms of income, benefits use, unemployment, lacking basic necessities and area deprivation. Much of the variation is self-reported health between and within BAME groups can be explained by differences in socioeconomic status (Parliamentary Office of Science and Technology, 2007).

There are a range of complex factors affecting the health of people from ethnic backgrounds, such as the long term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility.
The health status of Gypsies and Travelers is much poorer than that of the general population, even when taking into account factors such as variable socio-economic status and / or ethnicity (Race Equality Foundation, 2008).

BAME communities are disproportionately represented in both Mental Health care and Criminal Justice systems. However, BAME people are under-represented in substance misuse services. The severe social stigma associated with drug use in some cultural and ethnic groups may lead to underestimation of problems and inhibit service provision and take-up. There may also be a limited awareness among BAME groups of the range of services offering support and how they can be accessed.

LGBT (Lesbian, Gay Bisexual and Transgender)

A number of recent surveys have highlighted some key areas where the health and wellbeing of LGBT people are significantly different from the general population:

- Gay and Bisexual men are less likely to live an active lifestyle, but are more likely to have a normal BMI (Stonewall, 2013);
- LGBTQ+ people are less likely to engage with public initiatives such as HIV testing, STI testing and cervical smear testing than the general population (Stonewall 2012b, 2013);
- LGBTQ+ people are more likely to self-harm; Gay and Bisexual men are more likely to attempt suicide and Lesbian and Bisexual women are more likely to suffer from eating disorders;
- Gay and Bisexual men are more likely to experience Domestic Abuse and Transgender people are more likely to suffer intimidation, violence and harassment (Stonewall 2012b and Scottish Transgender Alliance, 2012);
- Gay and Bisexual men have higher rates of recreational drug use, smoking and alcohol consumption (Stonewall, 2013).

Gypsy Travellers

The ‘Health and Status of Gypsy Travellers in England’ report to the Department of Health (Parry et al, 2004) found that:

- Health problems amongst Gypsy Travellers are between two and five times more common than the settled community;
- Gypsy Travellers are more likely to be anxious, have breathing problems (including asthma and bronchitis) and chest pain. They are also more likely to suffer from miscarriages, still births, the death of young babies and older children.

Asylum Seekers

National research shows that asylum seekers can rapidly develop health problems whilst they are in the UK. There are a number of reasons why this is the case and these reasons may include:

- A number have faced imprisonment, torture or rape prior to migration and will bear the physical and psychological consequences of this;
- Many have come from refugee camps where nutrition and sanitation has

been poor thereby placing them at risk of malnourishment and communicable diseases;
- The journey to the UK could have affected them through various means such as extremes of temperatures, length of journey, overcrowded transport and the stress of leaving their country of origin

Sensory Impairment

National research shows that sensory impairment can have a significant impact upon the life of an individual and can place additional strain upon the health, social and economic needs of both individuals and society.

For example, being deaf or having hearing loss can be a big issue and often socially disabling. People with a significant hearing loss are often very isolated, with social communication becoming increasingly difficult and no external visible signs of the individual's impairment e.g. guide dog or white stick. Furthermore, deaf people often have very low literacy and comprehension levels making reading, writing and understanding the written words very difficult. This can often lead to a rise in frustration and tension, both within the individual as well as society on the whole.

5. YOUNG PEOPLE'S VOICES

Barnsley's children and young people are at the heart of our transformation plan and it is key therefore that they are able to influence the services that are developed to support their emotional health and wellbeing and to be involved in the commissioning decisions which make this happen.

Chilypep (Children and Young People's Empowerment Project) is a local charitable organisation that we continue to commission to facilitate engaging our young people and ensure their voices are heard and listened to. Chilypep have brought together young people from a wide range of backgrounds and life experiences and have trained them as Young Commissioners. Our Young Commissioners have called themselves OASIS (Opening up Awareness and Support and Influencing Services) and Barnsley are already benefiting from the huge number of projects that OASIS are involved in. Complementing OASIS are the Peer Mentors (also facilitated by Chilypep) who are Post 16 students providing peer support to students at Barnsley College.

Our Young Commissioners, OASIS are going from strength to strength and are positively influencing the commissioning and development of young people's services in Barnsley. Appendix 6 details the fantastic work in which they have been involved in and the video links below provide a unique overview of their activities and highlight the passion and commitment with which they involve themselves, both locally and nationally, in order to make a difference.

This is the Greatest Show - **https://www.youtube.com/watch?v=rKx1nS6m1vY**
This is still the Greatest Show - **https://www.youtube.com/watch?v=CO7hilB32qc**

Children and young peoples' services in Barnsley are now measuring themselves against the principles of the Manifesto, developed by OASIS in 2018 (Appendix 3), which contained the following 8 recommendations:

- Make our (young people's) voices heard
- Unite us – put in place peer support programmes
- Raise awareness of mental health in schools and colleges
- Improve signposting and information
- Involve young people in service design and evaluation
- Put in place training around mental health for professionals and communities supporting young people
- Support young people to manage stress and pressure
- Take time to build relationships with young people – give young people tools to make it easier for young people to navigate services and ensure they receive timely, appropriate support.

The Public Health 0 – 19 service were one of the first services to measure themselves against these services and as a result a number of changes have been made in the way the service is being delivered.

A key piece of work in which Chilypep have recently been involved is in relation to 'Transition Intervention', looking specifically at transition from schools to college (NB: In Barnsley only one of the 10 Secondary Schools has its own 6th Form, therefore the majority of post 16 education is undertaken at Barnsley's 6th Form College located in the town centre).

The 'Transition Intervention' (Appendix 4) was a collaborative project between Chilypep, MindSpace and Barnsley's 6th Form College to better understand the young people's opinion on transitioning from school to college with the aim of improving support to young people during this period.

Working together with MindSpace and their Mental Health Ambassadors (these are students at Horizon Community College and Kirk Balk Academy – both Barnsley Secondary Schools – who have received training and support from MindSpace with the aim of raising awareness of mental health within schools), Chilypep talked about young people's opinions on transitioning from school to college, how it affected them, what they were worried about and what would they change.

Following the consultation with Barnsley's young people Chilypep:

- Developed two 'mini zines', one about better sleep and one about the mental health first aid kid (Appendix 5). To be included in the College's support information
- Flyers were included for the Peer Mentoring service, with QR Codes for the on-line self-referral forms, alongside information from the College on free buses, wellbeing, financial and career support and a map of the campus
- A transitions day was trialled by the 6th Form College for those students who had indicated on their application forms that they need / wanted extra emotional support – this enabled them to familiarise themselves with the college when it was quieter. The College's Wellbeing support team, including Chilypep, attended on the day to answer any questions and to deliver a wellbeing activity supported by CHIL (Changing, Helping, Individual Lives) Peer Mentors.
- Sessions were held every week in August 2019 for any students to attend. CHIL Peer Mentors were present to facilitate and support new students. During this time a couple of students were supported to access mental health support from CAMHS
- Wellbeing Wednesdays take place weekly in the Student Union and CHIL Peer Mentors organised activities in GAINSpace – these services were provided throughout the transition project.

To better understand the breadth and depth of the involvement of Barnsley's children and young people, facilitated by Chilypep, and their influence on service delivery, the detailed report at Appendix 6, which contains links to videos and additional documents, provides a much greater insight.

6. SERVICE TRANSFORMATION

The vision for transformation of services in Barnsley is for early intervention and prevention models to provide innovative wellbeing and prevention focused services that can meet the needs of the children and young people already known to services and professionals across the borough, in addition to identifying others with needs that are currently not being met or supported by other services and extending the ability to recognise and offer to all those with emotional wellbeing needs.

The work is being delivered on an asset model and focuses on promoting factors that support human health and wellbeing (salutogenic) resources that build the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.

The services are operating within the context of wider systems to maximise synergy, reduce duplication and ensure impact across the existing systems and future developments, enabling the adults who form the child and young person's environment (teachers, professionals, parents, carers etc.) to role model high self-esteem and personal resilience, which in turn will allow children and young people in Barnsley to 'break the cycle' of low aspirations and improve mental and physical health associated with wellbeing.

The expected outcomes of the early intervention and prevention currently being delivered includes:

- Improved quality of life outcomes for children and young people by supporting them to build resilience, understand how to maintain their wellbeing and enabling self-care;
- Improved confidence and competence of children and young people-facing staff to identify, comfortably and compassionately engage with, and signpost children and young people into services via a clear pathway;
- Improved entry assessment and final evaluation outcomes of CAMHS by providing step-up / step-down – the newly developed CAMHS service specification moves away from the traditional medical, tiered model of delivery towards a whole systems approach, social model based on the iThrive principles (Appendix 7);
- Reduced number of referrals into secondary care / higher level services (for mental health / wellbeing);
- Reduced number of referrals submitted to CAMHS (utilising the whole systems approach);
- Reduced emergency admissions to hospital for children and young people with Long Term Conditions – children and their parents are less anxious and have access to information that allows them to effectively self-care;
- Reduced incidence of bullying in schools;
- Reduced incidence of child sexual exploitation;
- Reduced number of children and young people prescribed anti-depressants;

- Increased early identification at key development ages within existing services.

Improved information, advice and support available for children and young people, and their families and carers enabling them to effectively self-care and support the emotional wellbeing of themselves and those around them (Appendix 8 – Directory of Services)

Universal Services

Universal services such as Health Visitors and Public Health Nurses (encompassing the role of School Nurses) are well placed to offer early intervention support.

The Public Health Nursing Service has 6 local area teams which cover the Local Authority area councils; the lead practitioner in each area has established relationships with both area councils and GP localities (Primary Care Networks). The teams work collaboratively with colleagues across health and social care to determine the health needs of the areas and tailor service delivery to meet those needs.

The Public Health Nursing service is rolling out a programme of extended practice across the service to achieve a dual qualification for practitioners with a SCPHN qualification. This involves undertaking an additional period of practice assessment which then enables them to deliver services to children and young people across the 0 -19 age range. The wider skill mix team are already delivering across the 0 – 19 age range which significantly improves consistency for service users enabling practitioners to build effective therapeutic relationships with children, young people and families.

Service pathways have been developed in collaboration with the CAMHS service for Perinatal Mental Health, Parenting / Behaviour management, Sleep, Speech and Language, School readiness and transitions, Emotional Health and Wellbeing, Self-Harm, Eating Disorders and Support for young carers.

The service has implements dedicated Children in Care team who are responsible for the annual health assessment and delivery of the Healthy Child Programme to all Children in Care across the Borough. This has improved both the quality and consistency of health assessments for this vulnerable group of children and young people. The team work collaboratively with Social Care to ensure foster carers complete Strengths and Difficulties Questionnaires (SDQ's) prior to children's annual health assessments. The SDQ scores are analysed and incorporated into the health assessment and any concerns discussed with the social worker. Workshops have been delivered to ensure foster carers understand SDQ's, how they are used and the importance of returning them. Additionally, information sheets have been written for social workers to support their understanding and role in SDQ collection and action. They are provided with ongoing support to make referrals to services when needed. Young people in care are offered one to

one support to promote their emotional and behavioural development along with advocating for them within their care plan. Foster carers are guided and supported to manage difficult behaviours and provide therapeutic parenting for individual children. The CiC Health Team attend Foster Carer support groups to provide information, updates and facilitate group learning, topics frequently include emotional health and wellbeing. Additionally, the team support the weekly CiC CAMHS consultation clinic and work alongside the clinical psychologist to offer guidance and support to foster carers and professionals working with CiC and co-deliver a 12 week Fostering Lasting Attachment Group with CAMHS to foster carers twice per year.

The service is currently reviewing and developing the 5 – 19 service offer; they have worked with the OASIS Young Commissioners group who have undertaken a consultation with young people across the Borough to inform service delivery-recommendations from this consultation are being incorporated. This includes the development of 'Drop Box' drop-ins which are holistic nurse-run health and wellbeing clinics that offers secondary students the opportunity to discuss physical and emotional health issues to a professional, in a safe, friendly and confidential environment within school. The clinics have gone from strength to strength resulting in practitioners forming strong, therapeutic relationships with students.

Resilience Programme (Primary Schools)

The Public Health Nursing Service focuses on using a whole school approach and encouraging health promotion in schools. This whole school approach is mirrored in a programme funded by Barnsley's Future in Mind financial allocation and led by Public Health, to improve the social and emotional mental health and resilience of Barnsley's primary school-age children.

The aim of the project is to improve the social and emotional mental health (SEMH) and resilience of young people in Barnsley through increasing the number of Primary schools providing exemplary mental health support for their pupils, delivered through a whole school approach. There is clear evidence that schools play a vital role in identifying mental health needs at an early stage. The Department of Education (DfE) recognises that 'in order to help their pupils succeed; schools have a role to play in supporting them to be resilient and mentally healthy'. They also identify a whole-school approach to promoting good mental health as a protective factor for child and adolescent mental health.

A tender process identified an organisation called THRIVE who were commissioned to provide training to Primary School staff in order to enable schools to start using the 'Thrive Approach'. This whole-school approach works on both a universal and targeted level, the most needy pupils identified through an on-line assessment process.

To date, 10 courses have been funded with a total of 180 people from 36 schools receiving training to implement the Thrive Approach. Furthermore, 3 people have completed the Thrive 'Train the Trainer' course and are now

delivering Thrive training and CPD across Barnsley. The table below provides further detail:

	2016-19	2019-20	**Total**
Number of Licensed Practitioner / Blended Learning courses	7	3	**10**
Number of people trained as Thrive Licensed Practitioners	144	36	**180**
Number of people trained and qualified as Thrive Trainers	3	0	**3**
Number of people trained in 'Family Thrive'	2	0	**2**
Number of funded CPD days	0	72	**72**
Number of schools who have taken funded training places	36	Tbc	**Tbc**
Number of schools actively using Thrive in 2019	30	Tbc	**Tbc**

Evaluation:

There is evidence that building resilience through to adulthood reduces the burden of both mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.

This project has been evaluated using several different methods over the 3 years the project has been running. The table below gives a brief summary of the key findings:

Data Source:	Key Findings:	Notes:
CORC data	Inconclusive	Small sample sizes; complicated data collection and data collected very early in the process
Thrive on-line data reports for: 2016/17 2017/18 2018/19	147 pupils received a Thrive intervention in 2018/19. All 147 pupils had progressed through the developmental stages – this means that they were nearer to being at an age-appropriate developmental stage and had improved levels of emotional wellbeing	Consistently positive for all three years The case studies compliment this data and show the 'real-life' effect of these developmental improvements
Schools Questionnaire, 2018	100% said that behaviour had improved 78% said pupils are more engaged in lessons and achieving more academically	9 Schools completed the questionnaire

	78% said attendance is improved	
Student dissertation 2018	Cost of training as well as ongoing costs of using Thrive were prohibitive to schools using Thrive. For many schools this was the only barrier to engagement	Interviews with Senior leaders in 9 Schools
Staff and school case studies 2107 - 2018	"… his detention record has decreased dramatically.." "…he is beginning to develop academically as well as emotionally.." "…exclusion rates have decreased.."	Case studies and feedback from schools is overwhelmingly positive. Consultation with schools, pupils and parents adds to this and can be seen at https://vimeo.com/294180157 (password = thrive1)

Long Term Sustainability:

As can be seen in the tables above, the take-up of training and subsequent evaluation from schools has been overwhelmingly positive. Schools reported improvements in behaviour, academic achievement and attendance. All pupils who received a 1:1 intervention were progressing well through the development stages.

A total of 36 schools (approximately 50% of Primary Schools in Barnsley) started using the Thrive Approach between 2016 – 2019. As of July 2019 this number had dropped to 30 schools. Most schools that had not continued to use the Thrive Approach reported that this was due to the ongoing costs which schools had to pay annually for use of the online assessment tool as well as CPD for staff who have received the training. The longer term plan for the sustainability of this project was to negotiate a contract with Thrive for all of Barnsley's 77 Primary Schools to access Thrive online at a much reduced cost. Also, having our own trainers locally would enable us to offer training courses and CPD at a much reduced rate. Unfortunately, contract discussions with Thrive did not result in a satisfactory solution. Due to this, although Thrive evaluates well, we are in the process of exploring other options to supplement and compliment the ongoing Thrive work which will no longer be accessible to all schools due largely to the ongoing costs. We do however; still have the three trainers locally who can deliver reduced cost Thrive training. The project lead will continue to work closely with the 0 – 19 team and other colleagues in order to ensure a consistent approach and a variety of options for schools to support them to improve the emotional wellbeing and resilience of their pupils.

Integrated Model

As we are looking to continually looking to improve the emotional health and wellbeing support offered to the young people of Barnsley, we (being partners within the whole system) embarked upon a 'field trip' to Kirklees, driven by Barnsley's Director of Public Health, to learn from their implementation of the i-Thrive CAMHS model and the delivery of their integrated service.

Following our multi-agency field trip to Kirklees we have established a small working group to identify the learning and develop an action plan as to how this could be implemented in Barnsley. The group identified three key success factors to supporting an integrated commissioning and delivery model.

1. Strategic support for a long term plan

   The first action was to secure strategic buy-in for a long term vision. A workshop, led by Public Health but with senior CCG Governing Body members and key Councillors, took place where commitment from both the CCG and the Local Authority was secured. Moving forward the group will be working with Public Health England supported by The Health Foundation to deliver a whole-systems approach to improve young people's mental health. Public Health Barnsley are planning to lead 2 'Systems Mapping Workshops' with Public Health England and The Health Foundation plus key stakeholders across the Borough including children and young people - these workshops will take place in early 2020.

2. Communication and partnerships are key
3. Programme and Leadership Management

To support the second two actions the CCG and Public Health have agreed to fund a Transformation Lead and Project Support Officer to lead and support this work across the Borough.

MindSpace (Secondary Schools)

A significant proportion of the Future in Mind funding in Barnsley has been invested in developing a schools-led mental health therapeutic support service offering early intervention and prevention support for the emotional health and wellbeing of all secondary school pupils in Barnsley. This mental health support team was established in Barnsley prior to the publication of the Department of Education's Green Paper, 'Transformation of Children and Young People's Mental Health provision' but is clearly reflective of the ambitions contained within the Department of Education's paper.

The mental health support team MindSpace is widely known in Barnsley following a re-launch of the service in October 2017.

The most recent MindSpace report (Appendix 9) details progress to date and our ambition is to develop similar services for our Primary School-aged

children, especially the more vulnerable children in our Borough such as Children in Care, children attending the SEMH special school and children educated at home. This second Mental Health Support Team will be developed and become operational during 2020.

As part of the ongoing consultation with our young people it became apparent that they desired access to a young person friendly website which would contain an abundance of relevant information as well as self-help strategies. The young people provided a number of specific requirements, such as the need to be colourful and easy to navigate. Below are extracts from the current MindSpace website, developed following these consultations:

The website www.wearemindspace.com was launched in November 2017 and has proven to be an invaluable resource for young people and parents alike and users have the ability to self-refer into MindSpace directly via the website. The website is constantly being reviewed and improvements made to ensure that the site is easy to use for all ages and that the most appropriate advice and support is provided.

To date, over 2,300 young people aged 11 to 16 have accessed a 1:1 intervention, 45% male and 55% female (less than 2% of young people accessing MindSpace 1:1 interventions have needed 'stepping up' to specialist services.)

Over 1,400 young people aged 11 – 16 have accessed group interventions, 40% male and 60% female (0.02% of young people accessing group services have required further 1:1 interventions).

Over 500 parents have accessed the MindSpace Parent Counsellor or the Parent Liaison Service.

We are extremely proud to have been one of the first areas in the country to establish a mental health support team in schools and the benefits of having MindSpace within our Secondary Schools is evident to see.

Chilypep (Children and Young People's Empowerment Project)

In addition to facilitating the fantastic engagement work with our young people and supporting OASIS and Peer Mentors, Chilypep are also responsible for providing large elements of training to our school staff (teaching and non-teaching) which compliments the work of MindSpace. The attached report (Appendix 6) details the extensive training provided by Chilypep to date.

In 2018, Chilypep were commissioned to deliver the BRV (Belonging, Resilience, and Vocabulary) project in Barnsley to 15 boys. The BRV project works with a group of young men and boys (Years 9/10) to help them achieve a sense of belonging, resilience and improved understanding of themselves. Through group workshops, art and photography sessions, the boys explore and enrich their emotional intelligence. The boys engage with themes such as personal and group identities, health and wellbeing, how to manage difficult emotions, citizenship and core values. All of this enables them to navigate adolescence and help them to aspire to positive futures.

Outcomes of the BRV programme are that boys:

- Recognise, value and respect their emotions and those of others and recognise boundaries;
- Increase knowledge and understanding of self, and learn to like themselves more;
- Explore and challenge perceptions of contemporary masculinity within the context of their lives;
- Identify situations / places where they feel vulnerable, then learn how to address their emotions and develop helping strategies;
- Develop help-seeking behaviours and identify support needed;
- Identify and address risky or life chance blocking behaviours / attitudes;
- Be able to critically reflect and make informed choices;
- Increase sense of citizenship and belonging;
- Have positive opportunities and experiences to focus on their future in terms of career opportunities, relationships and emotional wellbeing.

Due to the fantastic success of this project Chilypep have been commissioned to deliver BRV to over 100 young boys / men over a 2 year period. Additional funding has also been provided to deliver the BRV programme to a number of boys currently on the CAMHS waiting list, where BRV is indicated as being potentially more effective than them accessing the NHS CAMHS service, to ensure that they receive appropriate support in a timely manner leading to better life outcomes for each of them.

TADS (Therapies for Anxiety, Depression and Stress)

Barnsley TADS is a Charitable Unincorporated Organisation who provide free complimentary therapies to the people of Barnsley. Although Barnsley TADS did not form part of the original transformation plan, they have become an enthusiastic and committed collaborative partner (through the extensive engagement, development and promotion of MindSpace) with whom the CCG are keen to work to enhance their offer of support to the young people of Barnsley.

Barnsley TADS have established a 'TADS Young People's Wellbeing project' which includes:

- Running a drop-in service twice a week between 3:30pm and 5:30pm;
- Offering a five-week wellbeing workshop teaching young people different ways to handle their issues;
- Provide therapies such as Indian head massage, reflexology and reiki, hypnotherapy and EFT (Emotional Freedom Techniques);
- A dedicated, confidential email and text messaging service for advice and / or support.

NHS Specialist CAMHS

The Barnsley Child and Adolescent Mental Health Service (CAMHS) is based at Upper New Street, Barnsley and provides a comprehensive and quality service to children and young people in the Barnsley area. The services are currently provided to children and young people up to their 18th birthday(NB the newly developed CAMHS service specification anticipates Barnsley CAMHS evolving in to a service for 0 – 25 year olds by 2025) who are experiencing a wide range of behavioural, psychological and emotional problems, difficult relationships, trauma or abuse. 100% of young people presenting to Barnsley CAMHS in an emergency are seen within 24 hours.

Barnsley CAMHS is made up of four teams:

- Child and Adolescent Unit;
- Intensive Home Based Treatment Team (previously Young People's Outreach Team);
- Community Early Intervention Team;
- Learning Disabilities and Development Disorders Team.

The services are provided in a variety of settings including health centres, clinics, schools or in service-user homes. There is a range of support and interventions offered to children, young people, families and carers who use the Barnsley NHS Specialist CAMHS service. Examples of this support includes:

- Brief solution focused therapy (a goal directed therapy that focuses on solutions instead of problems);
- Cognitive behavioural therapy (CBT) – a talking therapy that can help you manage your problems by changing the way you think or behave;
- Evidence based parenting interventions;
- Eye movement desensitisation reprogramming (a treatment used to reduce the symptoms of post-traumatic stress disorder);
- Family therapy;
- Group therapies;
- Play therapies;
- Psychiatric assessment and diagnosis;
- Psychologist assessment and interventions.

Barnsley NHS Specialist CAMHS has participated in the national CYP IAPT programme since the first implementation phase in 2012. The service is part of the North West CYP IAPT Learning Collaborative. There are currently 20 partnership members of the collaborative supported by Greater Manchester West Cognitive Behavioural Therapy Training Centre (GMW CBTTC) / The University of Manchester.

CYP IAPT is a pivotal factor in having delivered the recommendations of the Fiver Year Forward View For Mental Health and will be an essential requirement in delivering the ambitions of the NHS Long Term Plan for children and young people.

CYP IAPT works in partnership with children and young people to help improve and monitor services. A key component of CYP IAPT is the training of practitioners (and supervisors) in NICE approved and best evidence base therapies. Historically, NHS England has funded the backfill posts to enable staff to undertake this training, but this funding came to an end in 2018 and the responsibility to fund future training places now sits with Clinical Commissioning Groups. Barnsley CCG see CYP IAPT trained practitioners as a key workforce delivering the emotional health and wellbeing support to our young people and are therefore committed to continue to support the CYP IAPT training programme.

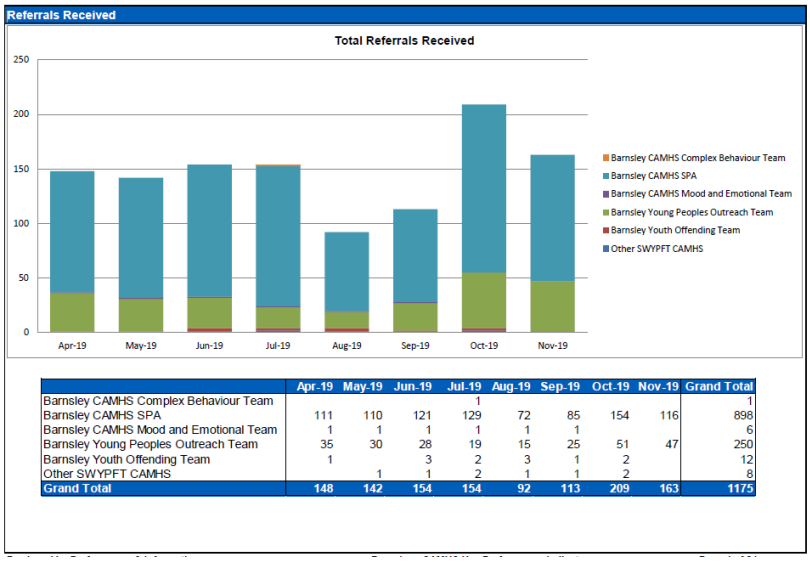
Additional investment of Future in Mind funding into a CAMHS Single Point of Access (SPA) has enable this service to become and remain fully operational. A number of the SPA staff members have attended the CYP-IAPT Enhanced Evidenced Based Practice Programme (EEBP) which has further embedded and sustained early evidenced based interventions. In addition, 2 CYP Wellbeing Practitioner trainees are co-located within SPA.

The Youth Offending Team (YOT) CAMHS staff are both trained to deliver evidenced based interventions and have successfully completed the CYP-IAPT CBT Post Graduate Diploma Programme. This support has been further enhanced so that these posts both now operate on a full-time basis.

Barnsley has a full Early Intervention (EI) pathway in place for children and young people and medical responsibility for EIT (Early Intervention Treatment) sits within CAMHS until they are 18 and/or whilst Transition is completed. All referrals from CAMHS to the EIT pathway are assessed for suitability (within 2 weeks if routine) and will fall into one of 2 categories. If the assessment concludes they are experiencing a first episode psychosis they will be offered a full 3 year package of care from the specialist team, with medical responsibility remaining with CAMHS. Children and Young people in CAMHS are care-coordinated by NHS Specialist CAMHS under the CPA (Care Programme Approach) framework.

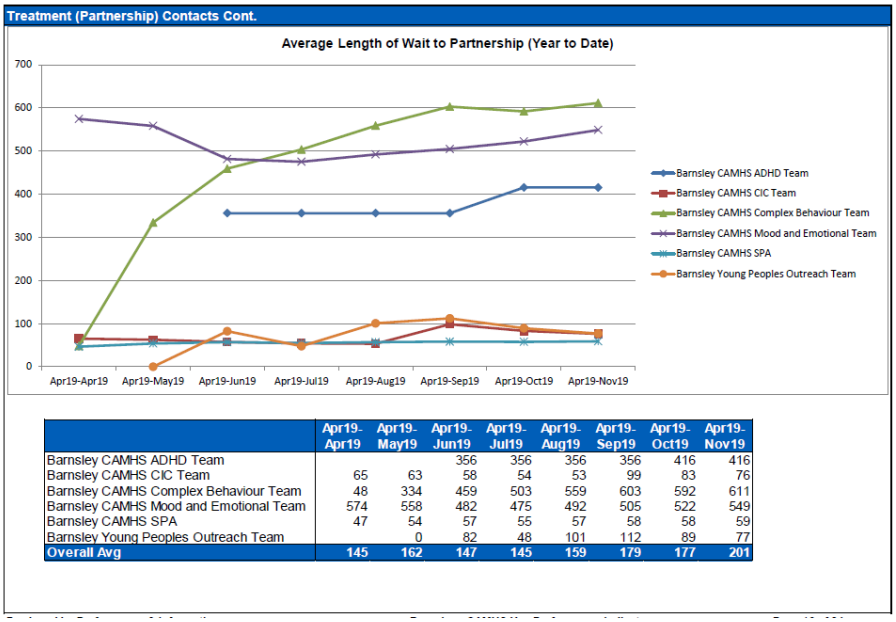
The second pathway in operation is the 'ARMS pathway' (At Risk Mental State). This is where the child/young person presents with a range of difficulties and experiences that do not fully meet the diagnostic criteria for psychosis, but, following the completion of the CARMS assessment (Comprehensive assessment at risk mental state), do indicate an 'at risk' mental state. This is assessed around frequency and intensity of unusual experiences, plus significant and recent decline in social function and first degree family history of psychosis. These children and young people will be offered 6 – 12 months of intervention which is focused on a CBT (Cognitive Behaviour Therapy) approach. If they transition into a psychotic episode in this time they will be taken onto the full caseload (for up to 3 years). The aim of this additional role for EIT nationally is, wherever possible, to prevent transition and to tighten up the care package for first episodes.

Demand for NHS Specialist CAMHS services has remained consistently high. The performance extract below highlights the number of referrals received into CAMHS for the most recent 12 month period but the Performance reports at Appendix 10 provide a more detailed narrative.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS Complex Behaviour Team				1					1
Barnsley CAMHS SPA	111	110	121	129	72	85	154	116	898
Barnsley CAMHS Mood and Emotional Team	1	1	1	1	1	1			6
Barnsley Young Peoples Outreach Team	35	30	28	19	15	25	51	47	250
Barnsley Youth Offending Team	1		3	2	3	1	2		12
Other SWYPFT CAMHS		1	1	2	1	1	2		8
Grand Total	**148**	**142**	**154**	**154**	**92**	**113**	**209**	**163**	**1175**

Aligned to the number of referrals is the continued challenge in Barnsley of our children and young people experiencing unacceptable long waits to access CAMHS. The current waiting times for each of the CAMHS pathways is shown in the table below:



	Apr19-Apr19	Apr19-May19	Apr19-Jun19	Apr19-Jul19	Apr19-Aug19	Apr19-Sep19	Apr19-Oct19	Apr19-Nov19
Barnsley CAMHS ADHD Team			356	356	356	356	416	416
Barnsley CAMHS CIC Team	65	63	58	54	53	99	83	76
Barnsley CAMHS Complex Behaviour Team	48	334	459	503	559	603	592	611
Barnsley CAMHS Mood and Emotional Team	574	558	482	475	492	505	522	549
Barnsley CAMHS SPA	47	54	57	55	57	58	58	59
Barnsley Young Peoples Outreach Team		0	82	48	101	112	89	77
Overall Avg	**145**	**162**	**147**	**145**	**159**	**179**	**177**	**201**

In April 2019, to help us to consider ways in which we could improve the NSH Specialist CAMHS service support offered to Barnsley's children and young people, the CCG and Barnsley's mental health service provider SWYPFT (South and West Yorkshire Partnership NHS Foundation Trust) invited NHS England's Intensive Support Team (IST) to undertake an independent review of the Barnsley CAMHS service. The overarching aim of the review was for the NHS England IST team to identify areas that could be improved with recommendations on how the improvements could be facilitated. The recommendations of the review are contained within a detailed report provided to the CCG and SWYPFT, which can be found at Appendix 11.

A key action following the Independent review of the Barnsley NSH Specialist CAMHS service was for partners to develop a new service specification for CAMHS. Working collaboratively with our partners a new CAMHS service specification was co-produced with our Young Commissioners, OASIS, which moves away from the traditional, tiered, medical model towards a more social, whole systems approach in delivering emotional health and wellbeing support to our children and young people (the new CAMHS service specification can be found at Appendix 7).

Additional non-recurrent funding has also been invested with SWYPFT, MindSpace and Chilypep to deliver waiting list initiatives up to June 2020 which will reduce the numbers of young children waiting to access CAMHS from 309, as at October 2019, to just 40 by June 2020. The ambition, contained within the new service specification, is that we will then be able to work towards the maximum wait for CAMHS being no more than 4 weeks

from the date of the routine referral in addition to evolving into a service for 0 – 25 year olds.

Community Eating Disorder

A children and young people's community eating disorder service, provided by CAMHS, has been established in Barnsley in accordance with the recommendations of the guidance for 'Access and Waiting Time Standard for Children and Young People with Eating Disorder'. The Barnsley service was established in 2016 through a collaborative commissioning arrangement with Calderdale, Wakefield, Kirklees and Huddersfield CCG's and is delivered on a hub and spoke model.

The 'hub' performs an important professional leadership and learning network role across the full service thus ensuring robust and consistent approaches to staff development and quality assurance. The initial focus has been on strengthening the local resource bases and pathways, investing in increasing the capacity and skills set of the current multi-disciplinary teams.

Since the pathway became operational the Barnsley service has consistently achieved the national access and waiting time standards and there are approximately 24 children and young people on this pathway at any given time.

In 2017 the Barnsley service undertook a 3 month pilot scheme named, by the children and young people themselves, as the Body Image and Feelings (BIF) Group. This was located at a local college and hosted by the Eating Disorder Team and a MindSpace Primary Mental Health Practitioner. This group offered early intervention and an opportunity for young people to discuss any concerns they have and complete a screening tool to enable self-referral to the specialist Eating Disorder team if required. Due to the overwhelming success of this scheme it has now been rolled out across other schools in the Borough, in response to the needs of the young people who attend. The offer is primarily psycho-education.

The service has revised the Eating Disorder Pathway to include GP and Paediatric protocols that have been developed in partnership with GP and Paediatrician representatives across the 4 CCG's.

In 2018 South Yorkshire Eating Disorder Association (SYEDA), a local charitable organisation was commissioned to raise awareness of eating disorders to pupils within Barnsley's Primary Schools. The report at Appendix 12 details the activities undertaken by SYEDA. Due to the success of the scheme SYEDA have been recommissioned to continue with raising awareness of eating disorders to our Primary school children throughout 2019 and in addition, have been asked to undertake a pilot in four of our Secondary schools to develop a school-based eating disorder counselling service.

Vulnerable Groups

A Dialectical Behavioural Therapy (DBT) has commenced to offer evidenced based group interventions for those young people with complex presentations and intense difficulties with emotions which often leads to self-harm. Given that hospital admissions due to self-harm in Barnsley for those aged 10 – 25 years old is increasing this is an area in which we need to identify how we can better support these young people. Aligned to this, additional, recurrent investment has been provided to further develop the capacity of the CAMHS Intensive Home Base Support to ensure the right care is provided in an appropriate and timely manner.

Youth Offending Team (YOT)

Exposure to crime and anti-social behaviour are one of the determinants of poor emotional health and wellbeing in children and young people. In recognition of this Future in Mind funding has been utilised to increase the CAMHS capacity to provide enhanced support to the young people accessing the Youth Offending Team. In 2018/19 additional, recurrent funding was agreed to enable the 2 CAMHS practitioners supporting YOT to operate on a full-time basis. These practitioners are hosted by SWYPFT CAMHS but located in, and offered first line management by, the YOT service supported by a joint management arrangement with the CAMHS Team manager.

The offer for young people identified by the YOT CAMHS staff as requiring Specialist CAMHS intervention is that they will have more rapid access than the generic population for routine face to face assessment when required. The generic expectation is for the offer of initial assessment within 5 weeks whereas for YOT this remains at no more than 2 weeks.

Both the YOT CAMHS staff are trained to deliver evidenced based interventions and have successfully completed the CYP-IAPT CBT Post Graduate Diploma programme. Additionally, the CCG agreed in 2018/19 to recurrently fund a YOT Parenting practitioner for the trauma-led pathway who was also to be trained in the use of EMDR (Eye Movement Desensitisation and Reprocessing). EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. Repeated studies show that by using EMDR therapy people can experience the benefits of psychotherapy that once took years to make a difference.

These enhancements to the support provided to the YOT service are enabling both timely access and improved support for this vulnerable group of children and young people.

Children in Care (Looked After Children)

Barnsley CAMHS published and promoted the revised Children in Care (CiC) CAMHS pathway (Appendix 2) in 2018 and this pathway is now fully established. The pathway is working well, leading to positive outcomes but

there are issues with capacity and sustainability as the pathway relies on the availability and expertise of just one mental health practitioner. The new CAMHS service specification acknowledges the importance of this pathway and requires the pathway to be more robust; however, the current, revised pathway maintains priority access to face to face assessment to be within 2 weeks of the referral.

The CiC pathway is based around a consultation model and a consultation clinic is offered within 6 weeks. This enables the network of professionals and carers to discuss how best to meet a child's needs. The offer is for support and training to carers and the wider professional network, assessment of children and young people's emotional health needs and, where appropriate, direct therapeutic work for trauma and attachment issues to a young person and/or their carers.

In addition the CAMHS CiC Pathway Lead Psychologists revised offer includes:

- Provision of consultation to Barnsley's children and young peoples' residential provision
- 12 week Fostering Lasting Attachments group (FLAG) for foster carers, Kinship carers and adoptive parents
- Representation at the Multi-Agency Victims of Complex Abuse (MVCA) Panel
- Attendance at the Children with Health Needs in Care group
- Potential to co-opt clinical consultation at the Children's Resource Allocation Group (CRAG)

The Local Authority Children in Care team are also providing on-going training to adult mental health practitioners to enable the adult mental health services to better understand the unique vulnerabilities of being a Child in care. It is envisaged that this ongoing training will enable the adult mental health services to prioritise these young people more effectively so that they receive the appropriate support in a timely manner, particularly of the young person has not accessed mental health services prior to becoming 18 years old or older.

Crisis Care

Barnsley CCG and its partners continue to work closely together to implement the Barnsley Mental Health Crisis Concordat to further improve the crisis response to anyone in Barnsley who requires such help, where and when they need it. Barnsley CCG reviewed the effectiveness of their Mental Health Crisis Concordat Group and this group is now re-energised with a much clearer focus and strong attendance from all partners.

There are now two established task and finish sub groups of the Mental Health Crisis Concordat Group, one is focusing on implementing a mental health triage tool for use in the Emergency Department https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triage

qrg~triagegrg-mh and is also assessing the crisis response, to people aged 8+ who attend due to some form of self-harm, against the standards outlined within Clinical Guidance 16 (Appendix 13).

The Mental Health Liaison Service based at the Emergency Department of Barnsley Hospital has previously excluded under 18's. However, due to additional, increased recurrent funding approved by the CCG's Governing Body, this service will operate as an all-age service from January 2020. Aligned to this, additional investment was also agreed to enhance the CAMHS Intensive Home Based Treatment Service so that appropriate crisis support within the community could be offered to young people 24 hours a day, 365 days a year. Additional funding successfully bid via NHS England will also enable the Mental Health Liaison Service to achieve Core 24 status (Appendix 14).

The Early Intervention Crisis pathway is fully embedded in Barnsley's mental health crisis pathways. Barnsley's Early Intervention Psychosis Team (EIP), which supports people aged 14 to 65, is one of the top 5 performing EIP services in England.

Early Intervention in Psychosis (EIP) are multi-disciplinary teams set up to seek, identify and reduce treatment delays at the onset of psychosis and promote recovery by reducing the probability of relapse following a first episode of psychosis. Timely access to EIP is shown to have a significant long-term impact on the lives and livelihood of individuals with psychosis and their families.

NHS England's aspiration is that at least 56% of people aged 14-65 who are experiencing their first episode of psychosis should start treatment within two weeks and 25% of EIP service providers to achieve Level 3 and above assessed by the National Clinical Audit of Psychosis (NCAP) and in accordance with NICE guidelines for psychosis and schizophrenia.

Barnsley's EIP service consistently surpasses the relevant national targets and will become a Level 3 service by March 2021.

To better support young people in Barnsley and prevent escalation to mental health crises, partners are working closely together to establish a children and young people's emotional health and wellbeing hub, similar to the PAUSE model developed in Birmingham.
(https://www.forwardthinking.Birmingham.org.uk)

As with Birmingham PAUSE the aspiration for the Barnsley emotional health and wellbeing hub, is for a drop-in service for under 25's. The intention is to provide easy access support for young people, seven days a week. It will also provide support for parents and carers who are concerned about their young persons' wellbeing. The service will provide guidance, psycho-education, signposting and self-help strategies, to help young people improve and better manage their wellbeing. The hub will also become the home of Chilypep and

other mental health support services / voluntary sector organisations with regular representation from the 0 – 19 service and other professionals. The Barnsley children and young people's emotional health and wellbeing hub will operate form the first floor of the YMCA building, which is located in the town centre and is an accessible, yet safe building from which drop-in sessions and other support services can be run effectively.

Learning Disabilities

There are key developments regionally in relation to the national TCP (Transforming Care Plan) programme which aims to improve the care of people with a Learning Disability, autism or both, and their families and carers.

The footprint for Barnsley's TCP is CKWB (Calderdale, Kirklees, Wakefield and Barnsley) although at some point in the future Barnsley may realign to the South Yorkshire TCP. There were three key aspects to the children and young people's part of the TCP programme and these were:

- To develop an 'at risk of admission' register
- To develop a robust CETR (Care, Education and Treatment Review) process based on national guidance (Appendix 15)
- To improve parental and young peoples' engagement

The 'at risk of admission' register has been established and is managed by SWYPFT (who provide the support services in Barnsley to people with a Learning Disability). It is evident that we need to consider how this register can be better used more proactively to ensure the appropriate support is put in place as early as possible.

Aligned to the development of the register was the development of a robust CETR process. National guidance was published in 2018 and in order to implement this guidance the CCG appointed a Complex Case Manager who has developed and implemented a robust CETR process and who also implements best practice in terms of oversight of the care of all of the children and young people admitted as in-patients who have a Learning Disability and/or ASC (Autistic Spectrum Condition).

CETR's bring together those responsible for commissioning and providing services (this will include nurses, social workers, commissioners, health professionals, education and social care professionals) with independent clinical opinion and the lived experience of children and young people and families from diverse communities with learning disabilities, autism or both.

CETR's are driven by the NHS but the involvement of local authorities and education services in the CETR process and its outcomes is integral to improving care, education and treatment for children and young people with learning disabilities, autism or both, and their families.

In 2016 Ofsted and the CQC commenced a 5 year programme of jointly inspecting all areas in England to look at the local areas effectiveness in identifying and meeting the needs of children and young people who have special educational needs or disabilities. The SEND Inspection Framework 2019 (Appendix 16) sets out the principles of how the effectiveness will be determined.

The local authority have brought partners together and collaboratively developed a SEND Improvement plan (Appendix 17), which is a live document and constantly being updated. The plan, influenced by young people with SEND, outlines the needs of people with special educational needs and disabilities within Barnsley, how those needs are currently being met and identify the areas for improvement and how those improvements will be delivered. To date, Barnsley has not had the SEND Joint inspection but the outcome and any actions required of the inspection, once it has taken place, will be reported on in any future iterations of the Local Transformation Plan.

Autism Spectrum Conditions (ASC)

Autism is defined as a developmental disorder of variable severity that is characterized by difficulties in social interaction and communication and by restricted or repetitive patterns of thought and behaviour. Autistic people therefore may:

- find it hard to communicate and interact with other people
- find it hard to understand how other people think or feel
- find things like bright lights or loud noises overwhelming, stressful or uncomfortable
- get anxious or upset about unfamiliar situations and social events
- take longer to understand information
- do or think the same things over and over

Autism is not a medical condition with treatments or cure and whilst a number of people with autism are able to function well, many others require help and support which may vary in degree and intensity over the course of their life.

It had been estimated that around 1% of the population of England would be on the autistic spectrum, however in Barnsley, as in the majority of other towns and cities in England, it is thought that a more accurate reflection of people on the autism spectrum is around 4% of the population. There is a national autism strategy which focuses only on adults, however, a refresh of the autism strategy was to be undertaken in 2019 and this was to include children and young people. Publication of the refreshed strategy is awaited.

Autism and assessment diagnostic services were established, but the capacity of these services was based on the premise of 1% of the local population needing access to the services, hence there is a significant lack of capacity within local services since the demand is over four times greater than provided for. The autism pathway for children and young people in Barnsley has been redesigned a number of times since 2013 and additional investment

provided, on a non-recurrent basis, to reduce the length of time people are waiting to access the assessment and diagnosis pathway. However these initiatives and their impact have not been sustained

In 2019 the waiting time in Barnsley in relation to assessment and diagnosis for autism for young people, ranged from 4 months to nearly 2.5 years. This is clearly unacceptable and resulted in the CCG's Governing Body providing additional, recurrent financial resource to the Paediatricians based at Barnsley hospital to reduce the waiting times, over a 12 month period, to no more than 18 weeks, with the ambition that a NICE-Concordant Autism Assessment and Diagnostic service will then be sustained.

In 2019 Barnsley CCG funded a parenting practitioner within Family Services to deliver support to all young people and their families on the ASC pathway and this is proving to be effective in improving life outcomes for these young people. Both CAMHS and MindSpace also provide support to parents of young people expected to have autism or other neurodevelopmental conditions

Barnsley are looking at developing just one neurodevelopmental pathway with a pre-requisite of accessing the pathway being that an Early Help Assessment has been undertaken. This will ensure that the appropriate help and support will be put in to place at the earliest possible opportunity, leading to many of the young people not needing to access the ASC/ADHD (Attention Deficit Hyperactive Disorder) diagnostic pathway.

Work has also been progressing on a regional basis in relation to Autism and is being driven by the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS). This work is looking to standardise the assessment and diagnostic processes and protocols used throughout the region and to improve the local support provided to people with autism and to those who have similar needs but no diagnosis. SYB ICS are also working towards the whole of South Yorkshire and Bassetlaw becoming an 'Autism Friendly' region. https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triagegrg~triagegrg-mh) .

Perinatal Mental Health

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of women and covers a wide range of conditions. If left untreated, it can have significant and long-lasting effects on the woman and her family. Perinatal mental health problems can also have long-standing effects on children's emotional, social and cognitive development.

Barnsley's Perinatal Mental Health pathway (Appendix 18) reflects the engagement with in-patient and outreach services to prevent relapse. Barnsley were pleased to be part of the successful collaborative bid, back in 2016, with Kirklees, Calderdale and Wakefield CCG's for national funding to improve perinatal mental health provision in the area.

This funding enabled the development of a Specialist Perinatal Mental Health team which is now well established and embedded within the relevant mental health pathways. The team consists of five senior perinatal practitioners, two part-time psychologists, a full-time peer support worker post, an administrator and a team leader. The service is organised on a hub and spoke model with practitioners working alongside mental health colleagues in each of the service providers' localities.

The Specialist Perinatal Mental Health service became operational in October 2017 and offers a range of different interventions depending on need and current involvement with other services. It works with women who already receive input from teams within SWYPFT (the mental health service provider in Barnsley), offering specialist perinatal support around care planning, contingency planning, medication, mother-infant interactions and coordinating the wider multi-agency team, such as health visitors. Staff will assess and care-coordinate people newly referred to secondary care services, either during pregnancy or up to the baby being one year old, referring then on to more appropriate teams if necessary.

The CCG also commission a Specialist Mental Health Midwife, based in the maternity services at Barnsley Hospital. This post is the cornerstone of perinatal mental health support in Barnsley as it contributes to the provision of a comprehensive and accessible Maternal Mental Health service throughout Barnsley, providing specialised knowledge, expertise, advice and guidance to women and their families within the hospital and community setting to support them with their mental health in pregnancy and in the early post-natal period. This post is also a source of expertise and advice for Midwives and other health and care professionals, providing maternal mental health advice and education.

There are close links with the maternity services in Barnsley hospital and Barnsley's IAPT (Improving Access to Psychological Therapies) service. Approximately 300 women per year are referred to Barnsley IAPT from the midwifery service, where appropriate, to receive timely intervention.

It is recognised however, that a gap still exists with regards to pre-conception support - how best to provide this is still under discussion. In addition, as recognised in the NHS Long Term Plan (https://www.england.nhs.uk/long-term-plan) we are already looking at how we can better support dads and other partners during this time of change.

7. COLLABORATIVE WORKING WITH NHS ENGLAND

Health and Justice

The Health and Justice priorities for 2020 include the following:

- Working closely with CAMHs to ensure that children and young people can access the trauma pathway, if required, following sexual assault.
- Encouraging CCG commissioners to review the mental health and SALT (Speech and Language Therapy) input into YOTs as the provision is fragmented and under resourced in some areas. The CCN has funded several of these posts in YOTs but more resource is required.
- Consider having a care navigator role to support children and young people transitioning from secure estates into mental health services based within YOTS to provide an assertive outreach role.

Specialised Commissioning

Last year's update highlighted the announcement of developing New Care Models into a steady state of commissioning for specialised services. Progress has moved at pace over the past few months which includes CAMHS in phase one for Lead providers to take on board the responsibility for their health population. This is a shift away from providers competing against each other, and instead collaborating to create a way of commissioning services that are integrated with community services. Provider collaboratives will receive delegated responsibility for commissioning services in these mental health areas and the budget. They will work collectively with STPs and ICSs to plan and commission services across the region, engaging with service-users and stakeholders to plan increasingly tailored services for populations, making efficient use of funding.

Within Yorkshire and the Humber region the chosen lead providers are:

- Humber Area: Humber Teaching NHS Foundation Trust.
- West Yorkshire: Leeds Community Health NHS Trust
- South Yorkshire: Sheffield Children's NHS Foundation Trust.

We expect each provider collaborative to go live between April 2020 and April 2021, where NHSE Specialised Commissioning will work with the Lead Provider to enable this transition.

Parallel to enabling Provider Collaboratives the CAMHS bed reconfiguration continues with the opening of the Hull CAMHS inpatient service by the end of this calendar year. Plans have been submitted for the West Yorkshire development and this work continues to bring 22 beds to this area, based at the St Mary's site in Leeds.

Finally, we have seen this year the opening of a CAMHS low secure service, something which has not been provided for previously in the Y&H region; this is providing more accessible care and treatment for young people requiring a low secure environment.

8. GOVERNANCE

Barnsley has had well-developed partnerships and integrated working arrangements for some time which has enabled strong partnerships to be developed to ensure delivery of the objectives of the local transformation plan. The NHS landscape is ever-changing as we see the developments of Integrated Care Systems and the emergence of Primary Care Networks so we need to continually review our governance arrangements to ensure they remain robust and fit for purpose.

The current governance arrangements are such that the Future in Mind Stakeholder Engagement Group (Appendix 19: TOR) is accountable to both the Children and Young People's Trust (formed in 2007) and the Trust Executive Group (TEG) which was established to ensure a partnership approach to encourage integration on the Children's workforce to prevent the developing of isolated solutions to system-wide issues. Membership of TEG includes the following:

Barnsley Metropolitan Borough Council (BMBC)

- Executive Director for the People Directorate;
- Service Director, Children's Social Care and Safeguarding;
- Service Director, Education, Early Start and Prevention;
- Head of Public Health;
- Interim Head of Barnsley Schools Alliance;
- BMBC Cabinet Members;
- Spokesperson for Achieving Potential;
- Spokesperson for Safeguarding;
- Barnsley Safeguarding Children Board Independent Chairperson;
- Voluntary Action Barnsley;
- Barnsley Hospital NHS Foundation Trust;
- Head of Midwifery;
- Barnsley Association of Head-teachers of Primary, Special and Nursery Schools;
- The Association for Secondary Head-teachers working in Barnsley Local Authority;
- Barnsley Clinical Commissioning Group – Chief Nurse;
- Barnsley College - Vice Principal Teaching, Learning and Student Support;
- South Yorkshire Police – Chief Superintendent;
- South West Yorkshire Partnership Foundation Trust (SWYPFT) - Deputy Director of Operations;
- South Yorkshire Community Rehabilitation Company (CRC), Sheffield/ Barnsley Cluster - Assistant Chief Executive;
- Barnsley Local Medical Committee – GP;
- School Governors;
- Youth Council;
- Job Centre Plus (to be invited as and when required).

BMBC

- Head of Commissioning, Governance and Partnerships;
- Strategic Lead, Procurement and Partnerships;
- Performance Improvement Officer;
- Governance, Partnerships and Projects Officer.

The seniority of the members of the TEG (which reports directly to the Health and Wellbeing Board) reflects the influence that each is able to bring to their organisations. Each member is committed to delivering the transformation plan and this commitment is pivotal in ensuring that the required culture change is effected, this being essential for the transformation plan to succeed.

Reporting to TEG is the Children's Executive Commissioning Group (ECG). Both the TEG and ECG are chaired by the Executive Director for the People Directorate at Barnsley Metropolitan Borough Council, who is also a member of Barnsley's Health and Wellbeing Board.

The Children's Executive Commissioning Group membership includes the following:-

- BMBC Executive Director People (Chair);
- BCCG Chief Nurse;
- BMBC / BCCG Children's Services Commissioners;
- Public Health;
- BMBC Service Director Education, Early Start and Prevention;
- BMBC Service Director Children's Social Care and Safeguarding;
- NHS England.

The Future in Mind Stakeholder Engagement Group is led by the CCG's Chief Nurse and reports directly into the Children's Executive Commissioning Group, in recognition of the fluidity of the group and the access required to key stakeholders to enable partners to drive forward the implementation of the transformation plan.

Barnsley CCG is the nominated lead commissioner for the Future in Mind project and therefore co-ordinates and chairs the Future in Mind Stakeholder Engagement meetings and updates ECG on a monthly basis. These clear and robust governance arrangements are effectively ensuring delivery of the priorities within the transformation plan.

9. SUMMARY – NEXT STEPS

Service transformation to support the emotional health and wellbeing of the children and young people in Barnsley continues to develop at pace due to the sheer commitment, dedication, enthusiasm, passion and vision of all of Barnsley's partners involved in supporting children and young people's emotional health and wellbeing. The evidence being gathered and the powerful testimonies of the young people and their families tell us that we are moving in the right direction. But there remains much to do.

We have developed a new CAMHS Service Specification based on the i-Thrive social model which requires the service to evolve into a 0 – 25 year old service by 2025; we are developing a children and young peoples' emotional health and wellbeing hub to be accessible by all children and young people in Barnsley and situated in the town centre; following the huge success of MindSpace we will develop a second schools-led mental health support team to better support our Primary school-aged children; we will undertake more focused work on 'transition' from children's to adult health services, from year 6 to year 7 and from school to college, to provide a more positive experience for our children and young people at these significant times within their life journey

It is very clear however that the biggest challenges to continuing to implement the local transformation plan are that of workforce and funding. The workforce issues are both a regional and national challenge and we are working closely with our NHS England regional colleagues and service providers to develop robust workforce solutions to ensure the children and young people of Barnsley have improved emotional health and wellbeing and remain resilient throughout their adult life.

As we come to the end of the 'Future in Mind' programme we find ourselves moving towards delivering the recommendations of the NHS Long Term Plan. Once again workforce and funding will be the key challenges to overcome in order to deliver these recommendations successfully and in doing so it will be imperative that we work collaboratively with commissioners and provider organisations (particularly third sector organisations) within the South Yorkshire and Bassetlaw ICS to develop sustainable solutions.

Appendix 1 FiM LTP October 2019 Refresh

Future in Mind - 5 year Funding Allocation

WORK-STREAM PRIORITY	FiM Investment Year 1 2015/16 £	FiM Investment Year 2 2016/17 £	FiM Investment Year 3 2017/18 £	FiM Investment Year 4 2018/19 £	FiM Investment Year 5 2019/2020 £
1. Developing a Community based Eating Disorder Service (Collaborative arrangement with Calderdale, Wakefield, Greater Huddersfield and Kirkless CCG's)	146,000	143,000	143,000	143,000	143,000
2. Building resilience in Primary School Children (THRIVE) (Public Health led)	111,000	98,000	111,000	98,000	110,000
3. School-led mental health therapeutic team (MindSpace) (Wellspring Academy taking the lead)	145,000	335,500 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)	320,038 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)	330,000 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)	320,038 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)
4. CAMHS: SPA / YOT (CAMHS is provided by South West Yorkshire Partnership NHS Foundation Trust)	60,000	103,500	103,100	103,100	103,100
5. Training Young Commissioners (Led by Chilypep)	30,000	20,000	39,575	39,575	39,575
BRV - Boys programme				15,000	40,000
6. Accessing information ('One-stop- shop') (Led by YOT Manager)	20,000	0	0	0	
SYEDA - Eating Disorder Counselling Service in schools- pilot				30,000	30,000
TOTAL INVESTMENT	**512,000**	**710,000**	**716,713**	**758,675**	**785,713**

Appendix 2 FiM LTP October 2019 Refresh

South West Yorkshire Partnership NHS Foundation Trust

BARNSLEY CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)

CHILDREN IN CARE (CiC) PATHWAY

Date issued: July 2017

Author: Children in Care Pathway Lead & General Manager

In consultation with Children in Care Service, Barnsley Metropolitan Borough Council

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Service Description:

The Barnsley CAMHS Children in Care (CiC) Pathway delivers specialist consultation, skills and training to children in care (0-18 years) and their carers' to promote emotional and psychological wellbeing and placement stability. The service offers support and training to carers and the wider professional network, assessment of children and young people's emotional health needs and where appropriate direct therapeutic with a young person and/or their carers for trauma and attachment issues. Liaison and progression to other CAMHS pathways can be made for specialist assessments or pieces of work and the service also signposts and facilitates referral to other services as appropriate to meet identified need.

Background:

The provision of mental health services for children in care have traditionally been viewed as highly complex and lacking structure, with children and young people in care frequently denied access as they often do not meet thresholds for diagnostic criteria, despite the high prevalence of mental health issues in this group (NICE 2015)[1]. There has also been concern around timely access to appropriate therapeutic support for those young people who are in short-term and/or unstable placements.

NICE guidelines on attachment offer best practice advice on the care of children and young people with attachment difficulties including those adopted from care, in care or at high risk of going into care (on the 'edge' of care). One of the key recommendations relates to the need to ensure all children and young people and their parents or carers get equal access to interventions for attachment difficulties regardless of their context.

The evidence suggests this client group needs targeted and dedicated provision that prioritises their needs, allows flexible and timely access to services, alongside the development of clear referral pathways and effective partnership and multiagency working. Statutory guidance is clear that a specialist mental health Children in Care (previously described as 'looked after children') should be provided to support children according to need.[2] The guidance also gives consideration to those on the 'edge of care', adopted from care and special guardianship arrangements. There are many such kinship care arrangements in Barnsley and there is a clear need for work targeting this client group.

Guidance for children in care (NICE 2010)[3] reports on the need for more flexible and accessible services from CAMHS to both help improve mental health and well-being, but also prevent the escalation of challenging

[1] Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care, (NICE, 2015 : nice.org.uk/guidance/ng26)
[2] Promoting the Health of Looked After Children(DoH and DfE, (2015) (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting the health and well-being of looked after children.pdf
[3] Promoting the quality of life of looked after children and young people (2010 NICE: https://www.nice.org.uk/guidance.ph28

behaviours and placement breakdown. The guidance has recommendations specific to CAMHS which includes early identification and prevention of physical and emotional health problems and access to specialist CAMHS services for children and young people who are in care. Guidance also recommends that professional consultancy and regular training; support and education programmes are available for social workers and carers.

The Commons Select Committee report (2016)[4] recognises the significant challenges children in care face accessing mental health service and recommends they be given priority access to mental health assessments by specialist practitioners, with subsequent treatment based on clinical need.

Current context:

NICE guidance reports that children and young people placed out of their local authority area are less likely to receive CAMHS in their new location and there is a clear need for services to prioritise this client group.

Information shared by Barnsley Local Authority in March 2017 indicates that there were 291 children and young people in the care of Barnsley local authority. Of these 93 children were placed outside of Barnsley

- 58 – 0 to 10 miles
- 11 – 10 to 20 miles
- 24 – 20 plus miles

For those Barnsley young people placed out of Borough the CAMHS service in the locality in which the child is residing will assess and offer any service requested to meet their needs.

Likewise Barnsley has significant numbers of out of area children and young people placed in the local area and the CAMHS service accepts referral of these children. There are a number of private beds located within Barnsley and the young people in these specialist placements have complex needs and often present for urgent assessment and crisis management due to presentations of high risk.

In line with statutory guidelines these young people are seen within the Generic Emergency Care Pathway in conjunction with the CiC Pathway. The proactive management of risk via the consultation and training offered to professionals and carers is a key objective of the CiC pathway.

Data:

From 1st April 2016 and 31st January 2017 52 of cases have been reviewed in the consultation clinic of which 32 were from Barnsley and 20 were placed in

[4] Mental health and wellbeing of looked after children: Government response to the Committee's Fourth Report of Session 2015-16, DH & DfE published 2016

Barnsley from another authority and are described as 'out of area' for the purpose of this pathway. Of these 30 cases were then offered a service within specialist CAMHS. This is 19 Barnsley and 11 out of area cases.

As at December 2016 there were 310 children and young people in the care of Barnsley local authority of which 115 had been known to CAMHS at some time and of these 34 were out of area cases.

Currently, the service provides a small dedicated resource for all CiC referred to CAMHS

Referral Process:

The Social Worker completes a referral form to CAMHS ensuring to identify the child as a 'Child in Care'. The referral is then triaged for urgency by the Single Point of Access (SPA) team at CAMHS. If the outcome of triage is that an Emergency assessment is required the referral will be allocated to the Emergency Care Pathway who will see the child and ensure liaison with the CiC Pathway Lead.

The core offer is that the CiC Pathway initially offer an appointment for a consultation clinic meeting with the young person's social worker, foster carers and any other professionals working with the young person. This meeting is not typically attended by the child/ young person or the birth parents. At this meeting, the young person's psychological and emotional health needs are explore and a psychological formulation of the young person's presentation is produced. The purpose of this meeting is to enable a supportive environment for those staff and foster carers to inform a decision about the most appropriate support/intervention including who will be responsible. This plan of care may be for further consultation and support, work directly with carers (either individual or group work), or the young person can be offered further assessment and/or therapeutic work for attachment and trauma issues. Where necessary the child may require an intervention via another Specialist CAMHS pathway and the CiC will always signpost and /or facilitate referral to other services as appropriate.

To facilitate a decision about who should be invited to this meeting the child's Social Worker will be asked to identify and or provide (at the point of referral) the following information:

- The Legal status of the child i:e : which care order they are subject to and who holds Parental Responsibility and the overriding authority for decision making.
- A detailed Chronology
- Any Previous work undertaken both in and out of area and copies of any reports commissioned by social care.
- Details of any prior CAMHS involvement from another CAMHS service and details of the service with dates that is held on the child's social care record (Note: NHS organisations do not have access to a

centralised health record and may need to request details from the relevant CAMH Service)
- Details of agencies involved and current placement details.

Involvement of Children / young people and birth parents:

Where a child / young person or birth parent has requested to attend the CiC consultation meeting the CiC pathway staff will consult with the child's Social Worker to enable a decision to be made on a case by case basis as to how the young person's psychological and emotional health needs are best explored.
Consideration will be given as to the benefits of a CiC consultation and subsequent family meeting or an integrated CiC initial review. This will typically be based on the age and competence of the child, legal rights of the birth parents and the risks and benefits to the child of any decision to include / exclude.

The CiC pathway will seek guidance from the Local Authority with regard the child and family's requests and rights to participate in part or all of the CiC offer. This guidance will also include the legal right to information such as the outcome of any decisions and plans of care agreed.

On reaching a decision upon the participation of children and birth parents the CiC pathway will advise the allocated Social Worker of the dates of any planned meetings and request that they invite the agreed family members in a timely manner**.**

Access to Service:

An appointment for the initial consultation meeting should take place within 6 weeks. If there is clear evidence that a child or young person needs a face-to-face assessment this is prioritised and they will be seen within 2 weeks of the request. This is compared to a commissioned 5 week wait in the generic population.
See flowchart for CiC pathway (see Appendix 1).

Current service provision:

The service will offer an individualised package of care based on assessed need. This package will be agreed by the multiagency team under the guidance of the CiC CAMHS pathway. The CiC pathway will then arrange the delivery of the package from a variety of interventions on offer as below.

1. Advice, consultation and training to carers and the professional networks responsible for the care of children and young people to facilitate the provision of quality parenting and care in order to promote the emotional wellbeing of children and young people in care. This includes the offer of a

12 week Fostering Lasting Attachments group (FLAG) for foster carers, Kinship carers and adoptive parents. This aims to provide carers with support for their therapeutic parenting and increase understanding of their childrens' emotional and behavioural needs through an increasing understanding of attachment theory and its application to the parenting of these children.

2. On-going consultation, advice and training to social workers to assist care planning, the identification of any therapeutic needs, help with placements and transitions for children and young people in care. Consultation is also available to support placements at risk of breakdown and this may be by invitation to a 'core stability meeting 'which is hosted by the Local Authority. Attendance will be by the appropriate member of CAMHS staff with the best knowledge of the family or of the presenting difficulty.

3. Direct assessment of children and young people's emotional health needs and appropriate therapeutic work for trauma and attachment issues from the CAMHS CiC pathway.

4. Access to specialist pathways in CAMHS where this is deemed more appropriate or as an additional requirement to the offer from the CiC pathway.

5. Liaison with wider services and signposting to other services as appropriate, for example early intervention services such as the schools based mental health provision for children in secondary education.

6. Teaching and training.
   The Children in Care pathway contributes to training via the Local Children's Safeguarding Board. The pathway also offer bespoke training on request based on identified need. This can be delivered to professionals and carers.

7. CAMHS representation at the Multi Vulnerability and Complex Abuse (MVCA) case meeting. This forms part of the overall offer for children to ensure collaboration and agreement to the required package of care to meet the needs of this high risk group of children.
   Note: attendance is typically from a member of staff from the CAMHS emergency/ urgent care pathway to ensure urgent response times for allocation are met where required. Liaison with the CiC pathway takes place for CiC cases discussed as required.

8. Provision of consultation to Barnsley's children and young peoples' residential provision.

9. Attendance at the Health & Wellbeing of Children in Care Steering Group.

10. Co–opted attendance for clinical consultation at the Children's Resource Allocation Group (CRAG).

APPENDIX 1

BARNSLEY CAMHS CHILDREN IN CARE PATHWAY

Contact details: Barnsley CAMHS, New Street Health Centre, Upper New Street, Barnsley, S70 1LP Tel: 01226 644829

Referral for Children & Young People in Care Received

Discussion and liaison prior to referral can be offered if required via the CiC pathway leads or CAMHS Single Point of Access (SPA) team
Tel: 01226 644829

Specialist CAMHS Single Point of Access
- Referral form identifies 'Child in Care'
- Screened for urgency (same day)
- Consultation Clinic appointment requested and / or routine face to face assessment within 2 weeks (unless emergency)

Routine

Emergency (24 hour response) or Urgent (1 week response)

CIC Admin / CiC pathway lead
- Arranges appointment for Consultation and sends invites
- Arranges 1-1 session with CiC pathway within 2 weeks if indicated

Emergency / Urgent Care Pathway
Duty Staff to offer response as urgent care pathway and liaise with CiC Pathway Lead to ensure continuity of care, share plan /agree meetings

CiC pathway lead
- Reviews information and requests further information / reports etc.
- Professional network identified confirming invitees with child's social worker
- Agreement reached and recorded as to child / birth family involvement, plan and liaison

Assessment by duty staff
Complete assessment and risk assessment including relevant outcome measures as appropriate

Communicate outcome to CiC pathway lead, allocated social worker and GP as a minimum in writing within 72 hours

Intensive input

Discharge

Consultation Clinic convened (within 6 weeks)
Multi-agency / professional and carer meeting to consider child's needs from attachment/therapeutic perspective.
Consultation with professional network to include foster carers, social worker, education, other health professionals, residential carers, formulate and plan from psychological perspective
Urgent slots and child/ birth family follow up meetings available as needed

Discharge

Further Consultation meetings As above and to support placements at risk of breakdowns

Assessment
(to include multi-disciplinary assessment of complex difficulties)

Intervention	
Attachment focused work	Video feedback (if possible)
Work with carers/system	Individual work with child e.g. trauma focused work / CBT /EMDR
12 week Fostering Lasting Attachment Group (FLAG)	Medical assessment and review when indicated
Theraplay	Dyadic work with child/young person
Consultation to Spring Lane 1 x monthly	Regular reviews/meetings with social care

Refer to other Pathway / Joint Work
E.g. Complex behavioural/Emotional/ASD/LD/ EMDR
(AS PRIORITY GROUP)

Discharge

Further Consultation Review

Communicate outcome to CiC pathway lead, allocated social worker and GP as minimum in writing

APPENDIX 2

South West Yorkshire Partnership NHS
NHS Foundation Trust

Barnsley Child and Adolescent Mental Health Service (CAMHS) Information for Referrers

About CAMHS

The service is designed to meet a wide range of mental health needs in children and young people. These needs will include emotional well-being and mental health issues as well as more complex and/or enduring mental health symptoms that are causing significant impairments in their lives.

Barnsley CAMHS is made up of a multi-disciplinary team that provides a range of evidence based interventions for children, young people and families.

Who can be referred?

All children and young people up to their 18th birthday who are registered with a Barnsley General Practitioner (GP) can be referred to the service where:

- there are concerns about their mental health and/or psychological well-being

and

- where it can be demonstrated that they have received support from professionals in universal services that has not helped to make sufficient improvement to their problems.

or

- their problems are at a significant level that means the referrer feels they need immediate access to assessment and treatment from mental health professionals.

In addition to this, the service offers consultation, assessment and interventions for children and young people with moderate to severe learning disabilities who also have mental health, emotional and behavioural problems.

There is a dedicated pathway for Children in Care who have mental health, emotional and behavioural problems.

The service also provides a 24 hour emergency response for young people actively displaying suicidal ideation or following suicide attempts, with severe symptoms of depression (with suicidal ideation) , life threatening harm to self, harm to others as a result of a mental health concern, acute psychotic symptoms or presentation of anorexia with severe physical symptoms.

How to refer

There is a single point of access (SPA) to CAMHS. Professionals are encouraged to telephone the service to discuss referrals in the first instance on **01226 644829** Monday-Friday 9-5pm.

A referral form for our service needs to be completed and can be posted to:

Barnsley CAMHS
Child & Adolescent Unit
New Street Health Centre
Upper New Street
Barnsley, S70 1LP

Or by Fax : 01226 280897

Or via **secure email** only (i.e.nhs.net) to barnsleycamhs.referrals@nhs.net,

PLEASE NOTE: *Emailed referral forms must come from a secure address such as nhs.net.*

If the national nhs.net guidance is not adhered to it will result in a breach of Information Governance; after which the necessary governance procedures will be followed and appropriate authority informed.

Barnsley CAMHS accept emailed referrals on a completed electronic referral form (not via referral letter)

Emails to the secure email address containing subject matter other than a referral form will be returned to sender

Who can refer?

- GPs, paediatricians and other health workers e.g. public health nurse (school nursing), health visitor.
- Social workers
- Educational psychologists, Special Educational Need & Disability Team , Teachers / educational staff and SENCO's
- Youth Offending Team, Substance misuse workers and Multi Systemic Therapy Team

It is essential to meet with both the young person and parents/carers to gain consent for the referral, explain the referral process and complete initial screening. This will help to identify actual need and encourage attendance for appointments as young people and their families will fully understand the reason for referral.

Referral Guidance Barnsley CAMHS

What makes a good referral?
The more information you can provide, the better we are able to prioritise and respond. Using the CAMHS referral form details the essential information we require, however, please provide any additional information that might be useful along with the referral form.

Routine CAMHS are coloured Black and will be offered an Initial Assessment usually within 5 weeks
Urgent CAMHS are coloured RED and will be triaged within 24 hours Monday – Friday
Where other agencies are more appropriate these are coloured BLUE
The CAMHS Out of Hours service operates for Emergency referrals outside of 'office hours'.

Issue	Symptoms / presenting difficulties	Discuss with / refer to :
Anxiety, General and Social	Worrying about specific situations, Clingy, tearful, bodily symptoms.	Therapies for Anxiety, Depression & Stress (TADS) The Core County Way Barnsley S70 2JW 01226 320 122 / 07597114156 www.tadsbarnsley.co.uk and or discuss with School Nurse or CAMHS SPA
	Panic attacks Severe and disabling phobias (Social and specific phobias). That have not responded to support from universal services	**CAMHS**
Behavioural issues *Poor Behaviour in one setting should be dealt with in universal services in the first instance*	Poor Behaviour at home only	Community Evidence Based parenting programme
	Poor behaviour at School only	School (Learning mentor etc.) Educational Psychologist
	Severe and persistent behaviour at School and home	**CAMHS**
Bereavement (Complex and Unresolved Grief)	**Before referring to CAMHS** The young person should have been given time to experience a normal grief reaction and should then be offered counselling either through school or a recognised bereavement counselling service. **A referral to CAMHS should be made** Where there is a prolonged grief response or where the child/ young person are experiencing significant distress following a death that has occurred in traumatic circumstances.	Explore local Bereavement counselling services, discuss with School Nurse, and family. **CAMHS**
Conduct Disorder	Very severe and persistent behavioural problems, at home, school and in the community, and unresponsive to parent training. If school related – preferable for school/	**CAMHS**

	Educational Psychologist to make referral with relevant background information.	
Deliberate Self Harm	Presenting with maladaptive coping strategies but less severe/frequent/recent.	Discuss with school nurse to support harm reduction, Access SPA for advice.
	Presenting with maladaptive coping strategies (e.g. self-cutting and where recent occurrence).	**CAMHS** Discuss case with duty team to help guide urgency
Depression and low mood *(Where symptoms present for at least 2 weeks)*	Low mood, not impacting on daily life and no risk evident (no suicidal thoughts or self-harm)	**TADS as above in Anxiety**
	Persistent low mood. Physical symptoms – poor sleep (or early wakening) or loss of appetite and weight Cognitive symptoms including pervasive negative thoughts Loss of interest/Social isolation/withdrawal at home and school. Suicidal thoughts without planned intent (discuss urgency of referral with team)	**CAMHS**
	Suicidal thoughts with planned intent **REFER URGENTLY**. Suicidal thoughts without planned intent (discuss urgency of referral with team) Previous attempts to end life	**CAMHS :** urgent priority in hours or discuss as possible CAMHS emergency Out of hours
Eating Issues	Eating Issues (Low Level) – Will only eat certain foods	Discuss with health visitor / school nurse or contact **CAMHS SPA for advice**
	Anorexia: evidence of self-induced weight loss and/or fear of fatness. Rapid and sustained weight loss Bulimia: Persistent binge & purge behaviour. BMI / height to weight ratio may be normal **Tests to be taken prior to referral – Blood tests, full blood counts, urea & electrolytes, liver function, thyroid function & random glucose, Cholesterol, Mg, Ca, Phosphates, ECG.*	**CAMHS** will classify urgency on same day **Where case is not high risk and has not been seen by GP in previous 2 weeks CAMHS will notify GP to request consultation with child in 2 days.*
	Weight to Height ratio will be one indication used by the service regarding the level of priority therefore referrers must include the height and weight information on referral forms.	**CAMHS**: urgent priority or CAMHS and paediatric emergency. **CAMHS may request consultation with GP same day.*
Gender Identity Disorder	Initial discussion / exploration required	LGBT Barnsley
	Strong, persistent cross-gender identification. Persistent discomfort in gender role. Above causing impairment in social, family	**CAMHS** **CAMHS can refer on to Tavistock if necessary after thorough assessment.*

	and school functioning	
Learning Disability	Mental Health, emotional and behavioural problems alongside moderate to severe Learning Disability.	**CAMHS**
Obsessive Compulsive Disorder (OCD)	Repetitive intrusive thoughts, images or behaviour affecting daily life and activity, and disrupting family life. Obsessions/compulsions causing functional impairment.	**CAMHS**
Psychosis or suspected psychosis *If child over 14 years and first episode refer to early intervention in psychosis team*	Active symptoms include: Paranoia, delusional beliefs & abnormal perceptions, (hearing voices & other hallucinations). Fixed, unusual ideas. Negative symptoms include deterioration in self-care & social & family functioning.	Requires consultation may be **CAMHS** or **CAMHS (Urgent)** or **Early Intervention in Psychosis Team**
Post-Traumatic Stress Disorder – Symptoms Following an event very traumatic to the individual	Avoidance of reminders of the traumatic event. Persistent anxiety. Repeated enactment of reminders of the traumatic event. Intrusive thoughts and memories – e.g. nightmares. Sleep disturbance. Hypervigilance. Symptoms continuing longer than three months following event.	**CAMHS**
Suspected Autism Spectrum Disorder / condition (ASD/ASC)	Persistent and severe problems with communication & social & emotional understanding in 2 or more settings – e.g. Home, School. Consider whether referral would be better made by school and/or Educational Psychologist.	**ASDAT**
Suspected Attention Deficit Hyperactivity Disorder (ADHD)	Refer if symptoms persist after parenting work. Poor concentration, Over-activity, Distractibility Impulsivity All the above of early onset before 6 years old and persistent and evident in at least 2 settings, e.g. home, school.	Initially refer to evidence based parenting programme. **CAMHS**

If in doubt please contact CAMHS on Barnsley 01226 644829 to discuss a referral

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Barnsley Child and Adolescent Mental Health Service (CAMHS) Referral Form

Barnsley C.A.M.H.S see Children & Young People with severe, complex or persistent mental health difficulties

Please refer to Barnsley CAMHS Referral Guidance document for further information

Please post to: Child and Adolescent Unit, New Street Health Centre, Upper New Street, Barnsley, S70 1LP

Ring: 01226 644829 *to discuss a referral with the Duty Worker* **Fax to:** 01226 280897 if urgent

Email to: barnsleycamhs.referrals@nhs.net (emailed referrals **must** be via secure email i.e. NHS.net, GCSX, pnn.police.uk)

About the Young Person	About the Referrer
Name:	**Name:**
Also known as:	**Job Title:**
Date of Birth:	**Agency:**
NHS Number:	**Address:**
☐ Male ☐ Female	**Postcode:**
Ethnicity:	**Telephone:**
First Language:	**Email:**
Interpreter required: ☐ Yes ☐ No	**Signature:**
Asylum Seeker: ☐ Yes ☐ No	**Date of referral:**
Home Address:	**Has the young person consented to this referral?** ☐ Yes ☐ No
Postcode:	**Has the parent/carer consented to this referral?** ☐ Yes ☐ No
Method of contact: Post ☐ Telephone ☐ Mobile ☐	**Other people / agencies involved:**
Postal Address (if different):	**Is an Early Help Assessment in place?** ☐ Yes ☐ No If so please attach latest copy and name of lead professional:
Postcode:	**Is a Child In Need plan in place?** ☐ Yes ☐ No If so please attach latest copy and name of lead worker:
Telephone:	**Is there a Child Protection Plan?** ☐ Yes ☐ No If so please attach latest copy and name of lead worker:
Mobile:	**Past CAMHS involvement:** ☐ Yes ☐ No
Parent / Carers names **Relationship**	**Date child/young person last seen:**
School / College:	**Is the young person in the care of the Local Authority?** ☐ Yes ☐ No If yes, please give name of Local Authority responsible for providing care:
Person to contact:	**Name of Social Worker:**
GP Name:	
GP Address:	
GP Post Code:	

Please circle as appropriate			
Is the client attending school?	Yes	No	Sometimes
Do they have positive friendships?	Yes	No	Sometimes
Do they settle and sleep in their own bed?	Yes	No	Sometimes
Do they keep themself safe from harm?	Yes	No	Sometimes
Do they participate in social activities?	Yes	No	Sometimes
Do they eat regularly throughout the day?	Yes	No	Sometimes

Referrers concerns and aims :

Details of mental health difficulties and how these are affecting the child / young person, current situation, relevant background information, what has been tried etc. (Please attach any further information as necessary)

Young Person's concerns and aims (if different)

Can they talk about how they feel? If so who to?

Parent / Carer concerns and aims (if different)

Have other support/self-help methods been applied prior to this referral?

Special Needs and Risk Factors

Does the child/young person have:

Learning disability: Mild ☐ Moderate ☐ Severe ☐ None ☐	**Poor mobility:** Mild ☐ Moderate ☐ Severe ☐ None ☐
Literacy problems: Mild ☐ Moderate ☐ Severe ☐ None ☐	**Sensory impairment:** Mild ☐ Moderate ☐ Severe ☐ None ☐
Other disability / special need – Please specify	
Child Health issues: ☐ Yes ☐ No	**Educational Breakdown:** ☐ Yes ☐ No
Family Health issues: ☐ Yes ☐ No	**Housing issues:** ☐ Yes ☐ No
Parental agoraphobia: ☐ Yes ☐ No	**Parental Separation:** ☐ Yes ☐ No
Parenting Issues : ☐ Yes ☐ No	**Risk of violence / Domestic Abuse:** ☐ Yes ☐ No
Substance Misuse Issues: ☐ Yes ☐ No Alcohol ☐ Drugs ☐	**Youth Offending issues:** ☐ Yes ☐ No Please attach appropriate details (contact name, report, etc.)
Other risk factor – Please specify	

NB: *Below is for CAMHS Internal use only*

Presenting Problem

Adjustment to health issues		Drug and alcohol difficulties		Obsessive compulsive disorder		Relationship difficulties	
Anxiety		Eating disorders		Organic brain disorder		Attachment difficulties	
Conduct disorders		In Crisis		Phobias		Self-harm behaviours	
Depression		Neurodevelopment conditions		Post-traumatic stress disorder		Unexplained physical symptoms	

Additional or Other - Please specify (Bi Polar / Other Psychosis / Emerging Personality Disorders / Gender Discomfort issues)

Office Use:					
Date Received:		**Date read at allocation:**			
People reading at allocation:					
Outcome at allocation:	Urgent : Passed to Duty Worker ☐	Choice ☐	Consultation Clinic ☐		
	Discuss at Team Meeting ☐	Other ☐	Not accepted ☐		

With **all of us** in mind.

Our Voice Matters, Innit

Manifesto

OASIS

OPENING UP AWARENESS & SUPPORT AND INFLUENCING SERVICES

#NotJustMe

RAISING THE VOICE AND AWARENESS OF YOUTH MENTAL HEALTH

CHILYPEP

CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

Horizon Community College

NHS Barnsley Clinical Commissioning Group

Making Our Voices Heard: call to action and change

In Barnsley, the OASIS group (Opening up Awareness and Support, and Influencing Services) have been using creative consultations to talk other children and young people about mental health and emotional wellbeing, to find out what they need and what problems they face.

Now we want to raise our voices to tell others what we've found out!

The Our Voice Matters, Innit? manifesto draws on our key findings and shows some of the issues and difficulties children and young people are dealing with in Barnsley, and more importantly, what has worked well for them!

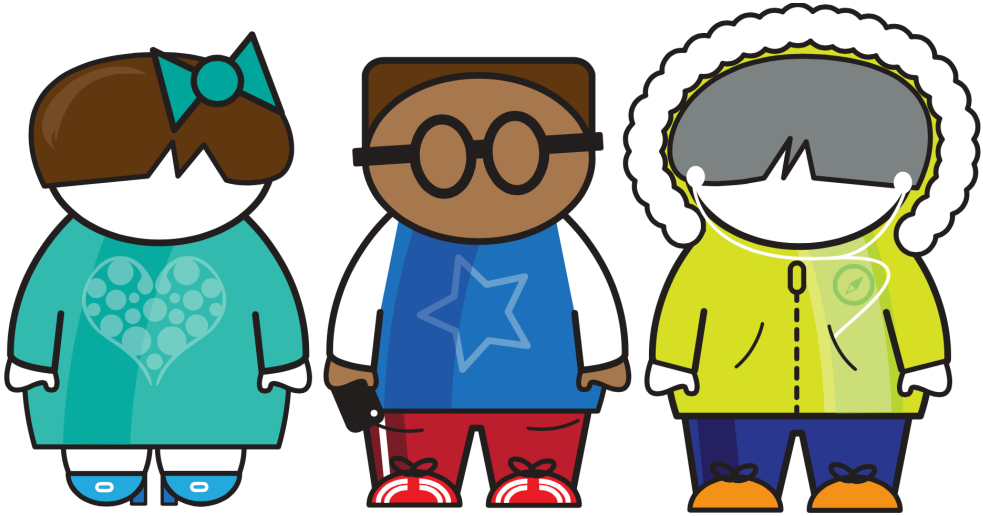
It is our Call to Action and Change, with 8 Key Recommendations, that we hope will inspire children, young people, families, communities, professionals and politicians to focus more attention on improving the emotional wellbeing and mental health of young people.

We want to see everyone in Barnsley work togetether to reduce stigma and isolation. To ensure that supporting young people's resilience, emotional wellbeing, and mental health are everyone's priority.

These stories illustrate the key problems young people face and how they can be improved by Barnsley's services and the wider community.

We hope that they will inspire everyone to think about what they can do to respond to the recommendations - as individuals, members of organisations and communities, and as service providers, commissioners and policy makers.

We believe that by responding to our Call to Action and Change, together we can truly transform services and support for young people today, and create a 'r8 Mental Health Friendly Barnsley' now and for the future!



The OASIS group are facilitated by Chilypep and funded by Barnsley Clinical Commissioning Group as part of the Barnsley Future in Mind Local Area Transformation Plan.

Unite Us: put in place peer support programmes for young people

How would you support someone close to you?

Name: Shelly
Gender: Non binary
Age: 15
Sexuality: Pansexual

I go to a youth group that has a peer-mentoring project for young people in the community. It's really good because other young people who all have similar experiences and understanding run it.

A teacher at school told me about the youth group and the peer-mentoring project. I needed some support and this is something that worked for me.

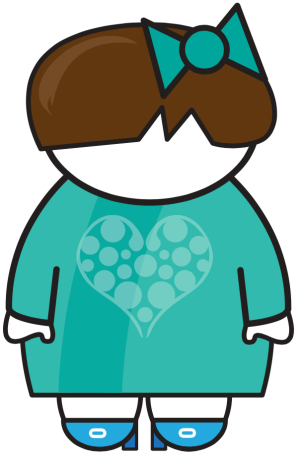
Peer support **unites us**. It gives young people a chance to come together and talk about our issues openly with each other. We make new friends at the group, have a right laugh and build our self-esteem and confidence at the same time.

I've built a great relationship with my mentor and I know the other mentors well. The group provides me with regular activities and a break from home, away from my caring responsibilities. I even get access to a quiet space to catch up on my school work in a relaxing place.

Providing emotional care for my mum who has mental illness is important and I'm glad to be there for her but sometimes I need time for me, which I recognise now. My mentor has shown me different healthy coping mechanisms, which actually work, and I feel more positive about my future and passing my exams at school.

The peer mentors are going to train new young people to become mentors and I think I'd be a good person to help others in the future. I think peer-mentoring projects would be good in different settings. They would support young people moving from primary to secondary school and then into higher education.

It would be great to see this kind of support in other places like mental health in-patient hospitals and supported accommodation. If young people work together it will **UNITE US.**



The majority of young people talked about the value of friendships, naming their friends as a key source of support. Young people involved in groups said that by meeting people of a similar age, with similar experiences, their confidence had improved as well as their general wellbeing. This highlights the need for peer support in relation to mental health and it is recommended that peer support models be developed, as well as therapeutic group work activities, to support young people's emotional wellbeing and mental health.

Left Unsaid: raise awareness of mental health in schools and colleges

What is your attitude towards mental health?

Name: Junior
Gender: Male
Age: 17
Sexuality: Heterosexual

I've had anxiety since I was really young. I didn't realise for a long time that what I was experiencing was a mental illness because I only understood the physical symptoms I had and there wasn't any information I could get about what anxiety is and how it can affect people.

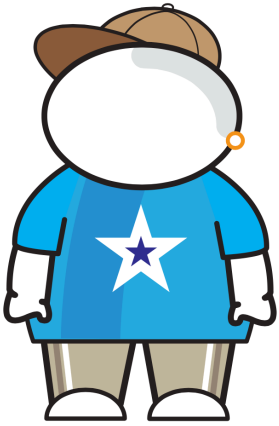
I had a lot of ongoing physical health checks before a doctor explained that what I was going through was in fact, anxiety.

Up 'til that point I didn't even know what anxiety was. I started to understand my illness more when I got counselling support. I couldn't help but feel that other young people might be feeling the same as me and not know why they felt the way they did or understand just like I did.

With anxiety and mental illness it's what is **LEFT UNSAID** that is a huge issue. I remember seeing a campaign poster displayed around the secondary school I went to that the year above me worked on. It was the first time I'd seen anything about mental health openly mentioned like that. We also had a mental health service that came into my school to do an assembly around mental health.

I think that if talking about your emotional wellbeing and feelings from an early age was taught in every primary school and then again at secondary and college age I would have felt less alone and isolated from others whilst growing up.

I always felt that they didn't understand me. Looking back now, other young people could have understood and felt the same and I may have been able to connect to them and get support for mental illness if things weren't **LEFT UNSAID.**



Whilst approximately 50% of those we spoke to had heard about mental health within schools, this was not routinely implemented across all settings. It is therefore recommended that there be more of a focus on mental health education within schools and colleges. This could include assemblies around mental health, workshops, peer-led sessions and talks from external organisations/ mental health providers, and those with lived experience of mental ill health. Young people said they would want this to start in primary school. This would enable young people to understand more about managing their emotions and signs of mental ill health and where to go for support earlier on and prevent issues from escalating at a later age.

Stuck in an 'Ole: improve signposting and information

Would you know where to go for help?

Name: Chrissie
Gender: female
Age: 19
Sexuality: Heterosexual

I'm at college part time but I also work one day a week. I needed some support around depression after I recently lost my dad to cancer and found it hard to cope. I didn't know who to turn to or where to start...

My mum encouraged me to see my GP when I was 18 years old and my GP referred me to a mental health service. It was all quite daunting and scary.

I didn't know what was going to happen next, I was told I would be contacted by the service to book an appointment. I didn't get a phone call and it had been a few days since the doctor referred me to the service and I was starting to feel more worried. I already felt **STUCK IN AN 'OLE** and I'd actually talked to a professional about how I felt and somehow I still felt stuck. I then got a letter for my first appointment one week after visiting the GP. The letter was addressed to me with a date and time and address of where I needed to go for my appointment inside.

I didn't know anything about the service which makes it intimidating but I hoped I could get help from them to make me feel better. My head is still spinning with questions, like, what is the person called that I am going to see? Will they understand what I'm going through? I don't know anything about them. It's making me feel anxious.

What about if someone sees me walking into the building that I know from college, will they judge me? If only the service had called me or sent a text explaining who I was going to see and given me a way to get in touch with them to ask them what treatment they could offer me.

It would be even better if they could meet me outside of the mental health service building in a space I felt comfortable going to. Help us help others to no longer feel **STUCK IN AN 'OLE.**

Whilst some of the young people did refer to mental health provision and services available locally, the majority of these already had experience of such services; there was less awareness about services amongst the general population. This highlights the need to raise awareness more widely amongst the general population of which services and support are available to young people who may be in need of mental health support. Young people said they would like to see the development of an 'online directory' of services so they could know where to go to for support and what is available to them. They would also like to know more about their rights in relation to mental health and the services available to them, and for services to be more flexible about meeting young people away from clinical settings.

Picture This: involve young people in service design and evaluation

Am I not the expert in my own experience?

Name: Jack
Gender: Male
Age: 16
Sexuality: Heterosexual

I guess my family can be a bit complicated sometimes. My dad lives in Thailand so me and my little brother, who is 3, live with my mum. Mum has to work a lot so it's up to me to look after my brother most of the time.

I don't hang out with my friends as much as I used to because I don't go to school any more. I didn't like it anyway. After school finished I spent a lot of time at home with my brother. I started to feel different and didn't know why. Then I was diagnosed with depression and anxiety. I wanted to get help.

I was referred to counselling but the counsellor didn't really get me and that made me frustrated. I didn't think it was helpful so I stopped going.

But then I got involved with what's called the Service User Involvement Group that the counselling service ran once a month. It's where everyone who has had counselling can talk about what it was like and things they'd like to be different. It was only once a month so I managed to make it to every session and still look after my brother.

The group made me feel like I had a voice that was being taken seriously and after a while I even started co-chairing the meetings.

Together the Service User Involvement Group made a young person friendly waiting room with young volunteers from the local college so that it seemed less clinical and more open and approachable for other young people like me. I was able to change counsellor with the same service and now I've built a great relationship with them. The counsellor looked at using different therapies to the ones I'd tried before and that made me feel better.

It really helped me get better when I realized that I could be a part of something that changed things for the better. **PICTURE THIS**...all you have to do is ask and involve us!

Young people showed a desire to be involved in shaping the services and support they received, coming up with many wonderful ideas in relation to service design throughout the consultations. Young people are the experts in their own experiences and in the services and support they would like to receive and it is recommended that there be opportunities for young people to influence service design at all levels to ensure that services best meet the needs of the young people using them.

This could include involving young people in the recruitment of staff, in the design of new services, and in evaluating and reviewing services. Young people said they wanted to be able to have a choice in the interventions they received and wanted to have more of a range of services and support available to them. It is recommended that commissioners and services work with young people to develop a range of interventions to suit individual needs, based on the views of young people.

Create a 'r8 Mental Health Friendly Barnsley': put in place training around mental health for professionals, and communities supporting young people

Are you ready to challenge your perceptions?

Name: Conor
Gender: Male
Age: 21
Sexuality: Asexual

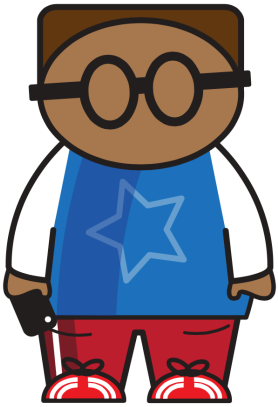
I live with my uncle now because my parents passed away after an accident a few years ago. I haven't really been coping well.

My uncle tries to understand and help but he doesn't get it. My school had no idea about what to do for students struggling with mental health and gave me no support. My friends at school tried to understand but didn't always know what to say or how to help. Most of the time I just didn't want to be around people.

My uncle got in touch with the local youth service and now I've started regularly going to the sessions there, The youth worker there gets it, he makes me feel understood and that helps.
I've made some new friends at the Youth Centre who also have mental health problems, they really understand and I know I can talk to them. I've been referred for counselling and I think the counselors are very supportive but they don't have all the answers.

I've noticed that the differences between the services and support I get from both professionals and friends/family depends on how much they know about and have experienced ill mental health.

Now I want all professionals, schools, colleges and youth workers to have mental health training. I also think parents, families, and other professionals like social workers and benefit workers should be trained around mental health. I think it's really important for everyone to have a greater understanding of mental health problems and the impact it can have on someone. There could be wellbeing events with taster sessions and awareness raising in the town centre to get people talking about mental health. I know that together we can create a **R8 MENTAL HEALTH FRIENDLY BARNSLEY!**



The majority of the young people we spoke to said they would go to friends, family, youth workers, or school or college for support. It is therefore recommended that there be more training and support in place for these workers so that they can feel confident to support young people around their mental health. This could include a training offer for youth workers and schools staff, as well as more awareness aimed at parents around engaging their children in conversations around mental health. As friends were an often named source of support we would recommend working with young people around 'how you could support a friend' to enable them to feel confident in having conversations around mental health and supporting their friends to get the right support.

Keep it Real: support young people to manage stress and pressure

How would you handle the pressure?

Name: Marie
Gender: female
Age: 16
Sexuality: I don't like labels

I have only just turned 16. I get a lot of pressure from my parents to do well in my exams this year.

Both my parents are doctors and they've always wanted me to be a GP too. My mum just had a baby too so I now have a sister and I'm not an only child anymore. I'm doing okay at school but I've had to work so hard on my revision and homework and I'm not sure I can keep it up.

I used to really like school but now all I can think about is how I have to do well in my exams.

I used to play football for my local team but stopped going to the training and kick-abouts because I just had too much work to do. I know the team really want me to go back and play but I just can't fit everything in.

I worry that I'm not getting as much exercise now though. I feel like I need to look a certain way, like my friends who seem perfect. I think they think I'm not pretty enough to hang out with them.

That's why I stopped eating regularly and my parents referred me to an eating disorder service, but I know they are worried that getting help in the medical sector will affect my future job prospects and maybe be a barrier to me becoming a doctor.

I think it sounds like I may have low self-esteem and anxiety. I need more emotional support from my parents but since they had the baby I know they're really busy and I feel like they don't have time for me as much.

So much stress and pressure is building up and all I want is to learn how to get support, know who might be able to help me and look after my own mental health without feeling like I'm doing the wrong thing. If only we could all build awareness around services, support and self-help coping strategies and mechanisms to **KEEP IT REAL** with young people who are struggling with school and peer pressure.

Pressure came up consistently as the main issue impacting on young people's mental health. A large majority of young people spoke about educational pressures, including exams, and pressure to achieve. Young people also felt wider societal pressures, such as pressure from the media to 'be a certain way', pressures around their identity and their futures, and peer pressure and discrimination. Whilst it might not be possible to eliminate the pressures young people face it is recommended that young people be supported to develop coping strategies to deal with the pressures they face and to prevent this from having a negative and lasting impact on their mental health.

Take Time: build relationships with young people

Have you got time for me?

Name: Jade
Gender: Non-binary
Age: 17
Sexuality: I like what I like

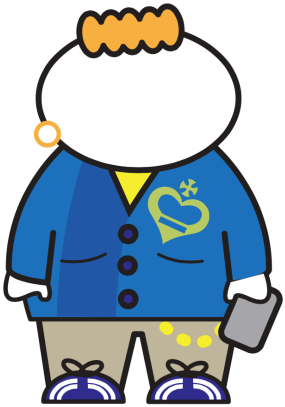
I feel like because I am non-binary, acceptance of my identity has created a lot of stigma amongst my family, and the village in which I live.

No one seems to understand being non binary and I feel pushed away from a community I wish supported me. I spoke to my GP as I was feeling displaced from society and everyone around me. The GP was okay I guess, they referred me to a mental health service but it didn't work for me because the worker had a spiritual approach - it may work for some but not for me.

I then got referred to the college counsellor, in my first session I was told it was one of 5 more sessions I would have with them and my homework was to think of something that makes me smile. Some days I couldn't think of anything. After my 6 sessions were up I was in no better place and was referred to the adult mental health team. In my first appointment I was told I was too young for the service, yet again I was reminded how displaced I felt, not only within the community but also within services and accessing support.

I was told that the Children and Adolescent Mental Health Service may better meet my needs. This time, in my first session I asked how many sessions I would have with them. The worker was really cool and kind and answered by asking me how long a piece of string was. This straight away made me feel at ease and made me smile. I smiled because I felt welcomed and felt able to open up. I was also signposted to the LGBT (lesbian, gay, bisexual and transgender) forum which opened me up to a community of likeminded people and additional support.

For a long time I felt I didn't fit. I began to feel more accepted and a sense of belonging with support from my counselor. **TAKE TIME** to build relationships with us or to get the right support package, not limited time in a certain number of sessions.



Relationships came out as a really important factor in young people feeling comfortable to be able to speak out about their mental health, as well as in how well they engaged with services. Young people said they did not want to have to keep repeating their story, but would instead like to build up a relationship with a worker who could support them consistently over a period of time. They said they wanted to have access to a range of interventions to support their wellbeing, including more informal interventions, and for services to be flexible in meeting their needs.

Knowledge isn't Understanding: give us tools to make it easier for young people to navigate services, and ensure they receive timely, appropriate support

Could you do things differenty?

Name: Lola
Gender: Female
Age: 14
Sexuality: Heterosexual

I used to secretly self-harm regularly as I thought it was helping me cope. I had no previous history of poor mental health and was seen as an A* Student with no problems through everyone else's eyes.

My eyes tell a different story. I opened up to a teacher one day at school as I felt really upset and I trusted the teacher. The teacher explained confidentiality to me and mentioned if I was to say something that causes me or anyone else harm they may have to take it further. I trusted the teacher, I desperately wanted someone to help me. Although I self-harmed secretly, deep down I wanted someone to know.

I used confidential phone lines but every time I felt I was getting somewhere I was told I could only stay on the phone to them for 35 minutes. I could call back but wasn't guaranteed it would be the same person I just spoke with.

I was referred to the Children and Adolescent Mental Health Service and despite a long waiting list, I was asked to sit in the waiting room that was very clinical, dark, and daunting and straight away made me feel anxious. I told the worker that the waiting room made me feel like that and they said they would take this to their Service User Group. Then 6 months later the service user group had painted the waiting room in neutral colours and made it young person friendly with bean bags and comfy cushions. I found my own ways of coping in the meantime by accessing online support but I was exposed to a lot of negative websites in the process. I'd prefer more interactive interventions and creative group work but I didn't know those things were available before I met my worker at the mental health service, so I just looked online.

KNOWLEDGE ISN'T UNDERSTANDING!

It can be very difficult to navigate services and support, particularly when you are experiencing mental ill health. In addition to ensuring young people know about where to go to for support, and what their rights are, we need to ensure that young people are at the centre of services and are able to receive timely and appropriate support. Waiting lists came up several times throughout the consultation as a barrier for young people, and they said they would like to get help early on to prevent their mental health from getting worse before it can get better. Young people said they wanted to have services available to them 24/7 and wanted to see more online support for young people. They wanted the spaces they went to, to feel 'less clinical' and more 'young person friendly'.

For more information visit
www.chilypep.org.uk/oasis

CHILYPEP
CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

NHS
Barnsley
Clinical Commissioning Group

MindSpace

Barnsley College

BARNSLEY SIXTH FORM COLLEGE

Transition Report 2018 - 2019

How students feel about transitioning from school to college

Transitions report 2018 -2019

Overview

Working together with Mindspace Mental Health Ambassadors (MHAs) we talked about their opinions on transitioning from school to college, how it affected them, what they were worried about and what they'd change.

Sessions started with playing transitions Jenga to get an overview of how the MHA's felt in general about transitions, following sessions gathered ideas around collecting information from the wider school population, connecting with the CHIL Peer Mentors, analysing findings and coming up with potential solutions college, sixth form and school could put in place to ease the worries of future students. It was important for MHA's to feel like they could be open and honest with no consequence if we wanted to understand how they really felt, so we spent time getting to know each other and making sure not to cut them off or contradict their points while they were talking.

Transitions Jenga

Transitions Jenga was used with Mental Health Ambassadors and OASIS to build relationships with young people in those groups and get their views generally around school, transitions and college. Concerns were mostly around the size of the college, fitting in and feeling like staff or teachers don't care about their wellbeing. The young people said they are looking forward to trying new things and focusing on subjects they like, this is reflected in the findings for the wider school population. When asked what would help them settle in or what they would want from peer mentors they felt knowing more people, having someone to show them round or support them and feeling like someone cared about their wellbeing would make transitioning a better experience, this is also reflected in later findings. Full write ups of the answers from the Jenga sessions can be made available on request.

Linking with CHIL peer mentors

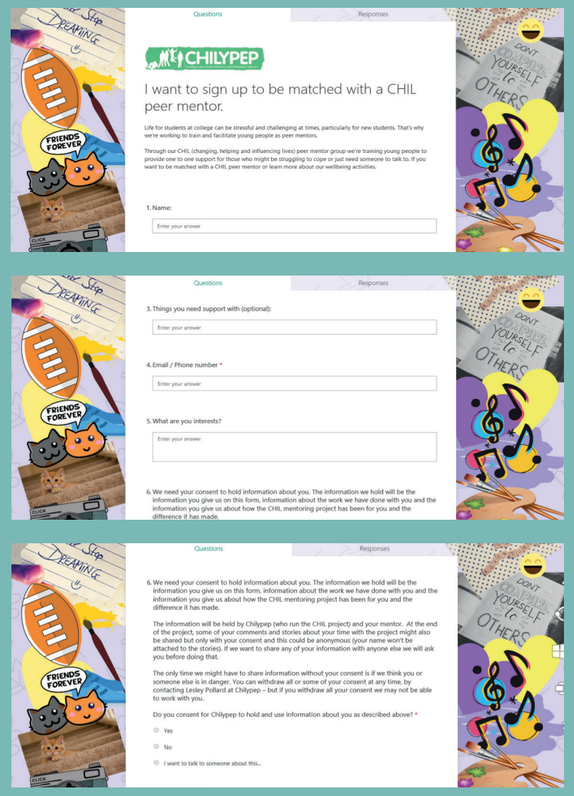
Since an important point that came up through conversations was about having someone to show you where to go and be there for you through the first few weeks at school, we thought about how we could link with the CHIL Peer Mentors already based in Barnsley College and Sixth Form.

The MHA's came up with the idea of being able to apply online to become a mentor or to be matched with one.

They felt this was more accessible for people feeling nervous and it meant that students could be linked with a mentor before attending college, at open days for example, to make the transition easier. The MHA's at Horizon Community College and Kirk Balk Academy designed their own online forms in sessions.

They were asked to consider what information we would need to know and why that information would be required. They decided only the name and contact details would be required and all other questions would be optional. This was to make sure that if someone was in need of a mentor they wouldn't be put off by answering too many questions. As a point of first contact this is all we would need and then when we (CHILYPEP staff) meet with students for the first time we would ask them to fill out our consent forms. MHA's also thought this would be a good opportunity for students to meet with their peer mentors for the first time, with a staff member present, to see if they felt comfortable with each other.

This is to keep the process as gentle as possible. MHA's emphasised how important it was to keep it as low pressure and as easy to access as possible. Opposite are the forms designed by MHA's.



Each group of MHA's chose images and colours they wanted to use to make the form look more inviting and YP friendly. These are going to be accessible via the CHILYPEP website and through schools emailing links to students. These could also be linked to on school websites around Barnsley to reach a wider audience.

Peer mentor pitches

During training of CHIL Peer Mentors we invited Mindspace and the MHA's to join us on the second afternoon. We arranged a tour of student services and health and wellbeing so MHA's will have a greater knowledge of what is available at college and sixth form. The peer mentors also worked on pitches for their ideas about making transitions from school to college easier. Mentors were divided into 2 groups and presented their plans to the MHA's for feedback. Some of their ideas were:

- **Enrolment / interview - people with anxiety could work themselves up into a panic. Intimidating, many students and people, bring someone with them for support.**
- **Induction - tours, fire drill, advise we have more information given than this.**
- **Start college - a room for people to meet if they don't know anyone yet.**
- **Open day - improvements, peer mentors should do group sessions before college starts to help vulnerable people find friends easier and make the first day bearable.**
- **You can meet new people at Wellbeing Wednesdays and GAINSpace.**
- **Travel: there are plenty of bus routes available (as well as the free bus)**
- **How you can destress - wellbeing activities, stress balls and glitter jars, listen to music, talk to someone.**
- **Organisation pack: revision timetable, stay hydrated, stress balls, get enough sleep.**

MHA's found both pitches easy to understand, informative and full of good ideas, one improvement they would make would be having more personal experiences along with the information. After this session one of the CHIL Peer Mentors made a stop motion video which can be found on the CHILYPEP website detailing their transition story, this was a creative and fun way to express their worries, hopes and experiences. We are working on developing case studies around transitions to share with new students. MHA's also made a video for part of their work, describing where students could find suggestion boxes and how to use them. Instead of having to address the whole year in assemblies the video allowed them to convey the same message, but also take pressure off themselves. This is an important tool at our disposal as we can use it to build confidence around speaking to large groups of people about emotional topics. These videos have the potential to be used as part of presentations at schools and colleges, on their websites and social media, as well as at open days.

Suggestion boxes

MHA's decided to collect the views of the student population via suggestion boxes placed in different school's libraries or wellbeing spaces, this would be anonymous so YP felt able to answer freely. Five questions were picked from the transitions Jenga questions, boxes and answer sheets were put in 6 schools across Barnsley, though only 4 ended up collecting responses. Horizon, Kirk Balk, Netherwood and Holy Trinity sent responses we collected 310 overall. MHA's promoted these via assemblies in their own schools and Mindspace supported this as well as doing them in other schools, with Horizon MHA's making a video in their own time for theirs. The charts below show categorisations of the answers and then a breakdown of the issues in those categories. MHA's went through every response reading them out loud and tallying the points for similar answers. This gave them a greater understanding of how the wider student body felt, as they were going to come up with ideas to support students better.

As you can see from the charts most student's concerns when going to college or sixth form were around relationships and education, mostly about picking the right course, getting the grades to get on that course, meeting new people and having no friends.

This changed when students were asked about what would make it difficult for them to attend. The focus shifted to the college environment and mental health mainly focussing around their own mental health and the transport and distance to college or sixth form. When asked about how their experience of transitioning could be improved this answered most of the worries and difficulties in the first two questions. Top answers being concentrated around getting to know the college environment via open evenings, taster days and a transitions week and having parties and meet days to make new friends.

Despite these worries or difficulties students are looking forward to growing personally through their new experiences at college, being more independent and learning more about the subject(s) they are interested in. Though meeting new people was one of the biggest worries, it is something students are also looking forward to the most. When thinking about activities or support college could provide to support better transitions, the top answers corresponded with answers on improving transitions. College could provide more open evenings and taster days, along with tours of the campus other top answers featured relationships, students wanted to have friends to go with before attending and clubs they'd be able to join.

Conclusion and moving forward

After looking at the data together we asked MHA's to decide which answers they felt most important, this meant looking at the quantity of the answers but also the importance and weight of an answer. With this in mind issues around mental health were also considered along with top rated answers.

We then asked the MHA's to think about what college, sixth form and schools could do to support students together overall. All agreed that a transition day or week would be helpful in making people feeling more settled in the college environment, this would include icebreakers, meeting teachers and course mates and getting a welcome pack from the college. Information about transport, any bus discounts or how to get a pass should be included in this pack.

Other ideas for getting used to the environment involve having tours, having school assemblies about college or being able to access a 'summer school.' Ideas for mental health support revolved around having someone to talk to (either staff member or peer mentor), an escape or chill out room to go to when things get too much and a box of fun, which would include the mental health first aid kit and added activities to help you calm down. Being able to join clubs before college is also something a lot of the MHA's felt was important as you might not share the same hobbies and interests as people on your course.

Have your say!

What are your worries about going to college or sixth form?

Is there anything that makes it more difficult for you to attend college or sixth form?

What would improve your experience when moving from school to college?

What are you looking forward to the most about college or sixth form?

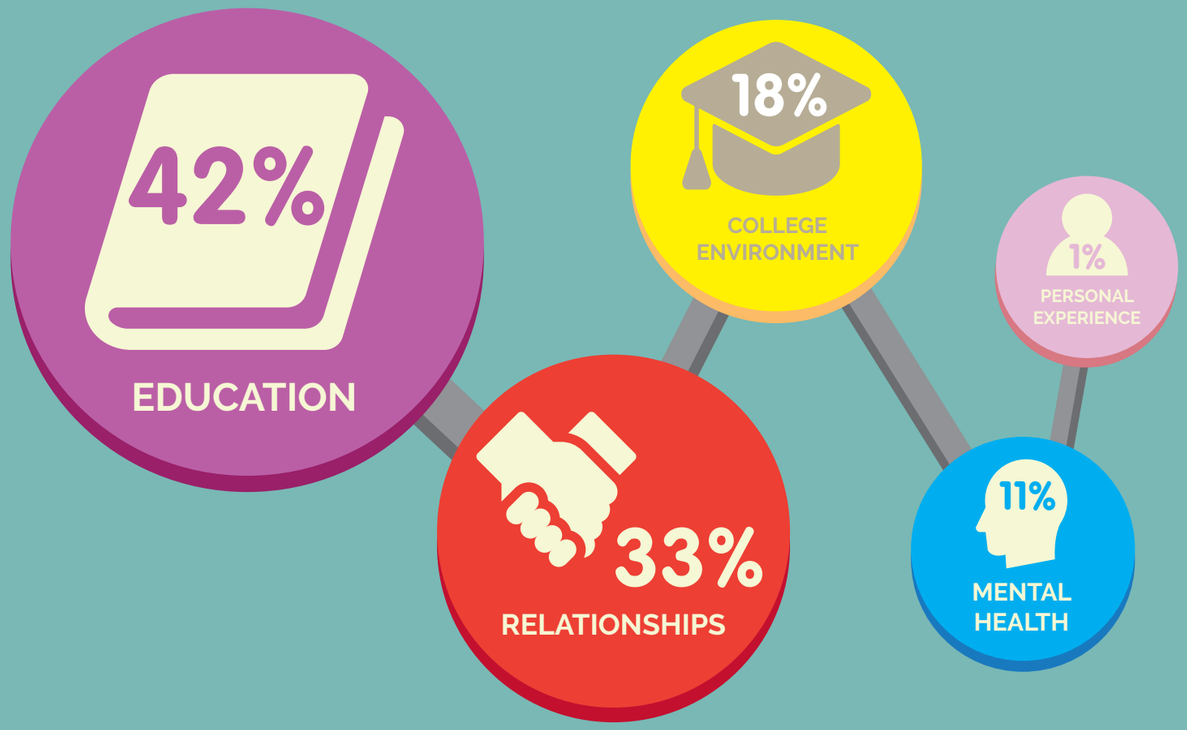
What activities or support could college or sixth form provide to make moving from school to college better?

Any other comments?

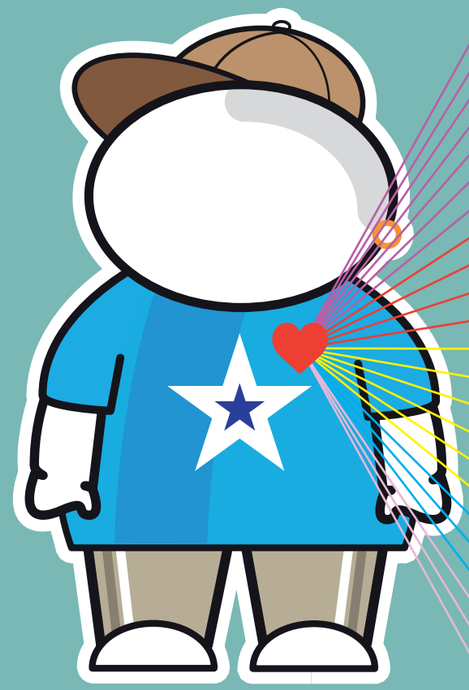
CHILYPEP
CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

MindSpace

Themes - What are your worries?

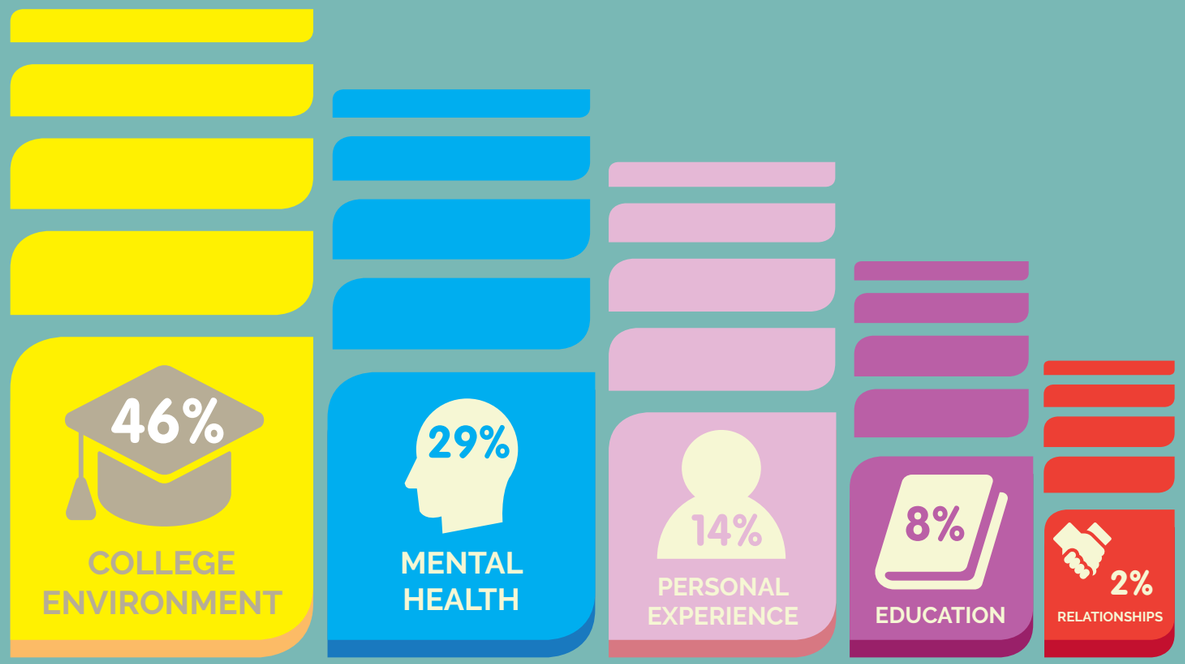


Details - What are your worries?



- 0% - Failing college
- 1% - Interview
- 1% - Expectations
- 5% - Not liking the course
- 6% - Hard work / work load
- 12% Choosing the right course / not knowing what course to do
- 17% - Getting grades / not getting on the course you want
- 0% - Seeing people from this school
- 7% - Fitting in
- 10% - Having no friends / missing friends
- 16% - Meeting new people / friends
- 1% - The food
- 1% - Losing friends
- 3% - New environment
- 4% - Getting lost
- 4% - Getting used to change
- 5% - Transport
- 0% - My depression
- 1% - Bullying
- 10% - Stress
- 0% - Waking up
- 0% - Racism
- 1% - Money

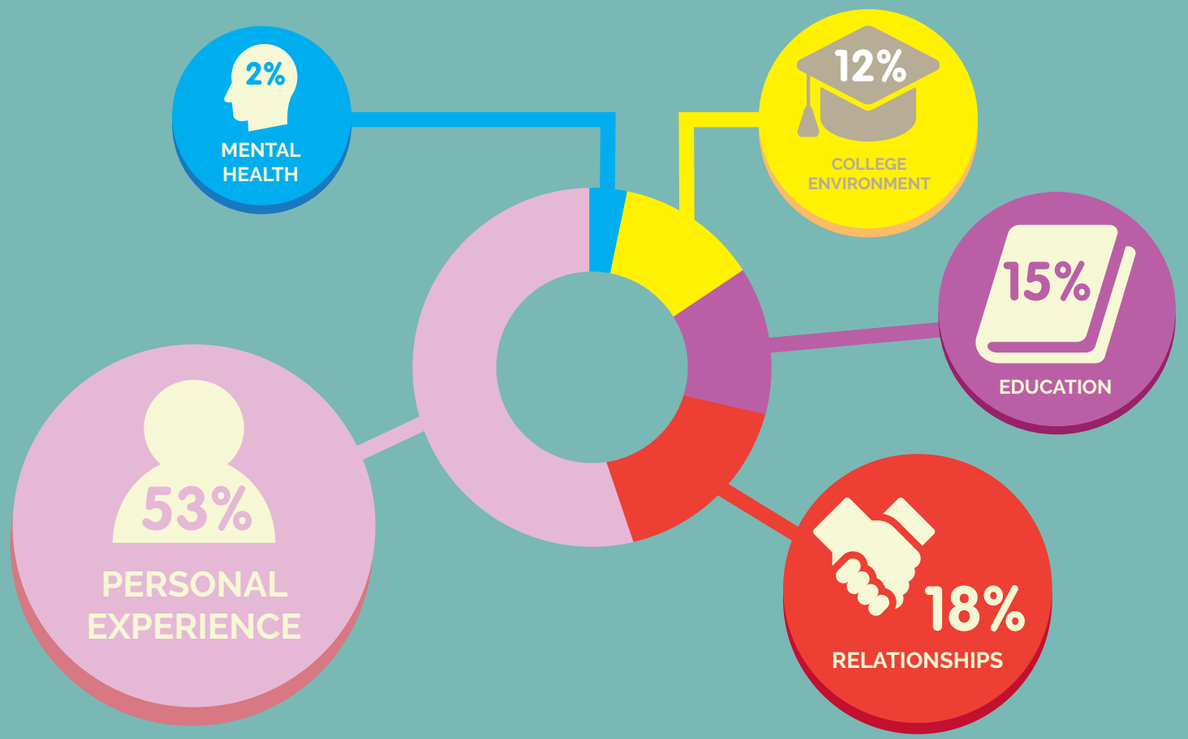
Themes - What makes it difficult for you to attend?



Details - What makes it difficult for you to attend?

- 6% - The distance
- 40% - Transport
- 1% - Change
- 1% - Depression
- 2% - Life
- 2% - Stress
- 5% - Mental health
- 5% - Paranoia
- 6% - Being alone
- 7% - Anxiety
- 1% - Speaking English / English being second language
- 1% - Racism
- 1% - Working
- 1% - Special Educational needs
- 1% - Getting different opportunities
- 2% - Being a parent
- 7% - Medical reasons
- 2% - Choosing where to go
- 6% - Grades
- 1% - Missing old friends
- 1% - Fitting in

Themes - What are you looking forward too?



Details - What are you looking forward too?

This piece of work has given us a great insight into what students are thinking about when it comes to transitioning to sixth form and college. Both the MHA's and CHIL Peer Mentors have come together to suggest possible solutions and support that could be provided.

We can measure the project and findings using Future in Mind criteria, developed by Stairways, NHS Yorkshire and the Humber Clinical Networks and Our Voice Matters, Innit manifesto developed by CYP in OASIS, (Opening up awareness and support and influencing services) is a Chilypep group based in Barnsley that aims to empower young people to shape mental health services.

Take Time: build relationships with young people, features in the Our Voice Manifesto, we have worked as best as we can to make sure we spend time building meaningful relationships with the young people we work with and showing they are truly valued by listening to their ideas, implementing them and coming back to them for evalua-tion, we have done that with both the suggestion boxes and online forms.

The Transitions Project meets several of the Future in Mind criteria, under theme 1: Promoting resilience, prevention and early intervention, we meet work being done to raise awareness and understanding of mental health in schools and Our Voice Manifesto point, Left Unsaid: raise awareness of mental health in schools and colleges by enabling MHA's to consult with and raise awareness around transitions to the wider school population. MHA's and CHIL Peer Mentors have met and some mentors continue to support MHA's they bonded with, as well as developing the idea of students being matched with mentors before college and potentially attending a 'summer school' together. We also want to develop better signposting inside college and to outside services by utilising the Barnsley Open up directory developed by OASIS with peer mentors striving to meet Stuck in an 'Ole: improve signposting and information, from Our voice Manifesto.

Under Future in Mind theme 2: improving access to effective support - a system without tiers, our work linking the MHA's with peer mentors provides a different setting for young people to gain support and when we carry out some of the suggestions made in this report we will be extending and deepening the access to that support. The CHIL peer support programme at college and six form also responds to Unite Us: put in place peer support programmes for young people and Keep it Real: support young people to manage stress and pressure in the Our Voice Manifesto. Reducing the stress and pressure students face when moving from school to college or sixth form by making sure the correct level of support is in place for a stressful time for many young people.

Transition day or week will provide easily accessible and direction to the multiple ways young people can access support through college and sixth form. Transitioning is a time where the most vulnerable need good support, through this work we have identified ways to find those people in need of support and care for them through the process, by making it so they can get in touch easily, either the young person or schools can point them in our direction, they can get in touch through the online forms and we are able to catch them before the transition. Therefore, having time to set up support to cater to their individual needs and levels.

Our presence in both schools, college and sixth form along with support from Mindspace will mean we have greater chance to raise awareness of the work, build relationships and catch vulnerable people at a pivotal time so they can be supported correctly. It is also a piece of the puzzle that goes towards 'Creating a 'r8 Mental Health Friendly Barnsley': put in place training around mental health for professionals, and communities supporting young people' by providing a supportive community at college.

Moving forward we will continue to involve the CYP in developing a resource and or welcome pack for students in collaboration with Barnsley College and Sixth Form. This is looking at addressing not only the concerns of future students but also 'Knowledge isn't Understanding: give us tools to make it easier for young people to navigate services, and ensure they receive timely, appropriate support' from the Our Voice manifesto. We are working towards building better relationships with MHA's in schools across Barnsley, CHIL Peer Mentors, staff and support teams at Barnsley Sixth Form and College. In future we hope to make the move from school, college or sixth form as seamless as possible we will do this by implementing the correct levels of support throughout the process.

To progress with this, we will be using the online forms to catch vulnerable people and potential peer mentors early, as well as advertising it with current college students. We hope to link up with college to provide training and meet ups over summer so young people are able to start college with support in place. We will be developing the ideas peer mentors had for activities aimed at new students and working on welcome packs with all people involved. It will be interesting to interview YP to see how they felt transitioning before and after these processes are put in place then we are able to measure how well processes are working and what impact they are having.

CYP have and will continue to be involved in developing this way of working, they will also be invited to evaluate how changes have been implemented and what difference that has made, meeting Future in Mind theme 4: Accountability and transparency, CYP are involved in service redesign and evaluation this also is in line with Picture This: involve young people in service design and evaluation, from Our Voice Manifesto.

Recommendations:

- **Develop ideas around transitions days and summer school.**
- **Create welcome packs with information YP feel they need.**
- **Continue to show we care about and value YP's ideas by using the 'You Said We Did' model.**
- **Developing ways to support students through choosing courses.**
- **Sharing the online forms created widely.**
- **Preparing activities with peer mentors to be ready at the beginning of college to support people making friends.**

www.chilypep.org.uk

For more information about the Transitions Report, Peer Mentoring or Mental Health Ambassadors please contact Charly: charly.calpin@chilypep.org.uk or call the office on the number provided.

For the full report check the CHILYPEP website under Resources & Reports.

Tel: 0114 234 8846
info@chilypep.org.uk

/Chilypep @Chilypep

‘Parity of esteem'
Valuing mental health equally with physical health!

“Mental health affects us all. It is estimated that 1 in 4 people will suffer from poor mental health at some point in their lives. We all know someone who has struggled with their mental health.

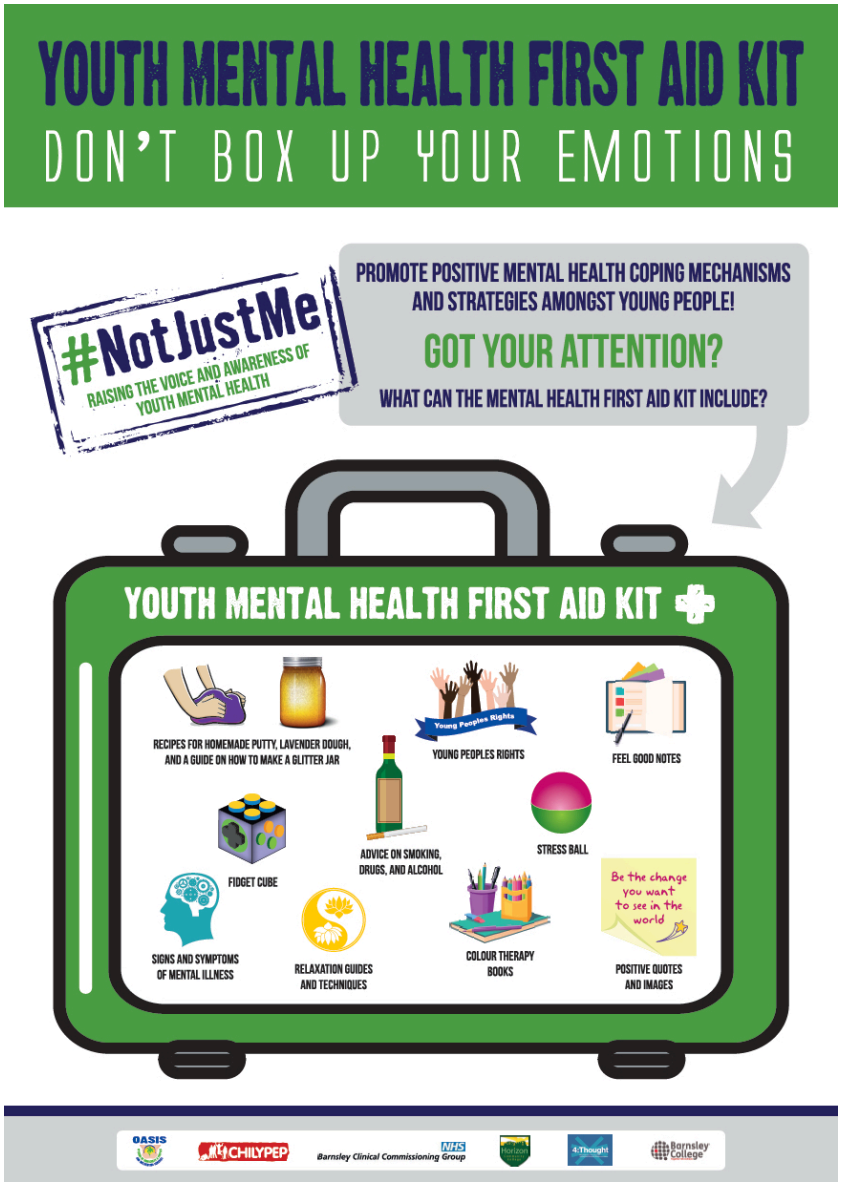
For far too long there has been a stigma attached to mental health. Too many people feel worried about coming forward and talking about it.

But whilst we still have a long way to go to achieve parity of esteem between physical and mental health, I am heartened by the progress we have made. Mental health is finally being seen as a top priority and that is because organisations like Chilypep and Hear My Voice have tirelessly advocated for it. I want to thank them for putting on this event today.

Here in Barnsley, we have been giving mental health the priority it deserves. The Barnsley Local Area Transformation Plan, working with Chilypep, has sought the views of young people about our local mental health services and what can be done to improve them.

Because of this work, a Mental Health First Aid kit will be distributed to all schools and colleges in South Yorkshire. This will make a real difference to young people struggling with mental health issues in our local area.

I would urge everyone here to keep talking to people about this and to keep campaigning for better mental health services.”
MP Dan Jarvis



We want to see a mental health first aid kit in every setting!

Promote self help coping mechanisms and strategies!

Barnsley Local Area Transformation Plan – Chilypep Monitoring Report

July 2019 – September 2019

Outcome 1: Young People will directly influence services and support provided to them through the Future in Mind Programme, by working alongside partners to develop effective services and participation structures within their organisations and in the Future in Mind decision making structures

Activity/Outcomes/ Impact

Strategic Development work

Chilypep Operations Manager represented Chilypep at three Barnsley CCC/SPG (Crisis Care Concordat/ Suicide Prevention Plan) meetings over this period, using one of these meetings to carry out a needs assessment with members in relation to suicide prevention training. As a result of attendance at CCC/SPG Chilypep have agreed to sit on two task and finish groups in relation to crisis care in order to represent young people's views in relation to crisis and emergency services; the crisis café task and finish group (1 meeting attended in this quarter) and the A&E Self-Harm assessment task and finish group (first meeting to take place in Nov 2019).

Meetings with professionals and partners to develop and deliver programme work

3rd July – Meeting with OASIS Member Beth and Public Health around young people's involvement in sexual health and teenage pregnancy services.

14th August – Meeting with OASIS member Beth to develop survey moneky to gain children and young people's views around barnsley sexual health servives.

Young Commissioners and strategic engagement

This year we are involving young people in activity with a range of partners who are responsible for young people's services across the Borough as part of the LTP for Barnsley. To achieve maximum opportunities for young people we will be setting up specific roles within the group with young people to focus on different areas of work, depending on their skills and personal interest. In addition to the weekly OASIS meetings, OASIS members will feedback from participating in their different opportunities outside of the group sessions by reflecting on what role they had and learning obtained through a young person friendly feedback form. This will also help OASIS members

remember the different opportunities they participate in along with the services they are working with. Additional to this for the members who learn through creativity as a way to evaluate the work we have asked them to create a scrap book in the weekly sessions around the work we do. The scrap books were presented at October stakeholder event. OASIS have also been given an individual personal file which they have taken ownership over and decorated and personalised. The folders consist of their own weekly evaluations and session checklist of which they're tasked to complete 3 of the 4 working tasks in weekly sessions.

Chilypep has engaged wider partners within FIM and ensured the voice of YP is being heard through engagement with these stakeholders.

Input at national level

17th and 18th July - BRIGHT Project Focus groups

3 OASIS Members, Georgie, Davina and Leona participated in faciliating focus groups for the BRIGHT Project across 2 different schools in Barnsley and Wakefield. This involved gaining feedbck from students who had been part of a trial invovling the Universtity of Sheffield, to find out what difference it had made and what had been the most helpful.

8th August - NHS Yorkshire and Humber – Stairways New consultation launch: "When I Grow Up I Want To Be…"

Background Information

Within the NHS Yorkshire and Humbers work to improve children and young people's mental health and emotional wellbeing they are often looking for ways to be able to demonstrate that what we do has an impact and is making a difference. One way we do this is by measuring 'outcomes'. An outcome is the end result of a range of activities. An example of an outcome would be that 'less children and young people are self-harming'. A selection of the current NHS Yorkshire and Humbers outcomes they're trying to achieve are measured in a quarterly data pack. Outcomes are often very difficult to measure because they are not achieved by just one thing changing, but as a result of lots of different activities in different places at different times.

Later this year the NHS Yorkshire and Humber will be adding more 'outcomes' to that quarterly data pack so would like young people's opinion on what to include. To achieve this they're launching a consultation called "When I Grow Up I Want To Be…"

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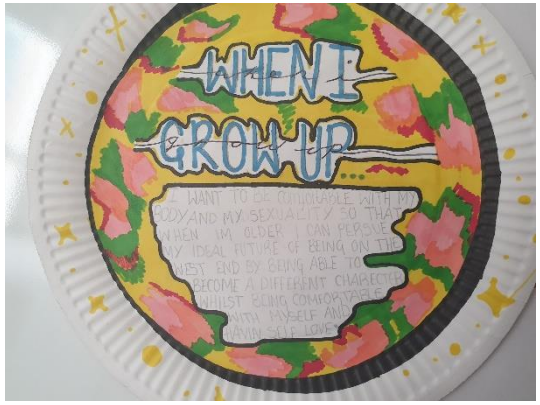
Young People from OASIS and Bransley College Peer Mentors participated in the ‘When I grow up, I want to be’ acitivity an all responses were fedback to the NHS Yorkshire and Humber.

Young People’s repsonses included:



Appendix 6

4th September – Youth participation at Health Innovation Expo 2019, OASIS attend Manchester EXPO Event to showcase digital toolkit

Appendix 6

NHS England/Improvement's Public Participation and Voluntary Partnerships Teams have been working hard to ensure that the contribution young people make to the NHS is reflected at Expo.

Young people were involved in:

1) Meeting and greeting guests and highlight key elements of the programme

2) Interview and film senior leaders and discuss the role of young people through volunteering and social action making a difference (through the Reporters Academy).

3) Participate in Main stage slots with key leaders in health

4) Lead dedicated timeslots on the NHS England/NHS Improvement Stand

5) Participate in activity in the 'zones' (for example the development of primary care, the digital zone etc)

6) Social media reporting using Twitter and Instagram

OASIS took part in the following workshop at the event:

Labels are for jars and jargon is for jokers - learning from the experts on how not to talk to and about children and young people's care

Facilitators at the workshop included:

Katie Matthews - Learning Disability and Autism Network Manager, NHS England;

Jake Mills - Founder, Mental Health charity: Chasing the Stigma,

Claire Murdoch - National Mental Health Director, NHS England and NHS Improvement,

Dr Jean O'Hara - National Clinical Director for Learning Disabilities, Amy Froucks has been involved in shaping the session and will be on hand to support

What young people were at the event?

Expo brought together young representatives from:

· The NHS Youth Forum

The Forum gives a voice to young people to express their thoughts on the health issues that matter most to them. The Youth Forum has been successful in developing campaigns specifically suited to young people and was very influential in the development of the Long-Term Plan.

· Alderhey Youth Forum (Liverpool)

As well as those that have accessed health services at the hospital with long term conditions, the youth forum has reached out to many young people who have been at risk of knife crime and gang culture and enabled them to utilise their energies to improving health services. This has given young people the confidence and aspirations to think about carers in health and social care. Mostly recently with the support of a youth led multi-media company they produced a film the NHS Youth Voice Summit coproduced by NHS England and Young people.

· Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospitals NHS Trust has helped 260 school-leavers as part of its “Young Volunteers” programme since it was set up three years ago. Many young people have since taken up apprenticeships at Hull Royal Infirmary and Castle Hill Hospital or have gone into other health-related careers. A further 50 people aged 16 to 24 have also been signed up as Young Health Champions as part of a project reaching out to young people with depression, anxiety, social issues or conditions such as autism and ADHD.

· Chilypep (Youth Children and Young People's Empowerment Project, Barnsley)

Chilypep works to involve young people aged 8-25 in the policy and decision making of services and organisations which affect them. The charitable organisation has been working with NHS England/Improvement and young people with lived experience of mental health to

create a participation toolkit. The purpose of the toolkit to is support professionals to understand the best way to work with young people with a focus on those affected by mental health.

OASIS Input at local level

21st August – Music Session at the LightBox Library

10 OASIS members attended a Music session hosted by staff at the LightBox Libraray, the session inclused a tour of the library including all facilaities and volunteering opportunities avialble, membership cards for the young people and a muisc recording session in the new studio.

Appendix 6

Since engaging young people from OASIS at the LightBox library and the taster music session, young people have continued to access the weekly music sessions supported by the LightBox. This has not only provided additional opportunity for young people to access activities to support their wellbeing but has also enabled young people to build more confidence on the skills and talent to express their selves.

13th September – Chilypep had telephone call with Valda Smith working around employment and opportunities for young people to discuss possibility of working with OASIS to gain their views around how young people can be involved to help shape change to make better access to employment/careers advise for young people. A future OASIS session date has been booked for representatives from he

services to attend and consult with young people. Chilypep have already began gaining young people's views and engagement around this during weekly sessions.

19th September – Public Health 0-19 services or children and young people's wellbeing needs attended OASIS to jointly feedback consultation finding around the local survey and plan next steps for OASIS involvement. With bullying being an apparent issue that young people in Barnsley would like support around it was agreed OASIS can support co-planning workshops around this that they could help public health 0-19 services facilitate. (See attached consultation findings report). OASIS also worked with Public Health to further prep and support the World Mental Health Day event – BeYou-tiful Minds. The event aimed to being together a range of different services such as Chilypep – OASIS, BRV, Peer Mentors, Public Health 0-19 services, TADS, Samaritans, MindSpace and GreenAcre school.

26th September – Chilypep and two OASIS members Georgie and Caitlin attended Barnsley NHS CCG's AGM at the digital media centre. OASIS helped on the exhibition stall and networked throughout the event. As well as continuing and strengthening the partnership work, OASIS members were able to see achievements around health across Barnsley that are funded through the CCG and feedback that information to the rest of OASIS.

Ongoing OASIS Development work

Appendix 6

4th July Participation toolkit development

4 OASIS Members Ellie, Lucy, Chris and Chloe take part in Digital toolkit filming/ voice over recordings at the Digital Media Centre. We aim to complete the Tooklit by October 2019.

You're Welcome Standards

Public Health consultation with OASIS focused on creating an action plan of development/ ongoing work

The group have already given their feedback and helped to create a new feedback form that is younger person friendly for the Public Health Nurses to use with young people they see. OASIS continue to work with Public Health to look at how they support and engage young people aged 0-19 with a particular focus as to how they can support young people with their mental health in school.

work toward the PHN action plan with OASIS has begun, some pieces of work completed and some ongoing. Within the action plan the following two actions will be worked towards in ongoing partnership.

Public Health Nurses and OASIS - Action Plan

OASIS
How to include social media in promoting PHN services
Video development

PHN Consultation

Consultation has been completed and given back to PHN. Further partnership working opportunities are being discussed, around how PHN, Chilypep and OASIS can continue to work together. PHN team would like OASIS input into the workshops they are delivering in schools with a particular focus on bullying,

15th August- Meeting with Nicola Public Health Nurse Team, shared resources from the Sleep Toolkit developed through work with Peer Mentors and Wellbeing Wednesday Sessions, discussed future working options and links. Nicola invited us to attend Neighborhood Task and Finish group, Children & Young People's Mental Health in Dearne on 3rd OCtober, to see if there is any way Chilypep and OASIS can feed in and support the work currently being done. Nicola continues to use the Mental Health First Aid Kit activities with children she is supporting and has had really positive feedback. Nicola and PHN are booked onto the MHFA training with Chantelle and are really looking forward to this and it has been identified as a gap in their learning.

19th September- Meeting with Nicola and colleague Kim who both attended OASIS session to begin planning for a joint World Mental Health Day Event. Discussed opportunity for OASIS memnbers to deliver some creative wellbeing workshops in the community alongside PHN team, starting with The Hill Primary School.

Youth MHFA Kit

Development of a Mental Health First Aid Kit in Greenacre School during MH week.

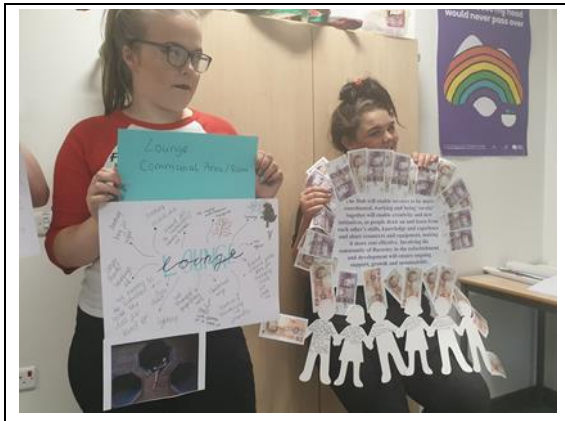
- **5th** June, Chilypep met with Greenacre school council to consult with young people around the design of their MHFA Kit

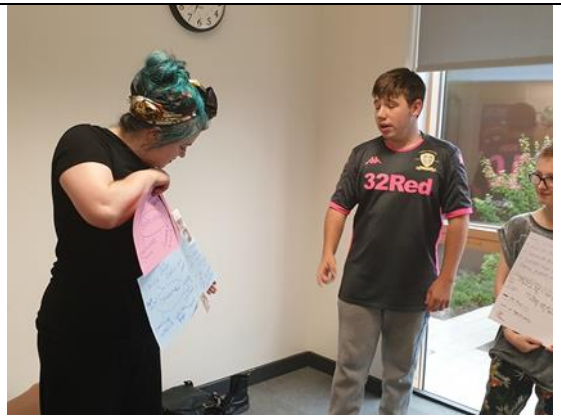
OASIS Session work

- Developing work for the participation toolkit
- Planning the stakeholder event
- Developing the new CAMHS service
- Input to NHS Yorkshire and Humber 'when I grow up, I want to be campaign'

OASIS members took part in developing their own D.I.Y campaign for development of the wellbeing hub in Barnsley. (See attached OASIS D.I.Y campaign write up).

Appendix 6





Outcome 2: Teaching school staff and young people's workers will have improved skills, knowledge and confidence to support young people's mental health and emotional well-being, and be more aware of when to make an appropriate referral to the relevant agency

Activity/Outputs/Outcomes

This year we were asked to develop a mixed programme that schools could choose from, to make the training more bespoke for each school's needs. As every secondary school in Barnsley has had participants attend mental health training through Chilypep, we are now focusing on training others working with young people outside of educational settings as well as primary schools, with the MH training having a focus for delivery to now reach Barnsley's Children and Young people's Workforce.

7th July- 10th July, 21st July -23rd July, 4th Agust-6th August, 2 OASIS Members Chloe and Davina begin their journey to becoming Youth MHFA Intsructors; this involved attending a training course lead by MHFA in Manchester over a 5 week period. The instructor training icluded tasks such as develping their own workshops around a topic of mental health, for Chloe the topic given was recovery and for Davina the topic given was Mental Health and drugs and alcohol.

The second part to completeing the intsructor training was to delver a part of the Youth MHFA Instrutor course, Davina was tasked with depression and Chloe with Eating disorders. Both Chloe and Davina were given extremely positive feedback and high marks from MHFA England.

Appendix 6

On the **19th and 20th August**, Chloe completed her first delivery of the 2 day Youth MHFA course to 10 staff from DOVE, a looked after children provider with fantstic feedback from all participants.

"Expanding my knowledge on mental health and not just the illness side. Loved having this opportunity" **Davina**

"Having the opportunity to train to become an instructor and deliver the training on youth mental health as a young person with lived experience" **Chloe**

"I feel proud to be a young person that has been given the opportunity to complete the Youth MHFA Instructor course, and being able to deliver the content about supporting young people, as a young person with lived experience" **Chloe**

"Proud to have completed the course and passed! It feels so good to be a young person with lived experience of mental health who can help educate others and try to get rid if the stigma surrounding it" **Davina**

Appendix 6

Appendix 6

Overview of Mental Health Training July - September 2019

Total Number of Participants trained in MHFA July-September:

Total number of Youth MHFA training sessions delivered to professionals and young people/students July-September

Training dates set for delivery July-September

24th June – Emotional Wellbeing Seminar Delivered at Barnsley Town Hall, alongside Barnsley College, Mindspace and CAMHS to talk about Mental Health Support and provision in Barnsley.

9 ½ days of training delivered this quarter July-September
Total number of participants trained July- September =

July

- 1st July – Youth MHFA Half Day – Barnsley Central Library
- 9th July – Youth MHFA Half Day – Barnsley Council
- 10th July – Suicide Awareness Training Half Day – Barnsley Council – Suicide prevention strategy training
- 15th and 16th July – 2-day ASIST – Schools
- 17th July – Suicide awareness – General Practice Nurses – Suicide prevention strategy training

August

- 7th August – 1-day Youth MHFA Champion training – Hospital staff
- 19th and 20th August – 2-day Youth MHFA training – Dove LAC Provider
- 30th August – 1-day champion days – Hospital staff

Appendix 6

September

- 17th September – 1-day champion days – Hospital staff
- 24th September – Youth MHFA Half Day – Barnsley Museum staff

Future training sessions booked:

- 14th October – Suicide Awareness – NHS Barnsley CCG/ Barnsley council– Suicide prevention strategy training
- 24th and 25th October 2019 – 2 Day Youth MHFA – Barnsley Primary schools
- 10th November – Half Day Suicide Awareness to Barnsley GP's – Suicide prevention strategy training
- 19th and 20th November – 2 Day Youth MHFA – Newsome Short Breaks
- 5th Feb – SafeTalk – Open course– Suicide prevention strategy training
- 7th February 2020 – Greenacre school staff
- 1st May 2010 – Greenacre school staff
- 2nd and 3rd December – ASIST- CAMHS – Suicide prevention strategy training
- 11th December – Safe Talk Training – Jobcentre – Suicide prevention strategy training

Barnsley Mental Health Training Delivered by Chilypep July-September 2019

The following courses were delivered

Date	Course Title & duration	Number of participants
20 & 21/6/19	Adult Mental Health First Aid, 2 days	12
24/6/19	Youth Mental Health First Aid, ½ day	8
1/7/19	Youth Mental Health First Aid, ½ day	6
9/7/19	Youth Mental Health First Aid, ½ day	6
10/7/19	Suicide Awareness, ½ day	3
15 & 16/7/19	ASIST (Applied Suicide Intervention Skills Training)	13

17/7/19	Suicide Awareness, 1 hour	32
7/8/19	Youth Mental Health First Aid, 1 day	13
19 & 20/8/19	Adult Mental Health First Aid, 2 days	9
30/8/19	Youth Mental Health First Aid, 1 day	15
17/9/19	Youth Mental Health First Aid, 1 day	17
24/9/19	Youth Mental Health First Aid, ½ day	18

Total number of courses delivered: 12

Total number of participants: 152

Full data input has only been done up to 7/8/19 so far – when this is completed, we will be able to provide information about learning outcomes and information about participants (employers, job roles etc).

Comments about the courses from June to 7/8/19 are given below:

YMHFA ½ Day:

- Interesting & Informative. Very good instructor
- Informative and very interesting
- Should have done the longer course. Interesting training course
- I wish we had done the longer course so we could delve into strategies for longer. That would have helped building my confidence in helping young people even more
- Eye opener about so many factors that affects everyone's mental health
- Very interesting to learn about different mental health - anxiety how so much are similar
- Would have like a bit more time spent on strategies to help, less on what causes it - eg a bit more of a positive balance, but appreciate probably more time for this in longer sessions
- Thank you it's been very informative

Appendix 6

YMHFA 1 day:

- Thank you. Very interesting and useful
- Thank you! Need more of this, very useful
- I found the course informative and relevant. I would have like the course to cover young people with SEND
- Inspirational thank you!
- Fabulous! Really interesting. Strongly recommend
- Very informative & interesting training. Very useful to use within practice
- Very helpful insightful course. Chantelle is a very good tutor

AMHFA 2 day:

- Excellent - thank you
- Case scenarios via video were very good in seeing an actual example
- Excellent course thankyou
- Excellent 2 day course! Best course I've done in 5 1/2 years of working here. Presentations were very open and shared personal experiences which encouraged everyone to share & collaborate honestly! Very valuable!!
- The most engaging training I have participated in for a long while. A very good mix of activities, well selected videos and the personal experience of the instructors. Well paced. Will recommend. Thank you.
- The course has been delivered very well, with engaging activities + discussions giving everyone the opportunity to learn about all the topics. Really enjoyed the course
- Really enjoyed course, good to co-teach real life experience, make it real and relevant
- Brilliant course! Everything handled professionally, the session felt comfortable, stress-free and extremely informative. Thank you!
- Chantelle & Roger provide an excellent course, both offering factual content, help & support, but also discuss their personal experiences which makes this easily relatable. Thank you
- Very good course. Both instructors were engaging

Suicide Awareness

What have you gained from the workshop?

- Gained knowledge & understanding & awareness
- Enjoyed the clips and discussion base
- How to approach subject of suicide
- more knowledge around suicide. Groups / demographics and signs to look for
- How to talk to someone with suicide
- Signs of suicide
- resources
- There is help out there but very limited
- Contact information - signposting services available. Ask question
- Advanced / improved knowledge in talking / understanding about suicide
- More knowledge & info re suicide & yp
- To be more aware of the signs, actions, character change
- Open up Barnsley
- Very good speaker
- Awareness & other services. Young person's issues & feelings
- Understanding of suicide and how to talk about it with patients
- That there is little help for some people when reporting depression, suicide. Feel may be able to talk about suicide after the talk - film
- More insight understanding. Statistics - always shocking. Lots of information from a personal level Chantelle Parke
- Helpful tips - signs suicide. How conversation broached

Anything that could be improved?

- A lot to cover - wide topic. Condense slides?
- longer session
- more help could be may available
- longer talk

- Improve waiting times for mental health teams. Support until then from CP family while waiting appt.
- No. Very informative

Further Training?

- Yes. More mental health training within primary care
- May full day workshops on basic skills to enhance listening, supporting, understanding mental health, warning signs
- All aspects of mental health / suicide. Services available

ASIST

- Clear structured phrases to use with a person in crisis. Thank you
- Good course, well presented and very relevant to todays world
- Helpful in role in school to be able to support young people and parents with times of distress
- Trainers were lovely. I would feel anxious about doing an intervention but I am more confident to attempt one
- Trainers created a very supportive environment. More exploration of the scenarios in the video would have been helpful
- Learnt lots thankyou
- Very intense course but very well structured

7th and 8th October – Two Chilypep ASIST instructors attended SafeTalk Instructor training In Brighton and can offer a half day SafeTalk training to support others to become suicide alert. This will be another training course Chilypep can offer under the Barnsley suicide prevention strategy.

Chilypep Barnsley College Project worker has begun a counselling training course to support personal professional development and the needs of young people in Barnsley.

Outcome 3: Young people will have greater resilience and coping skills, helping them deal more effectively with the difficulties they face during key developmental transitions, by receiving emotional wellbeing support.

Activity/Outcomes/ Impact

OASIS Wellbeing sessions

15th August Creative writing Session – Vicky from HIVE attended the OASIS Session and offered the young people an hour's taster creative writing session. All the young people took part and wrote a poem about 'Where they were from' many of the young people went on to attend further creative writing sessions at the Library. The young people's work will form part of a book and they will have the opportunity to attend a Poetry Reading Session on the 24th October.

29th August – OASIS group activity over the summer holidays – Nova City – Parkour and Trampolining

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Mental Health Ambassadors/Transitions work

Barnsley College Peer Mentors

Summer Workshops

Over the summer holidays we ran Four Summer Workshops throughout August for current Peer Mentors and Mentees to access support. We also opened the sessions up to students from year 11 who were hoping to come up to Barnsley College in September as a transition's opportunity. We circulated the Workshops through Barnsley College for promotion and through Mindspace to target students in year 11. Unfortunately, we had no year 11 students attend but this may because the information went out after year 11's had finished their exams. Future learning would be to promote the events much earlier.

The summer workshops were successful in allowing the Mentors to work with Lisa from Health and Wellbeing Team in creating a 'transitions' display board outside the Health and Wellbeing Centre. It was also an opportunity for students who had been regularly accessing the Wellbeing Wednesday sessions to continue to access support during the holidays. As the sessions were quieter it gave students more time to talk to mentors and staff. Through these workshops we referred one student to IAPT and chased up another student's referral to CAMHS as she has been waiting since January after having her initial assessment.

Feedback from Summer Workshops: "I don't know how I would have made it through the summer without these sessions"

Peer Mentor training – We had hoped to run the next round of Peer Mentor training over the summer, we had a list of 12 students interested from last year and some of the details for the Mental Health Ambassadors who are interested in continuing their journey in college as a peer mentor. Unfortunately we only had 3 students who could make the dates we suggested so we have decided to run the training again in October half term which will allow students who signed up through the welcome events to take part also.

15th August – A-level results day Chilypep were available for students on A level results day providing a quiet space for students to have time to reflect before making decisions.

September – Welcome Events & freshers fayres

Chilypep had a stall at each of the Welcome events across the College Campuses, we used the stall to promote the Peer

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Mentoring programme and to conduct a Consultation about their worries and hopes about starting college.

Monday @ Old Mill Lane we spoke to 30 students on the day about Chilypep and CHIL Peer mentors. Peer Mentor supported be in between her lessons.

No students signed up to be peer mentors, but head of the student council was interested in making Chilypep one of his charities of the month promoting us and raising funds. We made glitter jars and did colouring in, some students stayed for the whole time 10am – 2pm others came and made things and then left. We gave them all flyers with QR codes on to apply to be peer mentors or be matched with one. 4 people have used the QR code on the flyers so far.

Tuesday @ Honeywell & The Cube

Engaged with 19 individuals

9 signed up to wellbeing Wednesday/their interest in peer mentoring
Activities included glitter jars, mindfulness colouring, stress balls

Thursday @ Sixth Form: 12/09/2019 10-2pm at the Enrich Theatre

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We spoke to around 50 students on the day about Chilypep and the support and opportunities available with ourselves! Melissa Peer Mentor supported me with the event in between her lessons.

10 students signed up to become part of the Peer Mentoring Programme this year at the stall and others took leaflets away to think about it. All students were told about the Wellbeing Sessions and activities available in GAINSpace. Some of the students that signed up had been part of the Mental Health Ambassadors programme with Mindspace and we keen to continue their journey whilst at college.

There was no space the way the theatre was set up for us to do any wellbeing activities, although a couple of students did make stress balls.

We completed the consultation asking students about Worries and Hopes connected to starting Sixth Form. (see image above)

17th September – Sixth Form Assemblies

Delivered Mental Health Awareness Assembly and Chilypep Promotion to all first year students at sixth former. Over 5 x 45 minute sessions in the lecture theatre 362 students were reached.

18th September – Peer Mentor Information Session

All students who had expressed an interest in this years Peer Mentoring Programme were invited to an information session in GAINspace to find out more and complete paperwork. 8 students attended with others sending apologies due to it taking place during Enrichment time many already had plans. Next Training Dates booked for 30th and 31st October with 25 students signed up to take part.

Tutorials

The tutorials Chilypep have offered to Barnsley College this academic year are:

- Mental Health Awareness
- Sleep
- Managing Stress
- Self Harm and Suicide Awareness
- Men's Mental Health

Booking have been made for October up to December already.

25th September- Chilypep delivered Wellbeing Workshops to the new 14-16 provision alongside a member of staff from Health and Wellbeing Team – I helped lead and assist 2 wellbeing workshops with Tommy (who then did a further 3 workshops) to 15 students.

Activities included bath bomb making, salt chalk jars and stress balls. Students (especially the class of boys labelled as “boisterous”, who loved and were so engaged with bath bomb making) really engaged and enjoyed the activities.

Wellbeing Wednesday Sessions

18th September – A chilled craft and conversation wellbeing Wednesday session. 5 young people attended including a new member who has struggles with ADHD and autism, she really enjoyed the sessions and is interested to keep attending. Another member disclosure the barrier they have attending CAMHS appointments, so support was provided, and further work will occur in attempts to overcome these barriers. Creative activities included, ‘this is me’ writing and drawing about what makes us who we are, and mini zines.

25th September – A busy session engaging with about 13 young people. We discussed how we help our friends when they may be struggling and little things, we can do that help. Inspired by a great idea one of the young people had we made positive quote luggage tags to put all around college. We also answered some consultation questions for Charly’s transition project

October 2nd- Another busy engaging session with about 9 young people decorating sleep masks and discussing tips and things to avoid with sleep. The young people make incredible masks of their favourite characters, and really enjoyed this.

Development work

Discussions are taking place to offer some early intervention structured group work for targeted students who are either waiting for a referral into CAMHS/Counselling/IAPT services in the form of 6-week group sessions looking at psychoeducation and creative coping strategies that can be used to maintain positive emotional wellbeing. The idea is to pilot this with a department after October Half term.

BRV - Boys work

BRV welcomes a new project worker this quarter who will help further develop and support BRV project work with young men in Barnsley. The project worker has begun their Youth work level 3 training course to enable support of the youth work approach and principles and personal professional development.

BRV attended the BeYou-tiful Minds World Mental Health day event on the 10th October with 1 young man from BRV supporting the BRV stall, networking and facilitating discussions around what BRV is to others.

BRV also facilitated one 20-minute assemblies around Mental Health on World mental health day at Outwood Shafton to a total of 250

students.

Meetings for development work:

- 27th August - Safe space meeting with chilypep and who's your neighbour was about work in Doncaster prison and Barnsley area.
- 15th August - Development meeting for 2020 Conference around boys and young men for the BRV project
- Saving lives telephone conference around domestic abuse consultation with BRV boys
- 24th September – Barnardo's junction project – potential collaboration

BRV has continued with 14 young men from Construction at Barnsley college with this being the highest attended lesson with the young men involved.

A new cohort of young men have begun the BRV project at Outwood Shafton Academy across two classes. One to ones also offered on a Wednesday prior to these sessions taking place with boys from across group one and group two.

Group one – 8 boys aged 14/15 – 5 sessions

Group two – 12 boys aged 15/16 – 6 sessions and further opportunity to do continued work for an hour after BRV finishes.

STEM – Informal BRV with 4 boys in terms of developing marketing and publicity and 4 one to ones taking place, referred from Barnsley college

Outcome 4: Develop and deliver an awareness raising, anti-stigma, and information campaign to promote positive mental health, reduce stigma, and signpost young people to available services and support

Activity/Outcomes/ Impact

13th July - OASIS take part in the Mayors Pardade in Barnsley

Not only raising awareness of mental health and OASIS and Chilypep within the community, OASIS actively shouted out loud and proud around youth mental health whilst carring their campaign boards, and giving out awareness goodie bags deisgned and prepped in prior weekly OASIS sessions.

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Chilypep supported Lucy OASIS Young Commissioner and her Mum in their involvement of the suicide awareness film with Barnsley Council and this was launched on World Mental Health Day. This further support our partnership work with Barnsley council and their suicide prevention strategy/plan and their campaign #AlrightPal. The film has had positive feedback and had over 6000 views within the first week of the film being launched.

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For #WorldMentalHealthDay we're sharing Lucy's story of how talking to a trusted person and finding a new passion in life has helped to improve her mental health. #AlrightPal is all about sharing our thoughts and feelings as a first step to getting the right help and support.

The film also linked to providing information about support available in Barnsley at barnsley.gov.uk/AlrightPal and the Samaritan's SHUSH active listening tips to help you have a conversation with someone you might be worried about. #WorldMentalHealthDay

27th September - OASIS helped make the headlines again with positive headlines supporting youth mental health. Below are some of the highlights from the feature.

Members of Chilypep's Barnsley-based OASIS group campaign for better mental health services for young people.

Chilypep's OASIS group, made up of Barnsley Young Commissioners aged 14-25, took part in the Mayor's Parade in Barnsley while handing out mental health goodie bags.

The group are now now getting ready to hold an event called Be-You-tiful Minds, which will take place on Oct 10th, World Mental Health

Day, at the Learning Lab at Barnsley Museums. The event, taking place 1pm – 5pm, will bring together young people, parents and members of the community alongside Chilypep, TADS and other services.

Beth and Davina, 22 and 21 respectively, are both part of OASIS.

Beth, has been involved with the project for over a year and Davina for over two years.

“It’s a great project and I think my favourite thing is working with others to see a positive outcome,” said Beth. “Who better to deliver service improvement than those who have been involved with the services?

Davina added: “For the event on World Mental Health Day we wanted to create a sort of interactive exhibition, on how we can focus on young people better. We are trying to change how people are going into services, so that is why we are working with a lot of services including the public health team. “Mental health is such a taboo subject, but not talking about it isn’t doing anything and it doesn’t mean there aren’t issues there. It’s so important to let services know what they can do to help.”

On World Mental Health Day, members of OASIS are encouraging people to wear yellow, which links to Young Minds and its #HelloYellow campaign.

Chantelle Parke, participation and mental health training co-ordinator for Chilypep said: “The young commissioners from OASIS are truly dedicated to making positive change in the support and services young people get for their mental health. I see their passion and dedication weekly, and how they always go above and beyond to make sure their voices are heard.”

Appendix 6

Youngsters talking about mental health

By Alice Rose

A PROJECT for young people who have experienced mental health issues and which aims to improve services, campaign and get voices heard is holding an event for World Mental Health Day.

OASIS (Opening up Awareness and Support and Influencing Services) is made up of a group of teenagers and young people from 14 to 25 who are young commissioners for Barnsley.

They meet each week to work with local services to help them improve how they approach young people with mental health issues.

The group took part in the Mayor's Parade in Barnsley while giving out mental health awareness goodie bags, and is now getting ready to hold an event called BeYou-tiful Minds which will take place on October 10 for World Mental Health Day in the Learning Lab at Barnsley Museums.

The event, from 1pm to 5pm – will bring together young people, parents, members of the community, alongside Chilypep (Children and young people's empowerment project), TADS (therapies for anxiety, depression and stress) and other services. Beth Goodliffe and Davina Sands, 22 and 21 respectively, are both part of OASIS.

Beth, of Staincross, has been involved with the project for over a year and Davina for two years.

"It's a great project and I think my favourite thing is working with others to see a positive outcome," said Beth.

"Who better to deliver service improvement than the people who have been involved with those services?"

Davina, of Monk Bretton, added: "For the event on World Mental Health Day, we wanted to create a sort of interactive exhibition where it focuses on how we can focus on young people better.

"We are trying to change how people are going into services so that is why we are working with a lot of services, including the public health team.

"Mental health is such a taboo subject, but not talking about it isn't doing anything and it doesn't mean there aren't issues there. It's so important to let services know what they can do to help."

On World Mental Health Day, members of OASIS are encouraging people to wear yellow, which links to Young Minds (an emotional health and well-being charity) and its #HelloYellow campaign.

Chantelle Parke, participation and mental health training co-ordinator for Chilypep, which delivers Oasis, said: "The young people from OASIS young commissioners are truly dedicated to making a change for young people's mental health support and services they receive as well as shouting out loud about mental health in many different ways to reduce the stigma.

"I see their passion and dedication weekly and they always work above and beyond to make sure young people's voices are heard."

PARADE: OASIS members with Barnsley's mayor, Coun Pauline Markham.

Ongoing Campaigns/awareness work:

Open Up Directory

The Open Up Dircetory has been live to download since 22nd Octover 2018. This has also been promoted at national level at the NHS Digital innovations event as well as within every training course delivered to professionals and young people from the jan2019-

Digital Catalogue - click link to see the digital catalogue including some of the CHILYPEP/OASIS work – Youth MHFA Kit and Open Up directory (This link doesn't work??? It comes up with different page?)

march2019.

Updates to the directory include the following;

- Families Information Service: updated 16/2/19

- Early Help for families: updated 15/12/19

- Blink - updated 11/12/18

- Young Minds: added 5/12/18

- updated Barnsley CCG logo on 25/2/19

No updates requested this quarter July-September 2019

The Open up Directory has been promoted on every training course delivered to the Children and young people's workforce.

Youth MHFA kit – Continuing to be updated

Youth MHFA Kit, providing creative self-help wellbeing sessions to young people and teachers.

The Youth MHFA Kit has also been send into the NHS 70 year's good practice online marketplace and a poster designed for this. A postcard to promote the Youth MHFA Kit, manifesto and resources was designed in May 2018 with 200 of these printed and will be promoted out during stalls, events as well as on social media.

The new updated Youth MHFA book has been printed and available for download from the 24th April 2018. CHILYPEP had **500** copies of the Youth MHFA book printed and began handing out to young people in a multitude of young people's settings. The process began throughout May 2018 Mental Health week in the areas Chilypep delivered workshops and activities from the Youth MHFA kit. All 500 printed copies of the Youth MHFA book have now been handed out and will be continued to be promoted throughout delivery of training to the children and young people's workforce.

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Further updates to the Youth MHFA Kit - Ongoing

The Youth MHFA Kit has been updated in **March 2019;** this now includes an additional app page as well as a guide on how to make homemade face masks. We aim to keep updating this to keep adding a range of different creative wellbeing activities and information.

Development of a Mental Health First Aid Kit at Greenacre school - Ongoing

Each class were asked to develop their own mental health first aid kits for use within the classroom setting. All 17 classes across Greenacre School including satellite provision, were asked to develop a kit. Classes were asked that objects/ activities be placed in the boxes that could be used to support the mental health and well-being of each child and young person across all programme areas throughout School. This included pupils in free flow (reception) classes through to College students.

All staff were asked that the boxes stay in each classroom and that this is an ongoing resource available for use, as and when needed by pupils to support their mental Health and wellbeing.

Examples of objects in the boxes were such as bubbles, sensory objects, lavender fragranced products, feelings cards, magic sand, stress balls, feathers, music CD's etc. (We can provide photographic evidence of the contents of each box if needed). Staff are encouraged to add items to the boxes.

- **10th July 2018** – Chilypep attended the SEMH Meeting at Greenacre School to discuss the further development of a youth MHFA kit for primary schools and young people with special educational needs and offer of the Youth MHFA training to teachers. The next steps are for Greenacre School to get back in touch with CHILYPEP after the summer holidays to focus on the development of the kit.
  A meeting took place with Greenacre school on the **19th November** to further explore the development of the kit. Greenacre has developed emotional wellbeing measures which are being implemented into their Ofsted reporting procedures. This now looks at the emotional wellbeing development of young people and provides relevant interventions either class intervention or individual. As part of this the teachers have been asked to write up methods they use around exploring emotional wellbeing in relation to the 5 EWB measures, with this is mind and guides being created for these, discussions included these being part of their mental health first aid kit which Chilypep/OASIS will support the development of.
- **5th June 2019**, Chilypep met with Greenacre school council to consult with young people around the design of their MHFA kit

Manifesto

The OASIS 'Our Voice Matters' Manifesto has been reprinted at 200 copies and has been distributed alongside the Youth MHFA book. This has been continued to be promoted out on delivery of every training course to the children and young people's workforce as well as young people themselves.

The manifesto has also been promoted and used in guidelines as good practice nationally through the Stairways Yorkshire and Humber clinical network group. Stairways ask for feedback every year on the local area transformation plans nationally. To help guide young people Stairways gave a list of criteria to look for. The OASIS Manifesto is references and promoted within their criteria's for reviewing the plans. These criteria are called *'Key Lines of Enquiry'*. They are taken from the Stairways' Charter for Children and Young People's Mental Health Services, Chilypep's Barnsley Manifesto and the Future in Mind Easy Read version.

The OASIS Mission statement has been designed and 200 a5 poster prints printed.

The OASIS manifesto was shared and promoted out by the public health 0-19 nurses on their development day to 100 staff members.

The OASIS manifesto has also been shortened down and designed into a one-page manifesto in December 2018 and is available to download from the Chilypep website by following the link;

http://www.chilypep.org.uk/uploads/Our%20Voice%20Matters%20Manifesto.pdf

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	CYPMHS/2019
Service	Children and Young People's Mental Health Service
Commissioner Lead	Patrick Otway - Head of Commissioning (Mental Health, Children. Maternity and Specialised Services)
Provider Lead	
Period	3 years (with potential for 2 year extension)
Date of Review	September 2022

1. Population Needs

1.1 National/local context and evidence base

There has been universal acknowledgment in policy over the past ten years of the challenges that are faced by children and young people in building resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their parents, carers and the agencies that support them, the challenges are even greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that half of all mental health conditions start by 14 years of age but most cases are undetected and untreated.[1]

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet all of their needs. There is a duty of co-operation placed upon commissioners and services to work together for the benefit of children and young people.

There have been significant changes in Government policies and strategies during the last five years; in particular the ambitions which have been outlined in Future in Mind (2015); the Five Year Forward View for Mental Health (2016) and the NHS Long Term Plan (2019). National and local clinical consensus agrees that there is a need to adopt a whole system, person-centred approach to delivering safe, effective and relevant mental health services for children and young people. Better partnership working, earlier intervention and prevention methods will help to avoid children and young people requiring more intensive support.

[1]World Health Organisation (WHO): https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

1.2 Local Context

As per the Borough Profile (2019)[2] the population of Barnsley is circa 243,341. The 0-18 population is 52,858 (21.7%) and the estimated prevalence of children and young people with a diagnosable mental health condition is 5,080 (9.6%).

In addition to this:

- Nationally, the rate of young people being admitted to hospital as a result of self-harm is increasing, and this is also the case in Barnsley. Barnsley has a rate of 695.2 per 100,000 populations for hospital admissions as a result of self-harm (young people aged 10–24 years). This rate is higher than the England average (421.2 per 100,000) and the highest in the Yorkshire and Humber region (404.4 per 100,000). Nationally, levels of self-harm are higher among young women than young men.[3]

- Barnsley has a rate of hospital admissions for mental health conditions in children and young people (aged 0-17) of 67.7 per 100,000 populations in 2017/18. The rate in Barnsley is lower than the England average of 84.7 per 100,000 but higher than the Yorkshire and Humber average of 58.9.

- The number of Children in Care in Barnsley is currently 301. There are also 180 out of area children in care placed in Barnsley.

- The percentage of Barnsley school-age pupils with special educational needs (SEN) is 14.7% which is higher than the England (14.4%) and Yorkshire and Humber region (14.3%) rates.

- As per the 2018 Future In Mind: Barnsley Transformation Plan (2018 Refresh) approximately 75% of a CAMHS Consultant's workload on the ADHD pathway is related to young person's medication reviews.

- Mental health is one of three top priorities in the 2019-2022 Barnsley Children and Young People's Plan, as voted for by children and young people in Barnsley through the UK Youth Parliament 'Make Your Mark' Campaign (2018).

Integrated Service

This specification details a new approach to providing care for children and young people's mental health. The new model will see an integration of the low-level and specialised support for children, young people, their families and the agencies that support them. This will remove barriers, reduce waiting times and create seamless care.

Traditionally a Children and Adolescent Mental Health Service (CAMHS) specification has been commissioned on a four-tiered framework and this has been the case in Barnsley. The tiered model is now over 20 years old and this specification focuses on moving away from this to implementing the THRIVE model. By acknowledging the radical culture shift the new service will re-design how children and young people

[2] Barnsley Borough Profile 2019: https://www.barnsley.gov.uk/media/11759/our-borough-profile-20190724.pdf
[3] Fingertips data: https://fingertips.phe.org.uk/

access mental health and emotional wellbeing support.

This Children and Young People's Mental Health Service (CYPMHS) will therefore move from a medical to a social model where the medical aspects of a child or young person are assessed as part of their wider needs including their social, behavioural or psychological needs. This approach will avoid the risk of stigmatising the child or young person with language which labels them with pathology and will focus on the strengths and needs of children and young people. The expectation is to a move to a flexible, responsive model and this service specification has been developed to support such.

Children and young people live in families. The service offered will need to ensure that the child is not seen in isolation to their family; that the family is seen as a key partner in improving the wellbeing of the child and that the health of the family (and family members) is an important component in improving the health of the child.

We require Providers to be innovative and offer a solution that provides the right skills, in the right numbers. We require the ability to flex services to meet the needs of the children and young people of Barnsley in accordance with the framework described within this specification. The service must be continuously pioneering and trial new and approved innovations to achieve the best outcomes for children and young people, their families and carers.

Integration in Barnsley

Closer integration between health and all aspects of social care, including Early Help and Targeted Youth Support (TYS), is a fundamental part of both national policy and of local strategy and is essential for population health management. The NHS Long Term Plan (2019) sets out a clear vision for closer working between NHS organisations, social services and the wider health and care system.

Whilst there has been significant progress with health and care integration locally there is a need to accelerate the pace of change. There is growing pressure on budgets. Growth in activity, particularly non-elective hospital admissions, and cost will outstrip growth in funding unless we deliver sustainable service transformation.
We want to create a system for health where governance and accountabilities, contracts and finances, services and pathways, workforce, IT, estates and engagement and involvement are all focused on achieving better health outcomes for local people.

Barnsley Primary Care Network (PCN) and Neighbourhood Networks

Primary Care Networks (PCN) support groups of GP practices to come together in partnership with community services, social care and other providers of health and care services. PCNs build on the core of primary care to enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

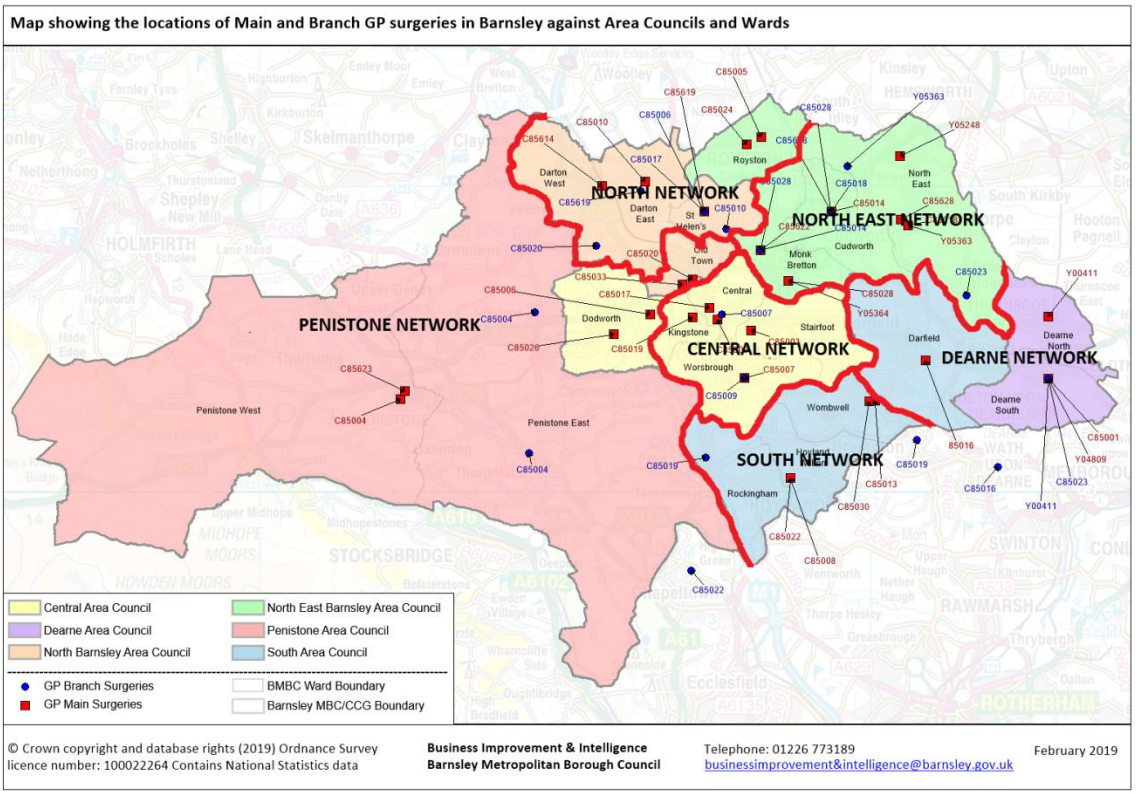
Core characteristics of a PCN:

- Practices working together and with local health and care providers to provide coordinated care through integrated teams;
- Providing care in different ways to match people's needs, including joined up multidisciplinary care for those with more complex conditions;

- Focus on prevention, patient choice and self-care, supporting people to make choices about their care;
- Use of data and technology to assess population needs and inequalities;
- Make best use of collective resources across practices and other health and care providers.

Barnsley Primary Care Network has six neighbourhood networks to deliver the neighbourhood service model, providing clinical leadership from primary care, figure one details the map of the networks.

Figure 1: Barnsley Primary Care Networks



Our Vision

The future of health and care in Barnsley is to create an integrated joined up health and care system. A system where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other across services regardless of where they are seen, be that in hospital, in the community or at home.

Patients and their families are supported and empowered by what feels like "one team", each delivering their part without duplication. Our goal is to dismantle boundaries at the point of delivery of care. The creation of a simpler, integrated health and care system would support a shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance. The aspiration would be for the "one team" to be considered to include Social Care and Voluntary Services.

The Provider(s) will work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their

individual needs, providing a holistic approach. The Provider(s) may also need to refer to other agencies, if the Provider(s) concludes that the needs of child/young people are better met by such. Referrals will be made using agreed protocols.

The multi-agency nature of CYPMHS will require a multi-agency approach to commissioning. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways to ensure appropriate communication and transitions.

Therefore, the Provider(s) should ensure they have excellent links with services regularly used by children and young people, or stakeholders who have an influence in children and young people's services; including (not exhaustive):

- General Practice;
- Schools and academies, further education colleges and other education providers;
- 0-19 Nursing Service;
- Children centres and early years settings (nurseries);
- Early help providers;
- Health visitors;
- Other mental health services (adult, forensic);
- Voluntary and independent sector providers;
- Inpatient and specialist outpatient services;
- Safeguarding – children and adults (Local Safeguarding Children's Board);
- Local authorities, Public Health, Health Education;
- Acute sector hospitals;
- Emergency departments;
- Community child health;
- Targeted Youth Service, including Youth Justice, Substance Misuse, Early help teenagers and support to families;
- Secure settings – including Local Authority Secure Children's Homes, and via the Youth Justice Service, Secure Training Centres, Secure Schools and Young Offender Institutes
- Substance Misuse services;
- Job centres and careers advice;
- School Nursing; and
- Perinatal mental health services.

Service Model

The new model will provide a truly integrated service with seamless care for children, young people and their families. Figure 2 below illustrates the support available from the four quadrants: Getting Advice (Coping), Getting Help, Getting More Help and Getting Risk Support.

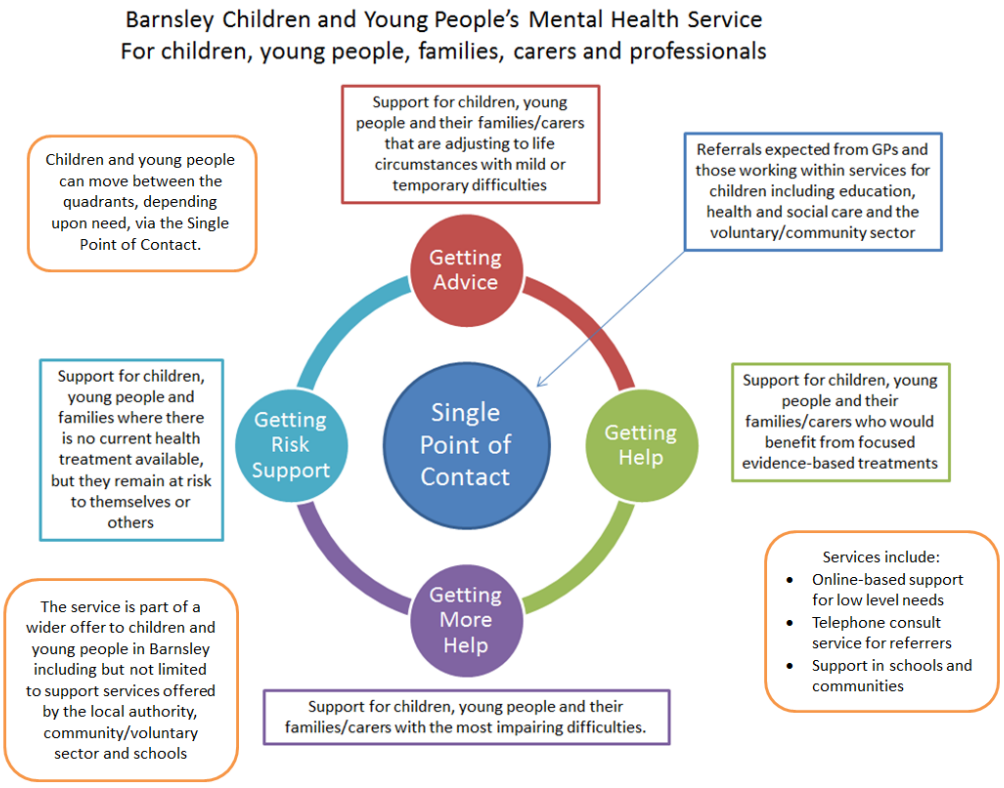
Children and young people will be referred for the right support for their needs via a Single Point of Contact (SPC). The service will also provide in-reach support to schools and communities, complementing the existing provision in schools, the local authority and local mental health charities.

Getting Help and Getting More Help will be managed by a specialist mental health Provider(s) and in line with the THRIVE model, Getting Risk Support will be social care led with a strong interface with the specialist mental health services. The aim is to remove the barriers between services to create seamless support at any level of the quadrants.

A key priority in delivering this service specification will be for the service Provider(s) to have a robust understanding of the required demand and capacity to appropriately support the emotional health and wellbeing needs of the children and young people of Barnsley. In addition to developing accurate demand and capacity modelling there is the potential value of increased group work plus greater use of briefer interventions such as groups, drop-ins and increased use of technology (for parents/carers as well as children and young people).

Whilst this specification is a tierless system, NHS England Specialised Commissioning commissions very specific services known as Tier 4 and it is expected that the Provider(s) will interface with this provision. Tier 4 CAMHS offers inpatient services for those children in the greatest need (section 11 of this specification provides detail relating to expected interaction with Tier 4).

Figure 2: Service Model



Age

As outlined in the NHS Long Term Plan (2019) between the ages of 16-18, young people are more susceptible to mental illness, undergoing physiological change and making important transitions in their lives. The structure of mental health services often creates gaps for young people undergoing the transition from children and young people's mental health services to appropriate support including adult mental health services. The new Barnsley model will aim to develop and extend current services to

create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults throughout the duration of the contract.

1.3 Local Engagement

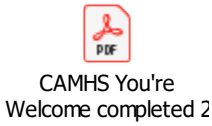
This specification has been developed in collaboration with stakeholders and will be commissioned by NHS Barnsley CCG. Within Barnsley there has been recent work to understand what people think about children and young people's mental health services.

This includes:

- John Healey MP survey on mental health crisis in Barnsley school (2018):

- Healthwatch: CAMHS Parents and Carers User Experience Report (2018):

- CHILYPEP and OASIS You're Welcome standards (2019):



In addition, to help create this service specification, engagement with children, young people, their parents/carers, professionals and the public has taken place. From this we have a detailed picture of what key stakeholders expect from a mental health service for children and young people.

The following key elements have been written into the specification based on feedback to date:

- A joined up offer of more low-level support as well as specialised clinical support;
- Offer children and young people robust, ongoing support while they are waiting to be seen;
- The service will see people up to the age of 25 (this would be a gradual change). NB – The Local Authority have a Statutory duty to support Children in Care up to the age of 25 – where possible and appropriate the CAMHS Children in Care pathway should provide support to Barnsley's Children in Care up to the age of 25 also – this may be a service development that is considered throughout the life of the contract
- The service will see children and young people outside of school/college hours wherever possible so that they do not have to miss lessons to get support;
- Children and young people want to be more involved in their treatment and care planning;
- Parents and carers would like more support when their child/young person is being seen by the service;

- The treatment environment should be suitable for children / young people, as appropriate
- The service should provide technologically-based support tools such as online self-help and apps.

We would anticipate key stakeholders being able to continue to influence service development throughout the duration of the contract.

2. Policies and Guidance

2.1 National and Local Policies

The Provider(s) must comply with all National and local requirements/duties within the listed legislation and policies and any subsequent legislation and policies relating to children's and young people's mental health and emotional wellbeing which comes into place throughout the duration of the contract.

National Policies

1. Mental Health Act (2007)
2. Mental Capacity Act (2005)
3. Children and Families Act (2014)
4. Equality Act (2010)
5. Care Act (2014)
6. No Health without Mental Health, Department of Health (2011)
7. Healthy Lives, Healthy People White Paper: Our strategy for public health in England (2011)
8. The Children Act (1989)
9. The Children Act (2004)
10. Counter-Terrorism and Security Act (2015)
11. Children and Social Work Act (2017)
12. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (2015)
13. RCPCH Safeguarding Children and Young People: Roles and Competences for Health Care Staff (2019)
14. NHS England: Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015)
15. Five Year Forward View to Mental Health (2016)
16. National Future In Mind Report (2015)
17. Transforming Care Model Service Specifications: Supporting implementation of the service model (2017)
18. Transforming children and young people's mental health provision: a green paper and next steps (2017)
19. NHS Long Term Plan (2019)

Local Policies

1. Joint Strategic Needs Assessment (JSNA) (2016)
2. Barnsley's 'Future in Mind' Local Transformation Plan (LTP) 2015-2020
3. South Yorkshire and Bassetlaw ICS Sustainability and Transformation Plan
4. Barnsley's Health and Wellbeing Strategy (2016-2020)
5. Barnsley Children and Young People's Plan (2019-2022)
6. Barnsley Children in Care and Care Leavers Information (2019)

3. Outcomes

3.1Service Outcomes

NHS Barnsley CCG support a positive culture shift through the application of the THRIVE model. The Provider(s) will embed the principles of the THRIVE model to commission a goal-focused, patient-centred, whole-system approach to supporting children and young people with mental health and emotional wellbeing issues. The service will be designed to fit around the needs of children and young people locally. The Provider(s) will be the champion across the system, utilising other services to form part of the wider local offer, and in particular low level mental health support services in Barnsley's schools / education settings (as per the Green Paper, Transforming children and young people's mental health provision, 2017). The use of a whole system collaborative approach and evidence from the needs assessment will support this new model of care.

The service will be expected to work closely with existing community and voluntary sector services which work with children and young people experiencing mental health issues, but in particular should develop strong relationships with CHILYPEP and Barnsley's Young Commissioners, OASIS.

The service will perform and operate to these following service outcomes and also align to the NHS Barnsley CCG's outcome framework stated in 3.2.

As per the Future in Mind (2015) key proposals, the service will:

1. Improve public awareness and understanding about mental health issues for children and young people to tackle stigma and discrimination;
2. Provide children and young people with timely access to clinically effective mental health support;
3. Instigate a step change in how care is delivered, moving towards a system built around the needs of children, young people and their families (away from the 'tiered' model);
4. Increase use of evidence-based treatments with services rigorously focussed on outcomes;
5. Make mental health support more visible and easily accessible for children and young people;
6. Improve care for children and young people in crisis so they are supported in the right place at the right time and as close to home as possible;
7. Improve access for parents/carers to evidence-based programmes of intervention and support to strengthen attachment between parent/carer and child, avoid early trauma, build resilience and improve behaviour.
8. Provide a better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when and where they need it;
9. Improve transparency and accountability across the whole system to drive further improvements in outcomes.
10. Ensure professionals who work with children and young people are trained in child development and mental health and understand what can be done to provide help and support for those who need it.

3.2 NHS Outcomes Framework Domains & Indicators

Domain	Description	Met (Yes/No)
Domain 1	Preventing people from dying prematurely	Yes
Domain 2	Enhancing quality of life for people with long-term conditions	Yes
Domain 3	Helping people to recover from episodes of ill-health or following injury	Yes
Domain 4	Ensuring people have a positive experience of care	Yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Yes

3.3 Public Health Outcome Framework

Domain 2	Health Improvement	X
Domain 4	Healthcare, public health and preventing premature mortality	X

3.4 Service Outcomes, Key Performance Indicators and Reporting Requirements

Outcome 1: To Deliver the THRIVE Model

The Provider(s) will implement a tierless system to children and adolescent mental health services.

To deliver this outcome you will:

- Ensure the service is designed around the needs of children, young people, their parents/carers and there is a proactive shift to early intervention and prevention;
- Depending upon assessment, children and young people may enter the service at any one of the quadrants: Getting Advice (Coping), Getting Help, Getting More Help, or Getting Risk Support;
- Ensure that children and young people receive the right care at the right time, with the right professional or clinician for their care, supporting escalation where necessary, whilst addressing the child's or young person's needs at the lowest possible level of intervention;
- Ensure that there is an effective referral system that prioritises referrals based on urgency, complexity and clinical need (see section 6 for more detail on the referral process);
- Ensure that however children and young people first present with difficulties, all referrals are responded to quickly and effectively, so that the child's or young person's condition does not deteriorate;
- Ensure that the child or young person is kept safe with the least restrictive intervention;
- Deliver consistent waiting times regardless of the child's or young person's age, location or referral method, providing equity of quality and access whilst providing a locality focus;
- Ensure there is support available within the whole system approach for lower level mental health issues to reduce the number of children and young people whose difficulties then escalate to needing a clinical response;
- Ensure the care provided is delivered by staff with the necessary competencies, training and skills and have the appropriate qualifications and registrations to

meet the needs of the children and young people;

- Operate a seamless step-up-step-down model of provision to ensure a responsive approach to managing children and young people's mental health according to their level of need and required support;
- Provide support and guidance for the child, young person, their parents/carers whilst navigating the mental health pathway to ensure that they are provided with appropriate support with the most relevant service to meet the needs of the child or young person;
- Work with parents/carers to understand reasons why children or young people are not brought to appointments and work creatively based on findings to maintain high engagement rates throughout the duration of the contract;
- Operate a policy which supports children and young people who are not brought to appointments making contact with the child or young person, parents/carers as appropriate and the Provider(s) will not close a case without informing the referrer that the child or young person has not been brought;
- The Single Point of Contact (SPC) will then make explicit re-engagement policies available to referrers, children, young people and parents/carers;
- Explore creative means to ensure that interventions are offered in styles and settings which promote engagement with children, young people and parents/carers;
- Routine Outcome Measures (ROMs) must be used to support clinical discussions and service improvement;
- Taking into account the treatment trajectories (to be agreed between Commissioner and Provider(s) prior to the commencement of the contract) the Provider(s) must have a full understanding of the service capacity levels and staff workloads. This will be evolving and the Provider(s) will continually work to understand demand and capacity;
- The Provider(s) will use technology which enables interaction with the Shared Care Record;
- The 'backlog' or number of children who have been waiting for treatment will be addressed, in particular for ADHD, by working in partnership with existing Providers and utilising technology for example apps or online support.
- The Provider(s) will deliver comprehensive early support to pre-school families including parenting programmes, to reduce the need for specialised support.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 2: To Deliver the THRIVE Model (Getting Advice - Coping)

To support children, young people and their families/carers that are adjusting to life circumstances with mild or temporary difficulties.

To deliver this outcome you will:

- Provide support, information, advice and guidance to children, young people, their families/carers through a variety of methods, who present with mild or temporary difficulties whilst navigating the mental health pathway to ensure that they are provided with appropriate support with the most relevant service to meet their needs;

- Develop, in collaboration with local third sector provider(s), two mental health support teams in schools which reflect the aims and objectives of the Green paper, Transforming children and young peoples' mental health provision (2017). One of these teams should support the emotional health and wellbeing of our pupils in each of the 10 Barnsley Secondary Schools and one team is to support the more vulnerable primary school-aged children, especially those who are educated at home, children in care and those pupils who identify as being part of the LGBTQ+ community
- Promote and enable increased resilience building and emotional wellbeing within children, young people and their families/carers and the wider community through a variety of methods (e.g. peer support models);
- Embed the principles of THRIVE by being the champion of the children and young people's mental health system and support the development of the capacity and confidence in staff across the children's workforce
- Provide advice, support and training to universal services to enable seamless access to the right support for children and young people, in particular it is expected that the service:
    - Provide in-reach support to communities including but not exclusive to parents and expectant mothers focusing on prevention and skills;
    - Provide in-reach support to schools and colleges;
    - Be a link between the service and healthcare professionals, schools, colleges and academies;
    - Provide a programme of any appropriate training to other services to evidence good quality care through identified pathways;
    - Promote other emotional wellbeing and mental health services and sign-post professionals to these resources,
    - Utilise local resources in developing the Barnsley Mental Health and Emotional Wellbeing Hub;
- Create a digital offer for children, young people and parents/carers which:
    - Promotes and develops self-help resources for children, young people their families/carers;
    - Provides free and timely access to online counselling for children and young people within the borough;
    - Provides effective sign-posting for children, young people and their families/carers to local services and other helpful resources;
- Provide comprehensive consultation, advice and liaison to other professionals when navigating the mental health pathway, including but not exclusive to telephone advice and consultancy.
    - The telephone consult is expected to reduce low-level referrals to the service to enable children's needs to be met efficiently;
    - Consultation and advice about the appropriateness of referral and for information about accessing the service;
    - Provide support, information, advice and guidance to other services and professionals who are working across the children's workforce through a variety of different and engaging ways.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 3: To Deliver the THRIVE Model (Getting Help)

Support children, young people and their families/carers who would benefit from focused evidence-based treatments.

To deliver this outcome you will:

- Provide targeted work with children and young people using focused, evidence-based treatments with clear aims and criteria for assessing whether the aims have been achieved;
- Provide short evidence-based interventions which are recommended by NICE guidance;
- Drive down average waiting times for treatment and reduce the number of children and young people on waiting lists;
- Ensure that the mental health support teams in schools offer robust, step-down options
- Ensure pathways are NICE concordant which will assist in the removal of barriers to access, ensuring that children and young people receive the same quality of care and provision according to their individual needs;
- Provide a variety of interventions at a variety of locations in ways that meet the needs of children, young people and their families;
- Provide positive, constructive interventions and treatment options to deter and avoid escalation to more extensive level of interventions;
- Support Children and Young People Improving Access to Psychological Therapies (CYP IAPT) across the children's workforce;
- Provide appropriate therapy such as Cognitive Behaviour Therapy (CBT), DBT (Dialectical Behaviour Therapy) and MST (Multisystemic Therapy) as per the clinical and supervision guidance
- Deliver the principles of attachment theory and trauma related work
- Sign-post children, young people and their families/carers with behavioural, communication, emotional and social difficulties to the early help offer.
- At the beginning of treatment, work with children and young people and (where appropriate to do so) their families to co-produce treatment goals and discharge plans ensuring these are shared;
- Operate plans and policies for supporting children and young people on waiting lists and define an offer of treatment to those who are currently on the waiting list for services.
- Define what support is available to those exiting the service and operate an open access back to the service within 12 weeks of discharge.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements

To be included as a separate schedule.

Outcome 4: To Deliver the THRIVE Model (Getting More Help)

Support children, young people and their families/carers with the most impairing difficulties.

To deliver this outcome you will:

- Provide extensive longer-term evidence-based interventions for children and young people who have the most impairing difficulties, this may include in-patient care or extensive outpatient provision;
- Work alongside and support children and young people with long-term

conditions;

- Provide support, assessment, diagnosis and treatment for all mental health conditions, including but not limited to:
    - The neurodevelopmental pathway includes Autism Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD). It should be noted that the ASC assessment and diagnostic pathway is provided by the acute Trust, Barnsley Hospitals NHS Foundation Trust but there is an expectation that there will be an element of post-diagnosis mental health support provision by CAMHS. It is anticipated that the Provider(s) will work collaboratively with all relevant partners to develop one neurodevelopmental assessment and diagnosis pathway in Barnsley (to include all neurodevelopmental conditions) and that this should be achieved within 2 years of the contract start date.
    - Emergency specialist mental health assessments (children and young people presenting as needing an emergency assessment include: those who have rapidly developed a serious or life-threatening condition, for example, a young person who is suicidal);
- Provide crisis support for all children and young people who would enter at any of the quadrants;
- Ensure that all assessments encompass the consideration of safeguarding concerns and that should any issues be identified, these are acted upon in accordance with the local multi-agency procedures;
- Work in partnership and deliver assessment and diagnosis through a pathway in a smooth and integrated manner.
- Access to a Consultant Psychiatrist for crisis support, where appropriate, or other, appropriately qualified practitioner, will be provided 24 hours a day, 7 days a week; (There is recognition that, where appropriate, this support may be delivered via another service, such as the all-age Liaison Mental Health service)
- Emergency specialist mental health assessments and crisis support will be provided 24 hours, 7 days a week including bank holidays;
- Appropriate interventions and support for all children and young people in a mental health crisis or emotional distress situation will be provided 24 hours a day, 7 days a week, including bank holidays to facilitate timely discharge from acute healthcare settings;
- Ensure that medication reviews are undertaken at appropriate times by appropriately qualified staff.
- Implement local arrangements to monitor the use of antipsychotic medication in people with autism and behaviour that challenges.
- Shared care agreement protocols to be implemented and maintained, supported by the CCG's Clinical Pharmacists if appropriate.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 5: To Deliver the THRIVE Model (Getting Risk Support)

Support the needs of children, young people and families where there is no current health treatment available, but they remain at risk to themselves or others. This is likely to be socially care-led

To deliver this outcome you will:

- Develop and deliver ‘Getting Risk Support’ for children; young people and their families/carers in order to avoid admissions to the NHS England commissioned Tier 4 service;
- Deliver short-term intensive interventions for those children and young people who are on the edge of entering Tier 4 services. It is expected that the model will include a community outreach service;
- Implement a responsive team to meet children’s and young people’s needs in a crisis, offering support within a range of settings but most especially within the individuals home and hospital settings;
- Provide support for children, young people, and their families/carers that are unable to benefit from evidence-based treatments but remain a significant concern or risk. This may include children and young people who routinely go into crisis but who are not able to make use of help offered or where help is offered, it has not been able to make a difference (e.g. self-harm, emerging personality disorders or ongoing issues that have not yet responded to treatment);
- Provide face-to-face assessments for children and young people prior to discharge from A&E;
- Have responsibility in developing close interagency collaborations with other partners and services to meet the needs of the child, young person and their families/carers;
- Ensure there is clarity around which agency is leading the case for the child or young person;
- Ensure safety plans are co-produced across other agencies and in agreement with the child, young person and parents (if appropriate);
- Ensure there is an integrated multi-agency approach to support children, young people and their families/carers across all agencies;
- Initiate an Early Help Assessment if required;
- Develop self-help materials appropriate to children and young people;
- Emphasise the development of peer support and personal support networks;
- Improve the services and support for children, young people and their families/carers that require ‘risk support’;
- Annual review of Safeguarding Arrangements, including audit;
- Evidence of co-produced risk and safety plans around the individual, with the young person, their families/carers and other agencies.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 6: To capture the voice of the child, young person their families/carers

Engage with children, young people their families/carers to understand their experience of services and the care that they receive.

To deliver this outcome you will:

- Engage with children, young people and their families/carers to capture the voice of the child through a range of methods (e.g. focus groups, surveys, workshops etc.);
- Ensure children, young people, their families/carers are active decision makers in goals and outcomes set and the care that they receive;

- Work with children, young people, their families/carers on the co-designing of services and any improvements to be implemented;
- Link to other agencies undertaking engagement and consultation with children and young people to ensure a collaborative approach such as OASIS Young Commissioners;
- Undertake a review of staff, patient and family views of the service on an annual basis which will be shared with key stakeholders including but not limited to children and young people in service, staff, families, carers, the CCG, local providers working with children and young people, Healthwatch, BMBC;
- Where children have a shared care arrangement ensure that those caring for children are given relevant updates around the child or young person's support from the service.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 7: Mental health and emotional wellbeing support is provided in the right place at the right time

To ensure the delivery of services for children, young people, their families and carers fits their needs.

To deliver this outcome you will:

- The Provider will have a base within Barnsley and operate a Hub and Spoke model incorporating the delivery of outreach services. Services will be provided in neighbourhoods as per the Barnsley six neighbourhood networks;
- The service will be delivered from identified community settings within Barnsley including but not limited to the home of the child or young person, Family Hubs, LIFT buildings, schools/academies/colleges, and GP Surgeries, IKIC (I Know I Can) Centres and Targeted Youth support buildings
- Rooms will be suitable, safe and welcoming for children and young people with adequate space;
- Provide services locally for children and young people across Barnsley proportionate to need;
- Ensure children, young people, their families/carers are offered appointments in a broad range of locations and times which suit them best, to limit the impact on the child or young person's education;
- Deliver care within, but not exclusive to, existing Family Hubs, community, IKIC Centres and Targeted Youth Support facilities, and academic settings across the borough including the home of the child or young person;
- Ensure that appointments are flexible, appropriate and convenient to support children, young people, their families/carers to ensure their needs are met in the right environment and location to support their age, neurological development and maturity needs.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 8: Develop effective working relationships with all partners and key organisations

Work collaboratively with partners and other professionals across the children's workforce.

To deliver this outcome you will:

- Act as the champion for children and young people's mental health system, guiding children, young people, their families/carers through the system;
- Work in partnership with a range of other services, including the community/voluntary sector;
- Work with a range of partners across the children's and adult's workforce and the social care system. There will be an expectation that the Provider(s) will be part of these formalised partnerships and support appropriate governance groups for example the CYP Trust Executive Group;
- Become a part of established partnership working and integrate seamlessly into existing care pathways, working with full range of partners and professionals to ensure that the child or young person receives the right support at the right time;
- Work collaboratively and jointly with all other partners and services across the children's workforce and align to other agendas and strategies and attend meetings as appropriate (e.g. multi-agency safeguarding arrangements, Looked After Children forums)
- Link with educational settings to ensure access to advice and support for young people through specified in-reach support to schools/colleges/academies;
- Ensure that advice and support is made available to staff who are working with young people with identified mental health needs in aged 16+ education provision;
- Work with professionals in identifying the children and young people with the most complex and challenging presentations;
- Provide an outreach element and links to other agencies, services and existing resources using a multi-disciplinary approach to meet the needs of children and young people
- Support Providers of services to children, young people and families/carers with a broad range of relevant advice and support for children and young people experiencing mental health problems, including those with complex, persistent and severe behavioural needs (e.g. attention deficit hyperactivity disorder, Autism).

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 9: Ensure transitions between services are planned and supportive

Ensure appropriate advice and support is provided throughout the transition journey for children, young people their families/carers

To deliver this outcome you will:

- Work collaboratively, liaise and link with Adult Mental Health Services to ensure a smooth transition and continuity of care;
- Ensure young people who will move from children's to adults' services have an annual meeting to review transition planning;

- Ensure young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after the transfer;
- Ensure young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer;
- Implement and manage appropriate and effective transition pathways to Adult Mental Health Services
- Ensure advice and support is available for children, young people, their families/carers who are likely to require a service from Adult Mental Health Services;
- Ensure that children, young people, their families/carers who are not likely to require a service from Adult Mental Health Services have a support plan in place following their discharge from the service;
- Ensure there are effective discharge policies and procedures which set out the steps in which a child or young person will be discharged in place, in agreement with the child, young person, their families/carers and in conjunction with the referrer, including discharge summary to the referrer, parent (where appropriate), the GP and any other relevant professionals within 7 working days;
- Ensure that the Care Programme Approach, or equivalent standard, is used on discharge from in-patient care and on transition from child to adult services.
- Where a young person is moving to another service, whether to adult mental health services or to a different service, the Provider will ensure that the agreed transition protocol is followed. As a minimum this will involve:
    - a joint meeting between the Provider and the new service that includes the child/young person and/or parent/carer, and a written discharge summary, followed up after 6 months to check that the transition has proceeded smoothly; and
    - the Service having protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the Service User and parents/Carers to plan in advance for transition (this is especially critical in the transfer from CYPMHS to adult mental health services and primary care or other services, e.g. voluntary/third sector). This includes local transition protocol.
- The Psychosis pathway 14+ is provided by adult mental health services – the provider will work collaboratively with this service.

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

Outcome 10: Ensure the service provided is accessible for all vulnerable groups

To provide an accessible and effective service for all children and young people who are vulnerable

To deliver this outcome you will:

- Work proactively with all vulnerable groups, including the following:
    - Children in Care (CiC) or children and young people who are subject to child protection procedures
    - Special Educational Needs and Disability (SEND)
    - Children or young people ‘Not in Education, Employment or Training (NEET)’

- Young Carers
- Refugees/Unaccompanied Asylum Seeker
- Homeless/Traveller/Trafficked children and young people
- Lesbian, gay, bisexual and transgender (LGBT)
- Gender identity
- Out of area children or young person who are placed in Barnsley
- Expectant mothers and their families
- Those supported via Early Help
- Those who are involved in the Youth Justice System
- Those at risk of exploitation

- Provide a service which meets the needs of a culturally diverse population and ensure that the mental health needs of children and young people from minority ethnic groups are met as appropriate with access to appropriate information and interpretation services;
- Deliver a service which provides priority access to CAMHS for Children in Care and those who are accessing Youth Offending services / support
- Work on a flexible basis with Care, Residential and Fostering and Adoption Services, providing innovative and creative ways of working with this vulnerable group of young people and their families/carers, to ensure a collective response via care planning processes.
- Provide direct access to advice and support and a direct referral route from Care and the Fostering and Adoption Services, via a specified pathway.
- Ensure high levels of information sharing with the CIC Health Team, Fostering and Adoption Team, Residential Units and Care, including sharing psychological reports and outcomes of emotional screening tools for looked after children (where appropriate);
- Connect with Children's Services to implement a graduated response which enables and supports Early Help and Child Protection processes.
- Provide a full range of specialist services for children and young people with a learning disability ensuring the service meets their needs and they will be able to access any aspect of any assessments, therapy and treatments that would be open to a young person without a learning disability;
- Ensure the service is provided by staff who have the necessary training and competencies to deal with children and young people who have learning difficulties;
- Provide advice and support to:
  - All relevant parties involved in the looked after child's care about their emotional and mental health both prior to the child or young person returning home, and once they have returned home following an episode of Care provision;
  - Adoption social workers;
  - Prospective adopters, regarding children and children and young people's needs and placement requirements.
- Provide advice and strategies to:
  - Parents who request support in managing children and young people's needs and behaviours post adoption
  - Foster carers and residential workers who request support in managing looked after children and care leavers mental health issues
- Provide direct work with children and young people;
- Liaise and link with services providing support for looked after children post-care arrangements, over 18 years old.

- Support the work of the Youth Justice partnership and wider Targeted Youth Support Services through the provision of an appropriate MDT, Co-located with TYS, and clinically supported by the provider
- Ensure that there is a clear and responsive pathway to provide forensic analysis of young peoples' behaviour and intervention to address needs, in partnership with the Youth Justice service

Key Performance Indicators:

To be included as a separate schedule.

Reporting Requirements:

To be included as a separate schedule.

4. Legal and Regulatory Framework

The service will operate according to relevant legislation and guidance, with particular reference to:

- Mental Health Act 1983 (amended 2007) and Code of Practice, including protocols for emergency assessment under Section 136
- Mental Capacity Act 2005
- Children's and Families Act 2014 including specific duties in relation to children and young people with SEND which are outlined within the SEND Code of Practice 0-25.
- Equality Act 2010
- National Service Framework, 2004
- Care Act 2014
- The Human Medicines Regulations 2012
- Public Services (Social Value) Act 2012
- The Children's Acts 1989 and 2004
- Safeguarding procedures (e.g. Working Together to Safeguard Children 2018)
- The findings from serious case reviews in particular the requirements to share information in a timely manner. See Working Together to Safeguard Children for further guidance
- Promoting the health of looked after children
- NHS Choice of Provider initiative
- Personal Health Budgets may be a good way of arranging services for some patients.
- If appropriate, the provider will be registered with the Care Quality Commission.
- The provider will ensure that all professionals will remain compliant with their relevant professional standards and bodies and be revalidated as required.
- The provider will have an indemnity scheme.
- The provider will have a governance system to manage and learn from complaints and incidents and to meet the training and supervision needs of its staff. A service that does not have any (formal or informal) complaints should be of as much interest as one with a high level of complaints. If children, young people, parents/carers or referrers do not have a mechanism to raise concerns, this could suggest a service is not working in partnership with its clients and referrers.
- Providers and commissioners may wish to consider the use of Independent Advocacy Services to support children and young people to gain access to information, to fully explore and understand their options, and to make their

views and wishes known.

5. Eligibility Criteria

- The service is for children and young people up to their 18th birthday.
- Throughout the duration of the contract the service will extend provision for children and young people up to their 25th birthday, potentially in a phased manner
- All residents and temporary residents (including students, gypsies and travellers and children and young people on placement) within Barnsley or where a child has been placed by the Local Authority or Youth Custody service out of the Barnsley area, but is ordinarily a resident of Barnsley.
- If it is more appropriate the young person can access support within the Adult Mental Health Service.
- Early Intervention Psychosis is provided by Adult Mental Health Services for those aged 14 and over (though the Provider will have transition arrangements in place to ensure that children and young people who require treatment for early signs of psychosis are referred to the Early Intervention Team for Psychosis)
- Please note: referrals specifically for consultation for private law proceedings (e.g. custody issues) are excluded from the service but the service will need to support Youth Justice requirements.
- If a child or young person does not meet the eligibility criteria as referred to above, the Provider will work alongside appropriate services to identify a pathway to alternative support options to the referrer.

Clear referral criteria to be established and agreed with commissioners prior to commencement of the contract and the criteria are to be defined in reference to the Thrive quadrant descriptors.

6. Referral Process

All referrals into the service will be managed through a Single Point of Contact (SPC). The SPC and earlier intervention will require partnership with and direct delivery by community / voluntary partners. There is the potential of developing the SPC model further, as part of the wider system's approach advocated by the THRIVE model, and as part of the children and young peoples' emotional health and wellbeing Hub which is evolving in Barnsley.

Referrals to the service are expected from GPs and those working within services for children including education, health and social care and the voluntary/community sector.

The Provider will:

- Accept appropriate referrals into the service from any professional (including but not exclusive to, all parts of the health service, social services, early help and/or education services);
- Support the screening process within the SPC, including developing and maintaining an algorithm and shall undertake specialist second stage screening for mental health needs requiring referral into the service;
- Confirm receipt of the referral to the referrer within 24 hours which will make clear that the universal case holder continues to hold responsibility for the child/young person and should maintain links until and throughout the child's input from the Provider;

- Confirm the outcome of referral within 5 working days of receipt of referral;
- Work in collaboration with the child, young person and their families/carers to be active decision makers in choosing the right approach for them;
- Work within local pathways combining personalised care and collaborative practice for the best outcomes.
- Where 'inappropriate' referrals occur, the referrer will be provided with advice and guidance for supporting the referred child/young person;

7. Assessment

The Provider will use a wide range of different evidence based interventions and treatment options which offer choice to young people, including but not exclusive to:

- Cognitive Behavioural Therapy (CBT)
- Brief solution focussed therapy
- Systemic Family Therapy
- Play therapy
- Art therapy
- Family therapy
- Evidence-based parenting and family interventions
- Psycho-social/education intervention
- Individual therapy
- Group work
- Psychiatric intervention
- Psychotherapeutic intervention
- Counselling
- Long term therapeutic work
- Medication
- Trauma-Focused Cognitive Behavioural Therapy,
- Prolonged Exposure Therapy
- Eye Movement Desensitisation and Reprocessing Therapy

In clinical terms the Provider(s) will be working with moderate to severe presentations which will include, but will not be exclusive to the following:

Anxiety Disorders

- Depressive Disorders
- Hyperkinetic Disorders
- Developmental Disorders
- Conduct Disorders
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorders
- Somatic Syndromes
- Eating Disorders
- Autism Spectrum Disorder
- Behavioural Problems
- ADHD
- Attachment Disorders
- Self-Harm

The service will work in a multi-agency approach to provide support for the

presentations outlined below:

- Family issues (where this is having an adverse effect and the child/young person is showing signs of developing a mental health problem or disorder)
- Mild, moderate and severe emotional and behavioural disorders
- Child behaviour problems (e.g. sleep, feeding, tantrums) once physical causes have been considered and the behaviour falls outside what might be considered to be within the range of normal behaviour
- Other mood disorders (e.g. low self-esteem)
- Adjustment reactions
- Simple phobias
- Self-harm (mild to moderate)
- Bereavement
- Bullying
- Anger management issues
- Relationship problems
- Conduct disorder and oppositional defiant disorder; PDA (Pathological Demand Avoidance)
- Suicidal ideation
- Dual diagnosis (including comorbid drug and alcohol use)
- Neuropsychiatric conditions
- Development disorders
- Significant mental health problems where there is comorbidity with mild/moderate learning disabilities or comorbid physical and mental health problems
- Mood disorders
- Harmful sexual behaviours, specifically around forensic assessments and needs but also to provide advice and guidance to practitioners working with these issues through the MDT process.

NB: Presentations that could be described as emerging personality disorder will be accepted under mood disorder, suicidal ideation and self-harm.

8. Consent

The Provider will establish a robust referral process with appropriate mechanisms to ensure all referrers obtain appropriate, informed consent prior to making a referral.

9. Days and Hours of Operation

9.1 Standard Services

The Provider will operate a flexible and responsive service that includes evenings and weekends to enable the service to meet the needs of the individual, allowing children and young people to access support at the right time. This flexibility will help to reduce its impact on absenteeism in schools and improve access to the service and promote early intervention. The exact opening hours will be negotiated with the Commissioner and informed by children; young people their families/carers that use the service.

9.2 Emergency Specialist Mental Health Assessments and Crisis Support

Emergency specialist mental health assessments and crisis support will be provided 24 hours a day, 7 days a week, including bank holidays.

10. Location

The service will be delivered within the Primary Care Network localities.

The service will be provided as flexibly as possible in appropriate locations that meet the needs of the children and young people and their families/carers. This includes the home of the child or young person, Family Hubs, LIFT buildings, GP surgeries and schools/academies/colleges.

Where community buildings are used, rooms will be suitable, safe and welcoming for children and young people with adequate space.

11. Tier 4 Provision

There is an expectation that the Provider will case manage these children and young people ensuring that outcomes are being met.

The Provider will:

- Have responsibility for working with and maintaining effective communications with the North of England Specialised Commissioning Group, Yorkshire and Humber Office Commissioners and Regional Case Managers to place children and young people in requiring day and inpatient services and some highly specialist outpatient services;
- Assess the children and young people in greatest need, consider the management of risk, establish appropriate management and treatment plans and refer to specialist services when required;
- Wherever possible the Provider should take ownership to facilitate children and young people being able to step down back into local community services as soon as possible, ensuring the child and young person's stay within inpatient services or highly specialist outpatient series is as short as deemed necessary;
- Inform commissioners of any incidents of admission into Tier 4 in real time and then also followed up within the contracting performance report data;
- Inform the commissioners of any trends identified and liaise with the relevant partners and agencies to identify the emerging trends;
- Ensure that the T4 care is reviewed regularly and every opportunity is used to bring the child or young person back into local services as early as possible.

12. Continuing Healthcare (CHC)

Children in receipt of Continuing Care have had the legal right to have a Personal Health Budget (PHB) since October 2014. This includes the provision of a direct payment, third party managed account or notional budget to meet their agreed health and wellbeing needs. From April 2015 people with Long Term Conditions including Mental Health and Learning Disabilities have also had the right to ask for a PHB. In April 2019 this has been extended to those entitled to Section 117 aftercare and Personalised Wheelchair Budgets. This specification supports the implementation of personalistion.

13. Standards and Quality Assurance

The Provider will have a clear set of internal Policies and Procedures to support practices and meet the requirements of legislation and local policy throughout the terms of the contract as described within the specification.

The Provider will comply with legislation and standards and are responsible for adhering to any new relevant legislation or applicable National standards during the term of the contract.

Applicable National and Local Standards Set out in Guidance and/or Issued by a Competent Body:

- Quality Network for Community CAMHS Standards
- Quality Network for Inpatient CAMHS Standards
- Wellbeing Directory & ACE V Quality Standards
- Child Outcome Research Consortium (CORC)
- Choice and Partnership Approach (CAPA)
- CYP IAPT Accreditation Council (NHS England) values and standards following a wide consultation with professionals, children/young people, parents and carers
- Associated Policy Documents
- Applicable Local Standards
- Infection Prevention Control
- Safeguarding Children
- Safeguarding Adults with care and support needs
- LSCB/SAB multi-agency Policies and Procedures
- Service Review
- All applicable NICE Guidance
- The Provider will submit the required information to the Mental Health Minimum Data Set and be compliant with all reporting requirements for NHS and commissioners statutory returns.

OPEN UP BARNSLEY

A guide to emotional wellbeing and mental health services for children and young people in Barnsley

CHILYPEP
CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

MindSpace

NHS
Barnsley
Clinical
Commissioning
Group

OPEN UP BARNSLEY

Open up Barnsley is your guide to emotional wellbeing and mental health services for all children and young people in Barnsley.

If you're a young person, parent or carer or someone who works with young people, this guide will help you find the right advice and support and see what services are in Barnsley.

Where can you open up?

There are lots of different types of services for all kinds of issues and needs.
Take a look at the different categories on the contents pages opposite to find out which services best match the help and support you need.

- Urgent help
- Mental health and wellbeing support
- Drugs and alcohol
- Bullying and abuse
- Health and Disability
- Relationships and family

URGENT HELP

MENTAL HEALTH & WELLBEING SUPPORT

DRUGS AND ALCOHOL

BULLYING AND ABUSE

HEALTH AND DISABILITY

RELATIONSHIPS AND FAMILY

SAMARITANS

WHAT?

If something's troubling you, then get in touch.
Our helpline is here 24 hours a day, 365 days a year.
We also have a local Barnsley Samaritans base that is open to callers at the door.

WHO?

We support anyone in distress around the clock through 201 branches in the UK and the Republic of Ireland.

HOW?

We know our service can help people before it's too late.
24 hours a day, 7 days a week, 365 days a year. We help you talk things through. We keep everything confidential. We're not a religious organisation

WHERE?

Samaritans Office – Open for Callers at the door:
77 Pitt Street West Barnsley South Yorkshire S70 1BN
e-mail address: jo@samaritans.org
Contact number: 116 123 (free to call) Free phone 0800 1111
Website: www.samaritans.org

WHEN?

Samaritans location opening hours open for callers at the door:
Monday....10:30 - 12:30 Tuesday...Closed Wednesday....12:30 - 15:00
Thursday.....Closed Friday.....12:30 - 15:00
Saturday.....Closed Sunday.....Closed

BARNSLEY
Metropolitan Borough Council

BLINK

WHAT?

BLINK is a local Barnsley helpline that provides a confidential service for anyone who needs someone to listen.

WHO?

For the residents of Barnsley.

HOW?

Helpline - BLINK has trained volunteers who will help you get things off your chest and enable you to see your problems from a different angle. They can also provide information about other local or national services that may be able to help. If you are feeling anxious or stressed about any type of situation whether it be life in general to housing or benefits worries, the team are there to listen.

WHERE?

Helpline covering the residents of Barnsley
Contact: 01226 203330

WHEN?

Contact: 01226 203330
Evenings only: between 6.30pm-9.30pm

URGENT HELP

WHAT?

Childline is the UK's free helpline for children and young people.

WHO?

For children and young people aged 18 and under.

HOW?

Over the phone. It provides a confidential telephone counselling service for any child with a problem. It comforts, advises and protects.

WHERE?

Childline's helpline is available 24 hours a day and is free to call for all children and young people across the country.
Phone or go online via the website to online chat and use message boards.
Website: www.childline.org.uk Freephone: 0800 1111

WHEN?

Childline's helpline is available 24 hours a day.
Freephone 0800 1111

Young Minds Crisis Messenger

WHAT?

If you are a young person experiencing a mental health crisis, you can text the Young Minds Crisis Messenger for free, 24/7 support.

WHO?

For all young people.

HOW?

The trained volunteer will introduce themselves, reflect on what you've said, and invite you to share how you're feeling. You'll text each other, only sharing what you feel comfortable with. By asking questions, listening to you and responding with support, they will help you think through your feelings until you both feel you are now in a calm, safe place. Our crisis messenger service could help with urgent issues such as: suicidal thoughts, abuse, bullying, self harm or breakdown.

WHERE?

The Young Minds crisis messenger service provides free, 24/7 crisis support across the UK. If you are experiencing a mental health crisis and need support, you can text us free and anonymously, text YM to 85258. For more information visit Young Minds website. Texts are free from EE, O2, Vodafone, 3, Virgin Mobile, BT Mobile, GiffGaff, Tesco Mobile and Telecom Plus.

WHEN?

We aim to connect every texter to a trained volunteer in less than 5 minutes to provide support in a crisis. They will listen to you and help you think through how you're feeling, and will aim to help you take the next steps towards feeling better. This service is powered by our trusted partner, Crisis Text Line.

FRANK

0800 77 66 00 talktofrank.com

Friendly, confidential drugs advice

WHAT?

Frank is a national, friendly and confidential helpline for advice around drugs.
Franks also offers a live web chat.

WHO?

For anyone, we offer friendly and confidential drugs advice, you can talk to Frank.

HOW?

Contact us through our confidential helpline

WHERE?

The helpline is available 24 hours a day and is completely confidential.
You can also text for quick questions that need an urgent answer and go online for a live web chat.
Website: www.talktofrank.com

WHEN?

Call: 0800 77 66 00 Text: 82111
Live web chat 2pm - 6pm
www.talktofrank.com

MENTAL HEALTH & WELLBEING SUPPORT

WHAT?

Rotherham & Barnsley Mind is an independent local provider of high quality mental health services in Rotherham, Barnsley and its surrounding areas. MIND aim to empower individuals to start on the pathway to recovery, We believe that no one should have to face a mental health problem alone.

WHO?

Young people, adults, people with a mental health problem and older people

HOW?

Rotherham & Barnsley Mind aims to be inclusive and accessible. MIND offer a variety of services including one-to-one counselling, group sessions, support for young people, training and services for employers. MIND provide group work for people with a mental health problem and counselling for people with a mental health problem and employment.

WHERE?

Arcadia House,
72 Market Street,
Barnsley,
South Yorkshire
Telephone:01226 211188

WHEN?

Contact Barnsley MIND for more information
Telephone:01226 211188
www.rbmind.co.uk

Therapies for Anxiety, Depression & Stress (TADS)

WHAT?

TAD is a voluntary organisation established in 2014. They have recently received long term funding from the National Lottery.

WHO?

TADS work with children who have a wide range of mental health issues including anxiety, self– esteem, self-confidence and stress.

HOW?

For young people aged 11-25, TADS offer one to one complimentary therapies such as; reflexology, hand massage and tapping techniques.

WHERE?

23 Queens Rd, Barnsley S71 1AN

WHEN?

TADS also offers an LGBT+ every 3rd Monday of the month 14 to 18s.
Website: www.tadsbarnsley.co.uk

MENTAL HEALTH & WELLBEING SUPPORT

MindSpace

WHAT?

Early intervention and prevention service for young people with mental health difficulties. We offer 1:1 and group sessions.

WHO?

Young people who attend a Barnsley mainstream secondary school

HOW?

You can self-refer to MindSpace by contacting hello@wearemindspace.com Your school or GP can also refer you.

WHERE?

The 3 practitioners are based in each of the 10 secondary schools which are: Barnsley Academy, Dearne ALC, Outwood Carlton, Darton College, Holy Trinity, Horizon Community College, Kirk Balk Academy, Outwood Shafton, Netherwood Academy and Penistone ALC.

WHEN?

Monday to Friday, times vary in each school. It's generally 8:30 until 3:30 or the end of the school day. Visit our website www.wearemindspace.com

WHAT?

The service offers support in the community for individuals who have an individual budget or are self-funding. he service offers support in the community for individuals who have an individual budget or are self-funding.

WHO?

For individuals who have an individual budget or are self-funding.

HOW?

We offer a range of practical and emotional support that can help to improve wellbeing. Our aim is to support someone to lead an ordinary life and encourage them to achieve their goals.
Barnsley Mental Wellbeing Services can help individuals in the following areas: Help in the home, Practical help, Looking after themselves, Getting out and about , Making choices, Finding new hobbies and interests, Volunteering

WHERE?

Room 31 Priory Campus Pontefract Road Barnsley S71 5PN
Contact: 01226 770 895
E-mail: barnsleymws@together-uk.org

WHEN?

Contact us to arrange an appointment.

MENTAL HEALTH & WELLBEING SUPPORT

NHS
South West Yorkshire Partnership
NHS Foundation Trust

WHAT?

The mental health access team aims to improve access to psychological therapy and recovery focussed treatment for people with mild to moderate anxiety and depression.

WHO?

For people with mild to moderate anxiety and depression.

HOW?

The mental health access team provides the following:
Improving access to psychological therapies (IAPT) service. The IAPT programme is a large-scale national initiative that aims to significantly increase the availability of National Institute for Health and Clinical Excellence (NICE) recommended psychological treatments for depression and anxiety disorders. IAPT is planned and not offered in an acute crisis.

WHERE?

Mental Health Access Team
Rose Tree Avenue,
Cudworth,
Barnsley S72 8UA Contact 01336 644900

WHEN?

Contact us for more information

VoiceAbility

WHAT?

We provide a hospital based advocacy service for people with a mental health illness in Barnsley.

WHO?

For people with a mental health illness in Barnsley.

HOW?

We can support you to:
· Get information about your rights
· Find out what choices are open to you
· Look at the possible outcomes of those choices

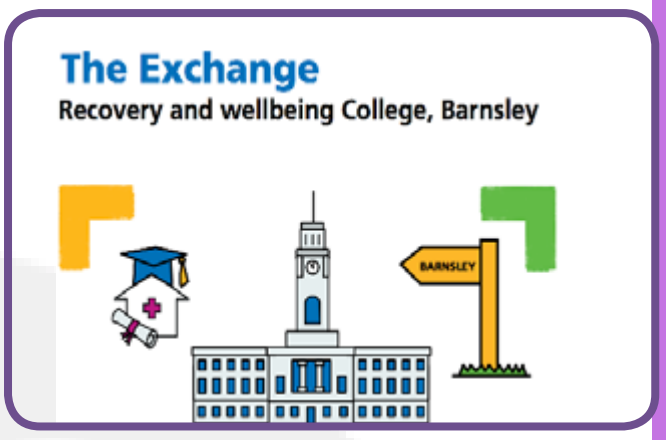
WHERE?

Unit 12, Oakwell Business Centre, (Oakwell View Off Pontefract Road)
Barnsley,
S71 1HX
e-mail: craig.milburn@voiceability.org
Contact: 01226 776830, 07557 85151
Website: www.voiceability.org/in_your_area/south_yorkshire

WHEN?

Contact us to find out more.

MENTAL HEALTH & WELLBEING SUPPORT



WHAT?

The Exchange is a growing recovery and wellbeing college based in Barnsley.

WHO?

It is open to young people aged 16+ and all adults who would like to improve their mental wellbeing or knowledge to aid their work with others. They offer a range of courses and one off workshops which all aim to improving wellbeing through learning.

HOW?

The courses focus on being mentally and physically healthy, staying well and developing the knowledge and strength to overcome the challenges that we can all face at times in our lives.
Courses aren't therapy – their aim is to provide a positive learning approach, share knowledge and provide the space to reflect on your own health and understanding

WHERE?

The Exchange Recovery College,
33 Gawber Road,
Barnsley,
S75 2AH

WHEN?

Contact Exchange to find out more
Barnsley.Recoverycollege @swyt.nhs.uk
01226732096

CHILYPEP
CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

WHAT?

The Children and Young People's Empowerment Project is a charity dedicated to raising the voices of young people and giving them the confidence, influence and platform to shape their world.

WHO?

For young people aged 11-25.

HOW?

Chilypep supports the OASIS young people's mental health group at Horizon College and the CHIL Peer Mentoring programme at Barnsley College/Sixth form. If you're a student at Barnsley college/sixth form and would like to be a Peer mentor or receive support from a Peer Mentor whilst being a student at College or Sixth form, get in touch to find out more.The OASIS young people's group meets weekly. The group work to reduce stigma around mental health and improve young people's mental health services in Barnsley. Click here to download a copy of the Youth Mental Health First Aid Kit book

WHERE?

The OASIS group meets weekly at a central Barnsley location.
The Chil Peer mentoring programme is based in the college and sixth form. Contact Chilypep to find out more

WHEN?

Contact Chilypep to find out more
Email chantelle.parke@chilypep.org.uk
01142348846
www.chilypep.org.uk

Creative Recovery

WHAT?

Creative Recovery is a people-led charity that uses creativity to support Recovery, boost wellbeing and bring about social change in Barnsley and across Yorkshire.

WHO?

Creative Recovery support individuals and families with experience of mental health and/or drug and alcohol issues.

HOW?

The team is innovative, dynamic and collaborative, putting people at the heart of it! The leaders and projects are award-winning, receiving national recognition for innovation, public service and social impact. Creative Recovery also work to develop communities, challenging stigma and nurturing community spirit, with the aim to create a more accepting, inclusive and creative culture for all.

WHERE?

Day to day, their experienced artists use a person-centred approach to create safe spaces and unique projects where individuals can thrive. Creative Recovery runs a number of different projects and courses focusing on wellbeing and recovery for those with alcohol or substance abuse problems.
To find out more visit: www.creativerecovery.co.uk

WHEN?

Contact Creative Recovery to find out more
wearecreativerecovery@gmail.com
01226 320147

Child and Adolescent Mental Health Services (CAMHS)

NHS
South West Yorkshire Partnership
NHS Foundation Trust

WHAT?

The Barnsley child and adolescent mental health service (CAMHS) provide services to children and young people up to their 18th birthday who are experiencing a wide range of behavioural, psychological and emotional problems,

WHO?

Barnsley CAMHS is made up of four teams:
Child and adolescent unit, Young people's outreach team, Community early intervention team and the Learning disabilities and development disorders team.

HOW?

We work in a variety of settings including health centers, clinics, schools or in people's homes.
Our specialist team includes psychiatrists, specialist nurses, psychologists, specialist social workers and therapists. We help children, young people and their families, on both an individual and group basis. We also offer our mental health expertise across children's services in the area.

WHERE?

Contact Barnsley CAMHS You can contact our team by calling 01226433163 Our team are based at: Child and Adolescent Unit
Upper New Street
Barnsley
S70 1LP
Referrals,
To find out more about making a referral to the Barnsley CAMHS team, visit our individual service directory page

WHEN?

9am-5pm, Monday-Friday

WHAT?

YMCA is an independent local charity that works for and with children and young people and their families in Barnsley.
YMCA delivers a wide range of children's and youth work, extended services and members activities. YMCA Barnsley aims to empower young people by involving them in activities that stimulate, challenge and enable them to realise their potential and participate fully in their communities.

WHO?

For Children and young people aged 8-25

HOW?

We provide a safe and welcoming space and positive activities for children and young people and support them so they can belong, contribute and thrive in their communities.

WHERE?

Address:
Blucher Street
Barnsley
South Yorkshire
S70 1AP
Phone: 01226 213123 Email: info@ymcabarnsley.org.uk
www.ymcabarnsley.org.uk

WHEN?

Contact YMCA to find out more about projects, activities and youth and group work.

Substance Misuse Team

WHAT?

The service offers advice and information on drugs and alcohol to any young person under 18.
The service is free and confidential.

WHO?

Young people aged 18 and under

HOW?

We offer one to one support in convenient venues of young person's choice (ie: in School, GP's surgery).
Advice and support to professionals supporting young people who may not yet be ready to access services.
We also offer C-card registration/distribution/chlamydia screening/ Blood Borne Virus screening / access to vaccination.
We also offer advice and support to parents /carers of young people who may be using substances.

WHERE?

Young People's Substance Misuse Service, (formerly Young Addaction/ Lifeline), Mclintocks Building, 1st Floor, BMBC, Crookes Street, Barnsley, South Yorkshire, S70 6BQ. Tel: 01226 705980.
Email: YoungPeoplesSubstanceMisuseTeam@barnsley.gov.uk

WHEN?

Office Hours Monday – Friday 9-5, however we will see young people at a venue to suit them and out of office hours. We are flexible to the young person's needs.

Recovery Steps Barnsley

WHAT?

Recovery Steps Barnsley is an integrated drug and alcohol recovery service for Barnsley. Our aim is to help as many people as possible to recover from and be free from drug and alcohol dependency, and to reduce the harm that is caused to individuals, families and communities.
The Recovery Steps service is delivered by Humankind on behalf of Barnsley Metropolitan Borough Council

WHO?

For anyone aged 18 + Living with drug or alcohol problems isn't easy - it's really tough.

HOW?

As part of our support, we will offer the following:
one-to-one support, structured group therapy work
support to family members, involving them as part of your recovery plan wherever possible and with your consent,
a health and wellbeing check, health screenings, blood testing and vaccinations, help you achieve a balanced approach to life through therapeutic intervention, Support to reduce harm and prevent overdose
Substitute medication is available for some drugs that you may use
Detox from alcohol and/or drugs

WHERE?

5-6 Burleigh Court, Burleigh Ct, Burleigh St, Barnsley S70 1XY, UK
humankindcharity.org.uk/service/barnsley-recovery-steps

WHEN?

Contact us for support or referral
You can contact us on 01226 779066, 9am to 5pm, Monday to Friday.
Anyone can make a referral to the Recovery Steps Barnsley service e.g. self-referrals, family members or professionals.

Barnsley Sexual Abuse and Rape Crisis Service

WHAT?

BSARCS (Barnsley Sexual Abuse and Rape Crisis Services) is the only group in Barnsley offering specialist services to people whose lives have been affected by rape, sexual abuse, sexual assault or any kind of sexual violence.We work with women, men, children and young people who live in the Barnsley area. We're an independent registered charity and we won't pressure you into reporting to the police or doing anything you're not comfortable with.

WHO?

We offer a range of different services to women, men, children and young people.

HOW?

We offer counselling & therapy to talk about emotional difficulties you're going through and to explore what might be causing them. Counsellors don't give advice or tell you what to do. The therapy we offer is a similar service to counselling, specifically for children and young people.
If you've reported what happened to you to the police, or if you're thinking about reporting it, our Independent Sexual Violence Advocates (or ISVAs) can support you through the process, from the first step right through. We also offer wellbeing support and support groups.

WHERE?

The Core, County Way, Barnsley, S70 2JW. Our premises are accessible and we have a number of rooms where we provide different types of support. www.bsarcs.org.uk

WHEN?

BSARCS can only see visitors by appointment. To make an appointment, or for more information call us on 01226 320140 or email us info@bsarcs.org For specific information about referring someone to one of our services, please see our How to Make a Referral page.

Victim Support

BARNSLEY
Metropolitan Borough Council

WHAT?

Victim Support gives emotional and practical help to people who have been affected by crime in Humberside or South Yorkshire.
Victim Support is an independent charity and you can contact for support regardless of whether you've contacted the police, and no matter how long ago the crime took place. Victim support will help you for as long as it takes to overcome the impact of crime.

WHO?

Victim Support gives emotional and practical help to adults and young adults who have been affected by crime in Humberside and South Yorkshire.

HOW?

Crime impacts people in different ways. This is why victim supports specially trained staff contact victims and spend time speaking to them to find out what kind of support they might benefit from to help them cope with the effects of crime and move on with their lives.

WHERE?

Victim Supports office address is:
Referral Unit, 126 Occupation Lane, Sheffield, S12 4PQ
You can access support from our phone lines, website and live chat 24/7

WHEN?

Our phones lines are open Monday to Friday 9am - 8pm and Saturday 9am - 1pm 0300 303 1976
If you need support outside of our open hours, call our Support line for free on 08 08 16 89 111 or request support via our website.
www.victimsupport.org.uk Alternatively, you can contact us via live chat

Pathways

WHAT?

Pathways family support provides services which enable people to re-build self-esteem, confidence and emotional resilience by the provision of a range of interventions.

WHO?

Young people, and adults

HOW?

Contact Pathways family support to find out about a range of different services. Ongoing flexible support enables people to make informed choices about their future, reach their short and long term goals, realise their potential and actively contribute to their communities and society.

WHERE?

Contact Pathways family support Pathways Family Support Centre (BDVG) 33-35 Peel Parade, Barnsley
S70 2RN

WHEN?

Contact Pathways family support Mon - Fri 9am-5pm on:
01226 731812
pathwayscentre33@yahoo.co.uk
Or visit: www.barnsleydvg.org.uk

Barnsley LGBT Forum

WHAT?

The Barnsley LGBT Forum brings the community together to look at issues and concerns that affected the local lesbian, gay, bisexual and transgender community. Barnsley college have their own SAGA group for the LGBTQ students in college. http://www.youngstonewall.org.uk/ There is also a youth group that our younger members of the community can access.

WHO?

For Young people and Adults

HOW?

The monthly meetings alternate between formal meetings and social meetings each month. In the formal meetings we discuss any items on the agenda about what we want to achieve or discuss event planning or any representation with our partners that need to take place.
The social meetings are about people getting together and having a chat with each other, meeting new people and to see what is happening around the borough, alternatively we arrange meal clubs, bowling nights, and film nights to meet up and have fun.

WHERE?

If this is something you feel you would like to be a part of, get in contact or look on the social media sites. You will always be made to feel welcome and you can do as much or as little as what your time allows. The forum is all about the members and how everyone can make things better for the community so come along and join the fun!

WHEN?

Facebook: www.facebook.com/groups/BarnsleyLGBTForum
Twitter: twitter.com/BarnsLGBTForum
www.barnsleylgbtforum.org.uk/
Email: Secretarybarnsleylgbtforum@gmail.com

Public Health Nursing Team

BARNSLEY
Metropolitan Borough Council

WHAT?

Barnsley 0-19 Public Health Nursing Service offer advice and support in a number of areas such as:
Healthy eating and exercise, Mental health, Emotional health, Sexual health including C Card, Managing medical conditions in school, Infant feeding, Continence, Healthy relationships, Safety in the home, Online safety, bullying, smoking and substace abuse.

WHO?

The service is for any family, child or young person within the Barnsley area. The Service consists of a team of, Health Visitors, School Nurses Public Health Nurses and other healthcare professionals.

HOW?

We can offer:

-Confidential support for children and young people either on a 1:1 basis or in group sessions.
-Advice and support for parents.
-Advice and support for professionals supporting families, children and young people.

WHERE?

You can be seen in most places by a school nurse....not just in school. We can offer home visits, attend youth clubs and schools....we can discuss where you feel most comfortable and is most convenient for you. Some schools have a school nurse drop in that you can access confidentially.

WHEN?

You can contact our service by calling our Single Point of Access administration team on 01226 774411, who can help you and pass on messages for a member of the Public Health Nursing team to contact you, Our office hours are Monday- Friday 9am-5pm.

MST
Multisystemic Therapy

WHAT?

Multisystemic Therapy (MST) works with families and other agencies, such as social work teams and Youth Offending Services, to safely keep young people with their families and in the community.

WHO?

Children
Young people, theri parents and carers

HOW?

Placing young people out of home in custody or care is usually not effective in reducing their offending or problem behaviour and MST works to prevent this happening where possible by strengthening parents' skills in keeping their child out of trouble and working to change young people's behaviour.
Increase parents or carers skills and confidence

WHERE?

Multisystem Therapy Team,
McLintocks Building, Summer Lane,
S70 2NZ

WHEN?

Contact MST for more information:
Email: MST@Barnsley.gov.uk
01226 774989
www.mstuk.org/mst-barnsley

The Challenging Behaviour Foundation
making a difference to the lives of people with severe learning disabilities

WHAT?

The Challenging behavior Foundation is the charity for people with severe learning disabilities whose behaviour challenges. We're making a difference to the lives of children and adults across the UK through providing information about challenging behaviour, peer support groups for family carers and professionals, supporting families by phone or email and running workshops to reduce challenging behaviour.

WHO?

For people with severe learning disabilities whose behaviour challenges

HOW?

We offer information about challenging behaviour to anyone who provides unpaid support to a child, young person or adult with a severe learning disability. We can also signpost you to other specialist organisations and sources of information.

You can call us on: 0300 666 0126
Or email us at: support@thecbf.org.uk

WHERE?

Contact us for more information
www.challengingbehaviour.org.uk

WHEN?

We are open at the following times:
Monday – Thursday: 9am – 5pm
Friday: 9am – 3pm

Scope
About disability

WHAT?
Scope is the disability equality charity. We won't stop until we achieve a society where all disabled people enjoy equality and fairness. At home. At school. At work. In our communities. Scope is a strong community, of disabled people and non-disabled people, with a shared vision of equality. Scope uses a collective power to change attitudes and end injustice.

WHO?
For people who may need support and information around disability.

HOW?
We provide practical advice and emotional support whenever people need it most. We do this through our Scope helpline, our online community, a range of employment services, community engagement programmes, and more. All of our services are developed to achieve our strategy, Everyday Equality.

WHERE?
Call 0808 800 3333 for support and disability information
For independent support or disability information, contact our free helpline.
Email helpline@scope.org.uk

WHEN?
Contact Scope for more information.
Contact Scope 9am to 5pm on weekdays. Scopes are closed bank holidays.
www.scope.org.uk

SENDIASS: Special education needs, disability information advice support service

BARNSLEY
Metropolitan Borough Council

WHAT?

The Special Educational Needs and Disabilities, Information, Advice and Support Service (SENDIASS) offers free, confidential and impartial: information, guidance, advice and support.

WHO?

It's available to all children, young people and parents and carers of children and young people who: have a Special Educational Need (SEN) or disability; are between the age 0-25 years and live in the borough of Barnsley.

HOW?

Services we can offer you:
The opportunity for you to talk things through and say what your concerns are; support when writing letters to school, early years and post 16 settings and the local authority; help with Statutory Assessment and Education; Health and Care Plan process advice or issues around school/setting placement; support at meetings; advice on who you should contact if there are behavioural, emotional or social difficulties information on appeals to SEND (Special Educational Needs & Disability)

WHERE?

SENDIASS Barnsley (formerly Parent Partnership service),
Corporate Mailroom, PO Box 634,
Barnsley,
S70 9GG Phone 01226787234

WHEN?

Contact us for more information (01226) 787234

Early Help for Families

BARNSLEY
Metropolitan Borough Council

WHAT?

Early help is the support we give to children, young people and their families where they have additional needs that aren't being met by universal services (services that are available to everyone, like health and education). When a family has additional needs, we make sure they have access to the support they need at the earliest possible stage to prevent their needs becoming greater.

WHO?

Early help offer is for children and young people up to the age of 19 (25 if

they have learning development needs or disabilities) and families..

HOW?

The best way to get support is to talk to a professional that knows you already, such as a GP, teacher, family support worker, school nurse, health visitor or early intervention and prevention worker. They'll be able to talk to you about what additional help you may need and how to access it. We offer early help, either through universal or targeted services, based on individual needs.

WHERE?

You can find out more details of our family centres by following the link: www.barnsley.gov.uk/services/children-families-and-education/child-care-nurseries-and-family-support/family-centres/

WHEN?

Contact for more information: 0800 0345 340
If you think the child's in immediate danger, call the police on 999 or (01142) 202020. If the child's not in immediate danger, but you're still concerned about them, call (01226) 772423 (weekdays before 5pm). Call our emergency duty team on 0844 9841800 if you're calling after 5pm,

BERNESLAI HOMES

WHAT?

We deliver the social housing service on behalf of Barnsley Metropolitan Borough Council and this includes the following services.
We manage the waiting list and let vacant homes.
We collect rent, repair, maintain and develop our homes and estates., support people facing financial difficulties and support people to manage their tenancy.

WHO?

For young people, and adults.

HOW?

We do as much as possible to support you in your home every step of the way. We know that sometimes it can be difficult to live a fully independent life without additional help or support, so we offer a range of services suited to your needs, your family and your life. We offer advice and support for all tenants including older and disabled people.

WHERE?

Contact Berneslai Homes for more information.

WHEN?

You can get in touch with us online by completing our online forms or via email. We also send out regular news and information to our tenants via email or text. If you would like to sign up for this information then please follow this link to sign up. Contact Berneslai Homes on: barnsleytaras@gmail.com

The Paediatric Therapy Service

WHAT?

The paediatric therapy service aims to support children to maximise their potential in all aspects of daily life.

WHO?

Children and young people and their families.

HOW?

If you are concerned about your child, you are able to self-refer to the service. Referrals are also accepted from: allied health professionals carers/family, consultants, GPs, health visitors, hospital staff, local authority staff and schools. The service works in close partnership with families, carers, schools, nurseries, and other professionals. Paediatric therapists see children in clinics, children's centres, nurseries, schools and in their homes.

WHERE?

Find us: Directions or location information
Telephone: 01226 644396
Hours:Monday - Friday 8.30am - 4.30pm
Visit our website at www.southwestyorkshire.nhs.uk

WHEN?

Contact us
The Lodge, Kendray Hospital, Doncaster Road
Barnsley, S70 3RD Telephone: 01226 644396
Hours: Monday - Friday 8.30am - 4.30pm

Barnsley Family Information Service

WHAT?

Barnsley Family Information Service provides free and confidential information and advice for the whole family.

WHO?

For families of children and young people aged 0-25 years with a special educational need, disability or complex health needs.

HOW?

We have a dedicated Family Involvement and Information Officer for Disabled Children and Young People. They support families of children and young people aged 0-25 years with a special educational need, disability or complex health need. They can offer support and information to families on: early help, family support and family centres a range of local and national service, including support groups, organisations and charities short breaks for children with disabilities, including help to apply for a short break.

WHERE?

You can access information via our website Barnsley Family Services Directory, or contact us. The website provides a huge range of information on childcare, including: funded places, help with childcare costs, recreational activities and things to do, how to access early help and family centres Barnsley's Local Offer and much more.

WHEN?

Gateway Plaza, Sackville St, Barnsley S70 2RD Hours:
Monday 9am–5pm/ Tuesday 9am–5pm/ Wednesday 9am–5pm
Thursday 9am–5pm/ Friday 9am–4:30pm
Saturday/Sunday Closed
Phone: 0800 034 5340

MENTAL HEALTH FRIENDLY APPS AND WEBSITES

This list has been complied by Chilypep as a guide to the apps available to support young people's wellbeing.

Please check the suitability of each App, and if there are any cost implications or compatibility issues. Please also be aware that some apps may not be free and always check the in-app purchases.

Doc Ready: For help and support expressing and describing your symptoms and medical history to a GP you can use www.docready.org to create a printable doctument to help get you prepared for your appoitnment.

Find, Get, Give: This is a mental health services signposting website for young people aged 11-25 where you can find help, get help and give feedback. For more information visit www.findgetgive.com.

Mood Bug: This is an app young people can use to share their mood with their friends and see how others are feeling.
For more information download the app or visit www.moodbug.me.

Head Meds: This website, powered by Young Minds gives young people more information about medication. Visit www.headmeds.org.uk

Stay Alive App: This app is a pocket suicide prevention resource full of useful information and tools to help you stay safe in crisis. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide.
Search Stay Alive in your app store.

MindSpace Report

October 2019

Since November 2016,

Over 2300 young people aged 11 to 16 have accessed a 1:1 intervention, **45%** male and **55%** female (less than 2% of young people accessing MindSpace 1:1 interventions have needed 'stepping up' to specialist services)

Over 1400 young people aged 11 to 16 have accessed group interventions, almost **40%** male and **60%** female (0.02% of young people accessing group sessions have required further 1:1 intervention)

MindSpace website https://wearemindspace.com/contact/ is useful for young people and parents to access to help them understand more about mental health difficulties, providing details of websites and apps offering self-help strategies.

Over 500 parents have accessed the MindSpace Parent Counsellor or the Parent Liaison Officer.

Single Point of Access – MindSpace have received over 150 referrals from Specialist CAMHS services 90% have been referrals made to CAMHS by GPs and triaged to MindSpace.

12 Youth Mental Health Ambassadors across 2 secondary schools, Horizon and Kirk Balk, plans are in place to train more ambassadors in partnership with Chilypep, by 2022 we plan to have ambassadors in all secondary schools. The Ambassadors are trained as peer mentors including Youth Mental Health First Aid Lite training. MindSpace work closely with the peer mentors at Barnsley College who offer a safe space for young people transitioning to College.

The Director of MindSpace was seconded in an advisory role to the Department of Education 2 days per week from January 2019 to July 2019 supporting the implementation of the new Mental Health Support Teams across the Trailblazer sites, contributing to policy writing and supporting documents for the CCGs and the successful Trailblazer sites.

The funding from the Department of Health and Social Care to support the Beyond Places of Safety project was delayed by almost 12 months, the money is to support the development of an app requested by the young people, the wireframes have now been developed and the design work is due to start, the funding will also provide supplementary information to the MIndSpace website, including a digital infrastructure at The Hub, supporting young people, professionals and families to access on line counselling and self-care/help strategies.

The **NHS IST** highlighted 2 recommended key areas for improvement for the MindSpace service

1. Assessment Tool to support initial assessment decision, IST recommended the Current View Tool.
2. Flow MindSpace data

Staff have received training on the Current View Assessment Tool, this will be in place from week beginning 4th November 2019.

Measures are in place to start and flow data monthly which is a total system change for MindSpace, Director of MindSpace attending an NHS training event 'CYPMH Access Data Support Session'

Appendix 9

Monday 4th November 10 until 1 at Sheffield CCG, this workshop will provide clarity enabling MindSpace to fully flow data early 2020.

This is what our service users say about MindSpace.

Young people's comments who attended the group sessions from across the 10 secondary schools, when asked from the experience of service questionnaire, 'What was really good about your care?'

"I liked the people that were in the group and have made memories and friends."

"I feel better knowing that others can cope so I can learn to do the same."

"It gave me things to help me and stopped me worrying about things and gave me more confidence."

"Everyone can share their problems, and something can be done to help."

"Helped me conquer my fears as well as overcoming stress."

"Everyone kept the group promise."

"It gave me time to reflect on revision I am doing and relax me about exams e.g to cope with them better."

"I feel as though it really helped me improve my behaviour at home."

"I know different ways to resolve my anxiety and stress when needed."

"I was listened to and understood. Any issues we had were dealt with in a positive manner. I felt comfortable and relaxed in every session."

"They helped me get comfortable at school."

"I got to understand people opinions and how to deal with emotions."

Young people's comments who attended 1:1 sessions from across the 10 secondary schools, when asked from the experience of service questionnaire, 'What was really good about your care?

"I was taken seriously, and all my concerns were treated with respect. I also feel I was helped with other things than just what I asked for."

"I was given the opportunity to open up about how I felt and fully understand what I'm going through, there is no fear of being judged."

"I was listened to and my thoughts and feelings were taken seriously."

"I know how to cope now and if I'm struggling, I know to get help, I'm also getting more help in class now."

"Having someone to talk to who will listen and cares, being given things I can use to help myself. Knowing I am getting the help I need now as well as in further education."

"They helped with my anger and how I can deal with it."

"I received help for my anxiety and mood and was actually taken seriously."

"Even though I'm not really comfortable talking to people I don't know, I felt safe. I liked that I was the one talking, not Jade guessing how I felt."

"They really understood my feelings and gave me advice to help."

"The care here was really good, I havn't had many panic attacks since starting 1:1 sessions and it hasn't affected my school work."

Comments from parents/carers who accessed the Parent counsellor and Family Practitioner service when asked 'What was really good about the support you have received.'

"Being made to feel important and helping me to develop skills and an understanding of my own importance, in order to deal with situations that arise but by ensuring that I have time for me in order for me to be there to support my family."

"There was no pressure to complete in a set number of weeks and no criticism if certain issues weren't resolved immediately and took a while to sort out, David was very patient, if I regressed from week to week over family sessions. I was told the sessions were my space to discuss what I needed to discuss – I guess in the early sessions I probably repeated things but this wasn't necessarily a bad thing as it allowed me to work through things and I have benefited overall."

"I felt listened to and was able to off-load to remove pressures that had been building .I feel I have benefited as I can now reflect and open up to others, something I wasn't confident at doing before."

"I was listened to and coping strategies were discussed as to what would be best for us, not just as a general."

"Rachel has advised me very well in every think very happy with her."

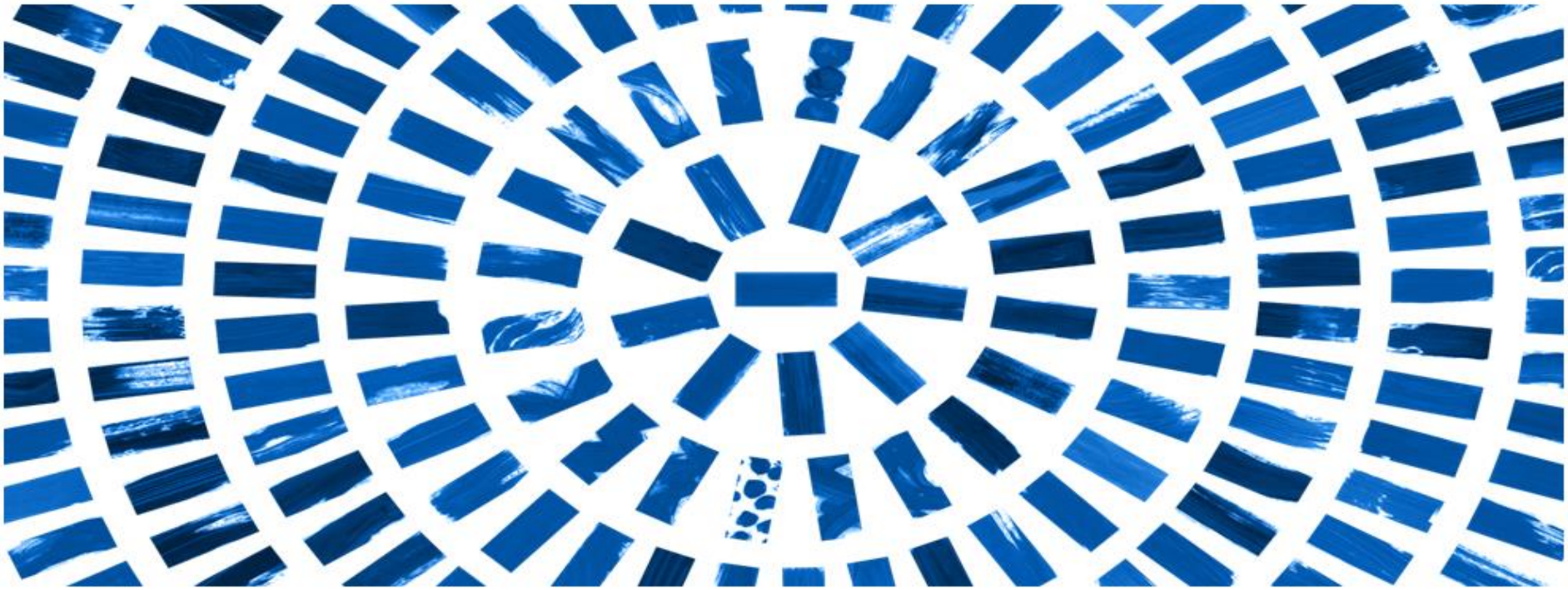
"Really caring and understanding. Rachel has been brilliant and listened and not rushed anything. I have had a good rapport with her. A lovely manner and helped with things I never thought I could manage. Everyone should have a worker like Rachel she cares for the well-being of people with a warm and friendly way."

"Rachel has advised me very well in everything, very happy with her."

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

CAMHS Key Performance Indicators

Barnsley



November - 2019

With **all of us** in mind.

Contents

Supporting Information

For the following KPI topics, activity and performance are reported based on the CCG of the client:

- Referrals
- Contacts
- Waits
- Did not attend (DNA)
- Caseload

For example - Total referrals received KPI: contains any Barnsley CCG client no matter which SWYPFT CAMHS service they have accessed. The CCG of the client is determined by the GP practice the client is registered with.

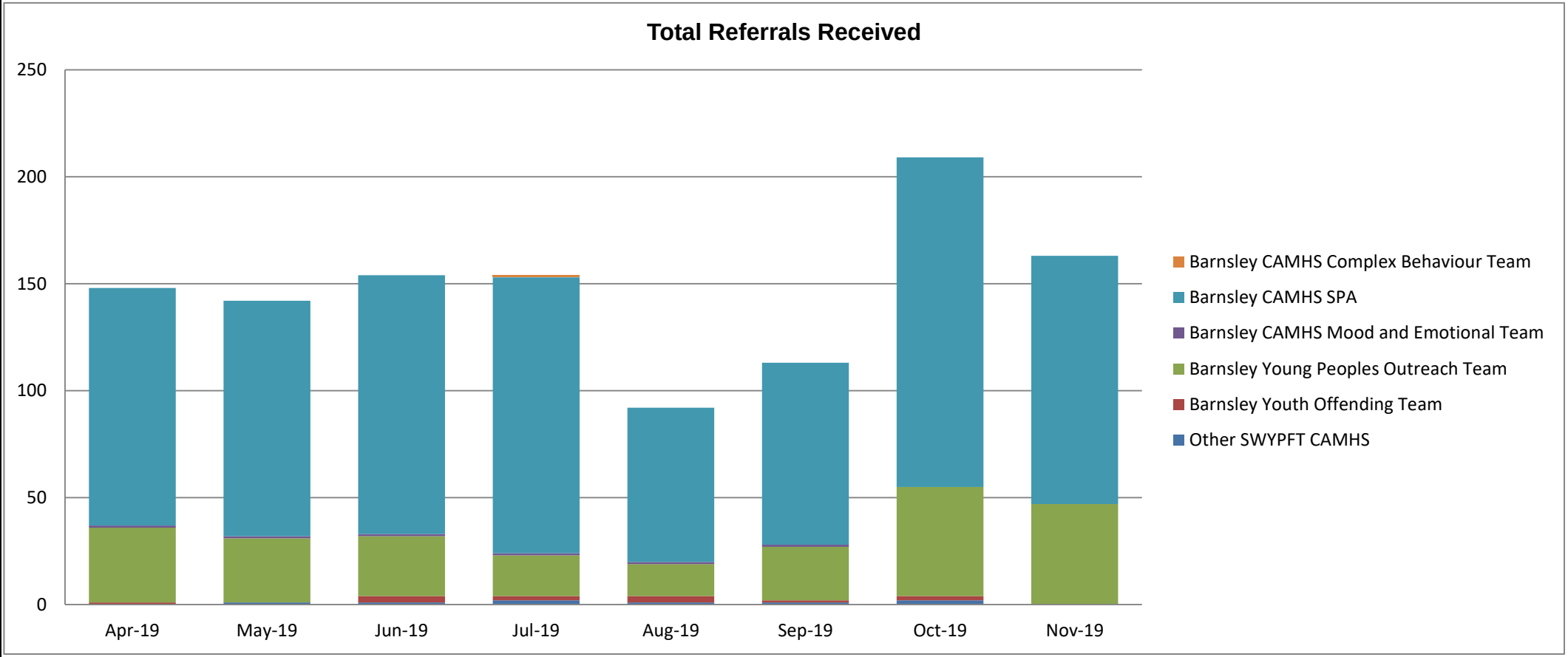
Pathway Information

The Complex Behaviour Pathway is our specialist pathway where children and young people are accepted for assessment and treatment around such presentations as neurodevelopmental issues, mental health issues that would present through behaviours, attachment, LD, postdiagnostic ASD work (list not exhaustive) this is where cases awaiting ADHD assessment and treatment are held currently.

The Mood and Emotional Pathway is our other specialist pathway where children and young people are accepted for mood disorders such as anxiety, low mood, OCD, phobias, attachment issues, eating difficulties (list not exhaustive)

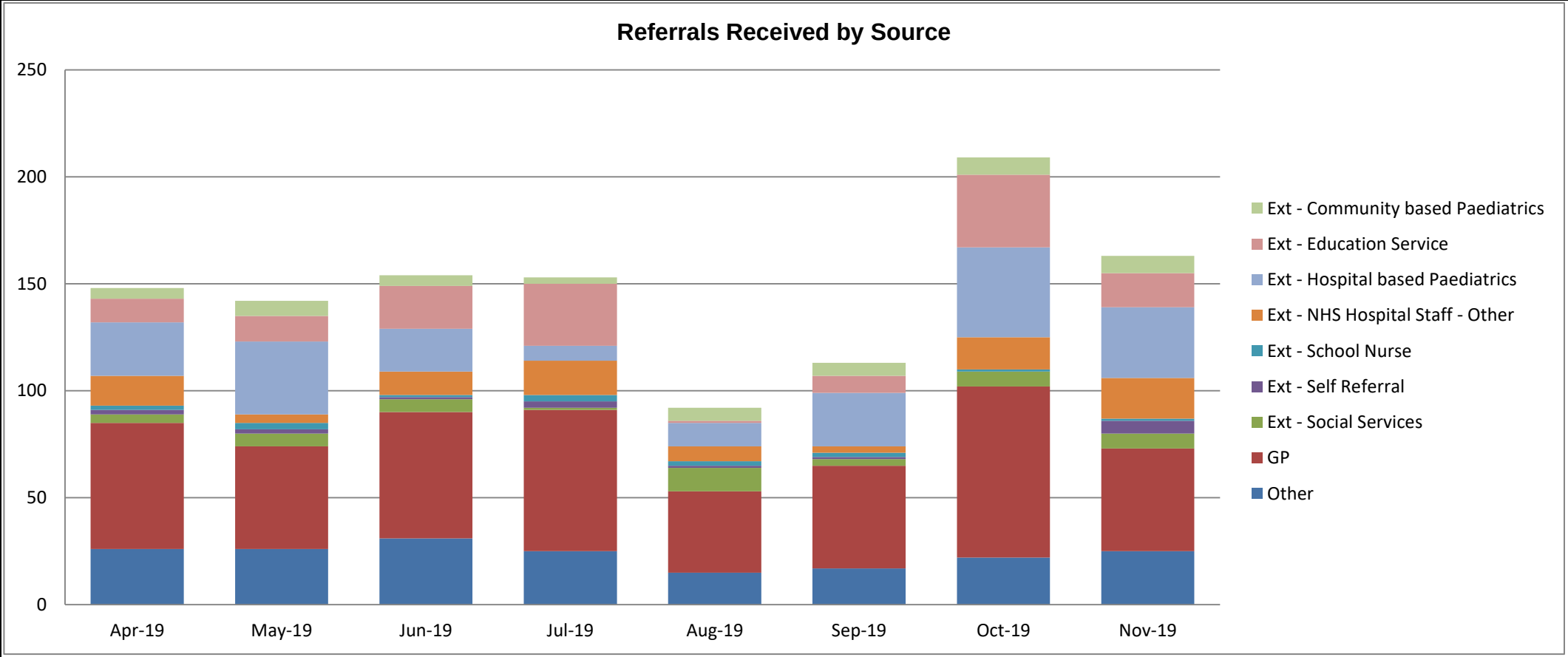
Following a change of clinical system in March 2019, South West Yorkshire Partnership NHS Trust have experienced data quality issues. This has impacted on the completeness of CAMHS data. Please bear this in mind when conducting any analysis.

Referrals Received



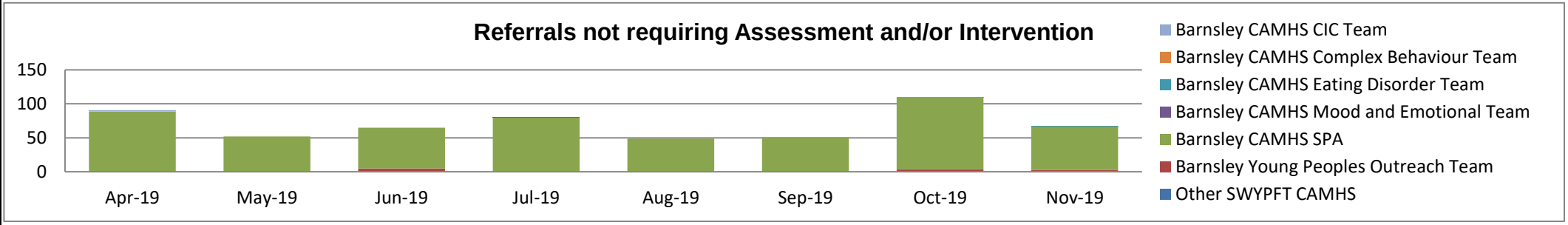
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS Complex Behaviour Team				1					1
Barnsley CAMHS SPA	111	110	121	129	72	85	154	116	898
Barnsley CAMHS Mood and Emotional Team	1	1	1	1	1	1			6
Barnsley Young Peoples Outreach Team	35	30	28	19	15	25	51	47	250
Barnsley Youth Offending Team	1		3	2	3	1	2		12
Other SWYPFT CAMHS		1	1	2	1	1	2		8
Grand Total	**148**	**142**	**154**	**154**	**92**	**113**	**209**	**163**	**1175**

Referrals Received Cont.

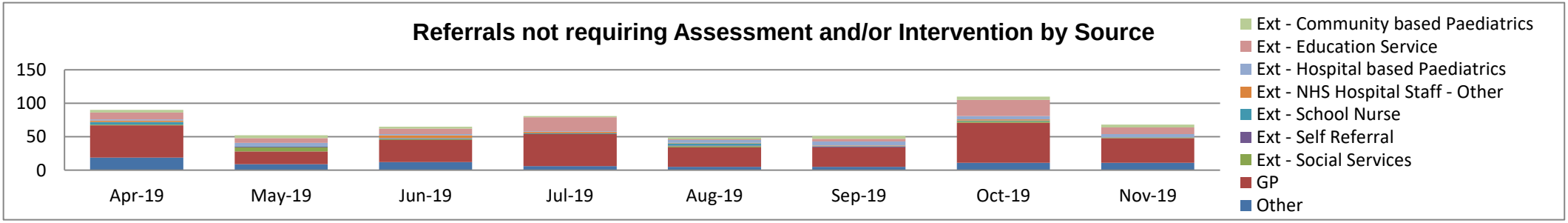


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Ext - Community based Paediatrics	5	7	5	3	6	6	8	8	48
Ext - Education Service	11	12	20	29	1	8	34	16	131
Ext - Hospital based Paediatrics	25	34	20	7	11	25	42	33	197
Ext - NHS Hospital Staff - Other	14	4	11	16	7	3	15	19	89
Ext - School Nurse	2	3	1	3	2	2	1	1	15
Ext - Self Referral	2	2	1	3	1	1		6	16
Ext - Social Services	4	6	6	1	11	3	7	7	45
GP	59	48	59	66	38	48	80	48	446
Other	26	26	31	25	15	17	22	25	187
Grand Total	**148**	**142**	**154**	**153**	**92**	**113**	**209**	**163**	**1174**

Referrals Received Cont.

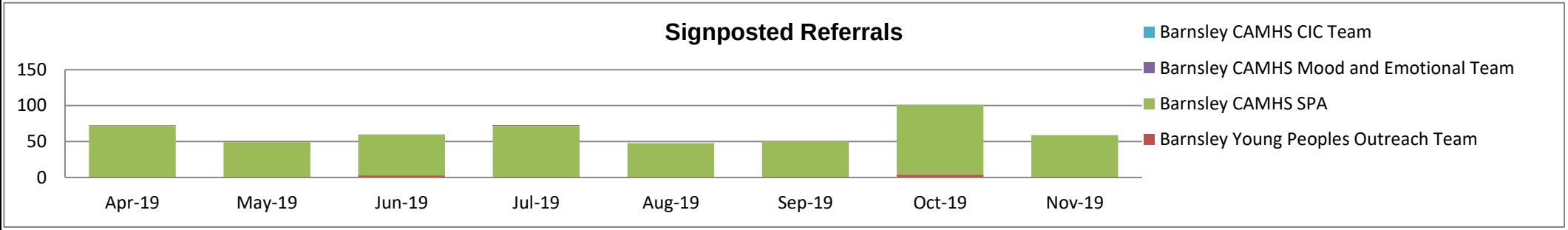


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS CIC Team	1								1
Barnsley CAMHS Complex Behaviour Team							1		1
Barnsley CAMHS Eating Disorder Team								1	1
Barnsley CAMHS Mood and Emotional Team				1					1
Barnsley CAMHS SPA	88	51	60	79	49	50	105	64	546
Barnsley Young Peoples Outreach Team	1	1	4	1		1	4	2	14
Other SWYPFT CAMHS			1					1	2
Grand Total	**90**	**52**	**65**	**81**	**49**	**51**	**110**	**68**	**566**

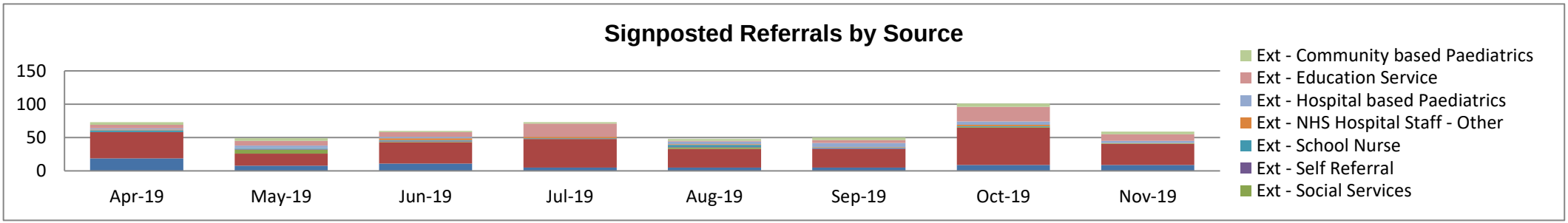


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Ext - Community based Paediatrics	4	4	3	2	3	4	5	4	29
Ext - Education Service	10	7	8	21	1	4	24	10	85
Ext - Hospital based Paediatrics	2	5	2	1	4	6	5	5	30
Ext - NHS Hospital Staff - Other	2		4	2	1	1	2		12
Ext - School Nurse	4	1	1	1	3	1	1		12
Ext - Self Referral		1	1		1	1			4
Ext - Social Services	1	6	1		2		2	1	13
GP	48	19	33	48	29	29	60	37	303
Other	19	9	12	6	5	5	11	11	78
Grand Total	**90**	**52**	**65**	**81**	**49**	**51**	**110**	**68**	**566**

Referrals Received Cont.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS CIC Team	1								1
Barnsley CAMHS Mood and Emotional Team				1					1
Barnsley CAMHS SPA	72	49	57	71	48	49	97	58	501
Barnsley Young Peoples Outreach Team			3	1		1	4		9
Other SWYPFT CAMHS								1	1
Grand Total	**73**	**49**	**60**	**73**	**48**	**50**	**101**	**59**	**513**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Ext - Community based Paediatrics	4	4	2	2	3	4	5	4	28
Ext - Education Service	5	7	7	20	1	4	22	10	76
Ext - Hospital based Paediatrics	2	4	2		4	6	5	3	26
Ext - NHS Hospital Staff - Other	1		3	2	1	1	2		10
Ext - School Nurse	3	1	1	1	3	1	1		11
Ext - Self Referral		1	1		1	1			4
Ext - Social Services		6	1		2		1	1	11
GP	39	18	32	43	28	28	56	32	276
Other	19	8	11	5	5	5	9	9	71
Grand Total	**73**	**49**	**60**	**73**	**48**	**50**	**101**	**59**	**513**

Referrals Received Cont.

Description:

Referrals received includes all referral sources, urgencies and those referrals that are assessed as not requiring a service from CAMHS.
Referrals not requiring assessment and or intervention includes all referrals marked in the electronic patient record as "inappropriate", "inappropriate advice/liaison given" or "inappropriate (signposted)" upon discharge.

This could be done as soon as the referral comes into the service or may happen after the initial or choice appointment. It does not include any clients where they have been signposted to another organisation/agency after treatment with the service.

Signposted referrals are a subset of the total referrals not requiring assessment or intervention.

Comments:

2 additional referrals were received from out of area CCGs, both from Wakefield CCG. One was an inappropriate referral from Barnsley College which was referred to Wakefield CAMHS and one has recently moved to Barnsley.

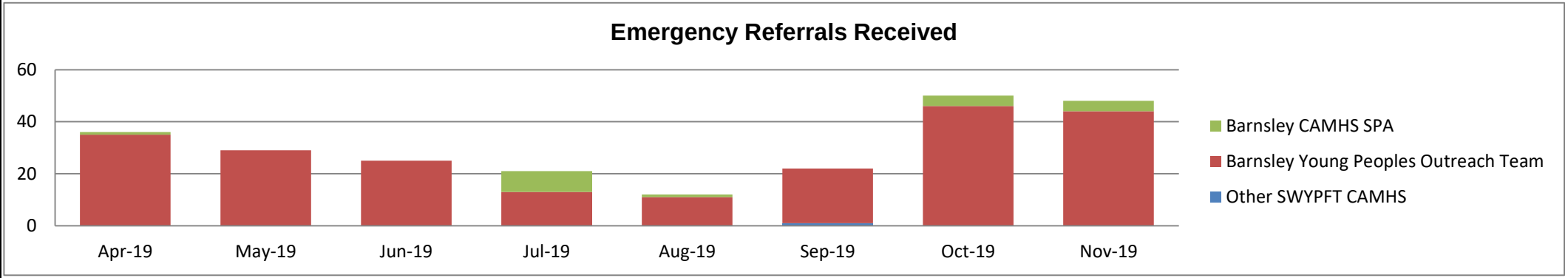
SPA - Inappropriate Referrals and Signposting

The total referrals marked as “Referrals not requiring Assessment and/or Intervention” for November 2019 do not solely relate to referrals received in November 2019, this is based on the month of discharge. 10 referrals were received in previous months.

Signposting destinations in November 2019:

0-19 Public Health Nurses, OT, Paediatrics, School Services and Opticians	1	Mindspace	12
ADHD Pre-Requisites	8	Mindspace and MIND	1
ASDAT	5	Mindspace and Unravelled school service	1
ASDAT, Early help, O/T Solihull parenting, and Cygnet	1	Mindspace, Sheffield Sleep Clinic and Paediatrics	1
ASDAT, OT and CYGNET	1	OOA LAC	1
Back to Consultant for more physical investigations	1	Parenting / Early Help	1
BSARCS, TADS	1	Safety advice, TADS and School Refusal Service.	1
College Counsellors and Barnsley Bereavement	1	Stability in setting, life story work by social care and if stepped down FSW /family centres	1
Diabetic team and maybe 0-19 PH Nurses.	1	TADS	1
Doncaster CAMHS	1	TADS and THRIVE	1
Early Help	5	TADS, ASDAT, Barnardo's	1
Early Help and Educational Psychology.	1	YPOS	1
Early help, EHCP, Parenting Course	1	Back to SPA (not ED)	1
Early help, family centre, parenting course, nurture group	1	SENDIASS, communication n interaction team O T sensory workshop and CYGNET	1
Early Help, Family Support Worker, Bereavement Services, SENDIASS	1	Parenting / Early Help	1
Early Help, Family Support Worker, Parenting Course and Nurture in School	1	Safety advice, TADS and School Refusal Service.	1
Early Help, TADS, ASDAT and Cygnet	1	Stability in setting, life story work by social care and if stepped down FSW /family centres	1
Educational Psychologist, Nurture in school and Family Centre support.	2	TADS	1
Educational Psychologist/ EHCP prior to ADHD Assessment.	3	TADS and THRIVE	1
FIS/MST	1	TADS, ASDAT, Barnardo's	1
IAPT	2	YPOS	1
IAPT / MST	1	Back to SPA (not ED)	1
Kooth Counselling	1	SENDIASS, communication n interaction team O T sensory workshop and CYGNET	1
MIND, Space & Safety	1		

Emergency Referrals



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS SPA	1			8	1		4	4	18
Barnsley Young Peoples Outreach Team	35	29	25	13	11	21	46	44	224
Other SWYPFT CAMHS						1			1
Grand Total	**36**	**29**	**25**	**21**	**12**	**22**	**50**	**48**	**243**

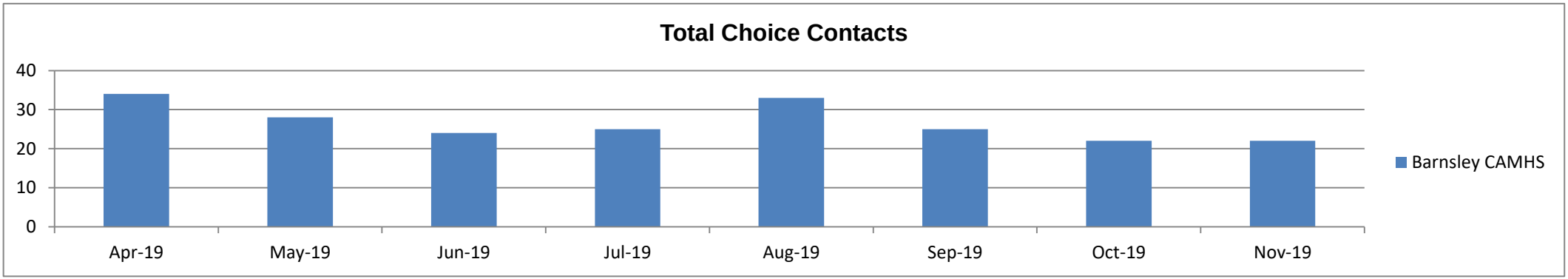
Description:

Emergency Referrals Received counts any referral with an urgency of "Emergency". Response within 4 hours is a direct (face to face) or indirect contact following receipt of referral.

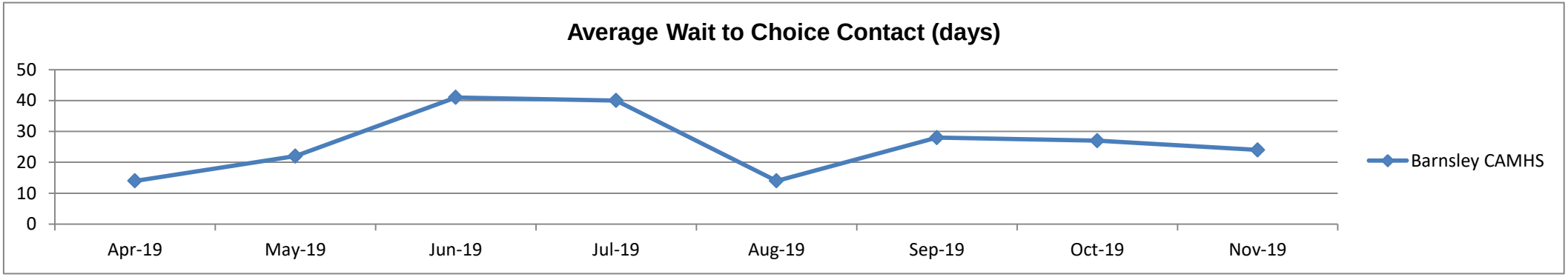
Where 'Other SWYPFT CAMHS' is stated the data refers to clients previously with an address and/or GP from other CAMHS within the SWYPFT geographical footprint.

Comments:

Assessment (Choice)

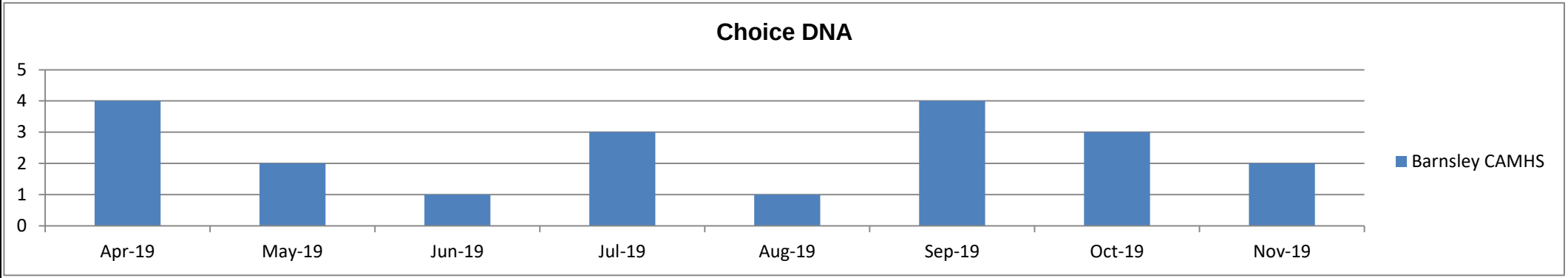


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS	34	28	24	25	33	25	22	22	213
Grand Total	**34**	**28**	**24**	**25**	**33**	**25**	**22**	**22**	**213**

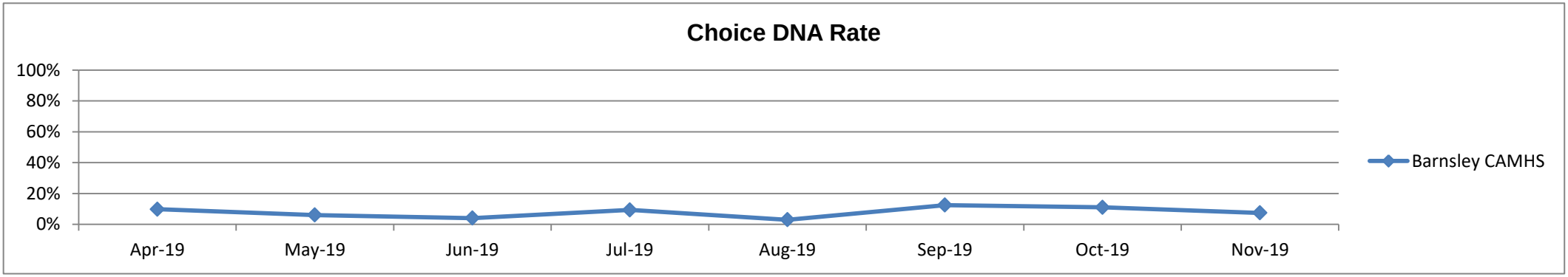


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Barnsley CAMHS	14	22	41	40	14	28	27	24
Grand Total	**14**	**22**	**41**	**40**	**14**	**28**	**27**	**24**

Assessment (Choice) Cont.

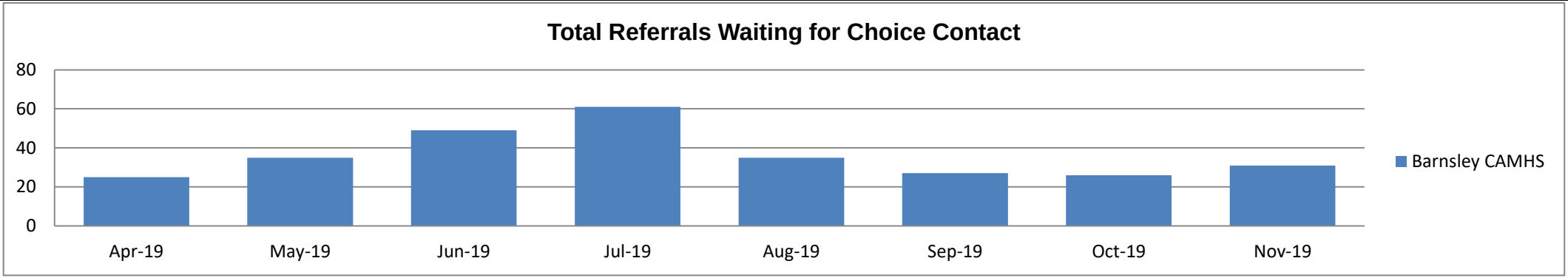


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS	4	2	1	3	1	4	3	2	20
Grand Total	**4**	**2**	**1**	**3**	**1**	**4**	**3**	**2**	**20**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Barnsley CAMHS	10%	6%	4%	9%	3%	13%	11%	7%
Grand Total	**10%**	**6%**	**4%**	**9%**	**3%**	**13%**	**11%**	**7%**

Assessment (Choice) Cont.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Barnsley CAMHS	25	35	49	61	35	27	26	31
Grand Total	**25**	**35**	**49**	**61**	**35**	**27**	**26**	**31**

Description:

The total number of assessment (Choice) contacts reflects all choice contacts where the client attended that have an outcome attached to them.
The average wait is given in days. Please note that whilst appointments may be available, clients may choose an appointment that suits them better outside of 4 weeks. The total referrals waiting for assessment (Choice) is a snapshot at month end; these clients could have a Choice appointment booked but not yet attended.

Comments:

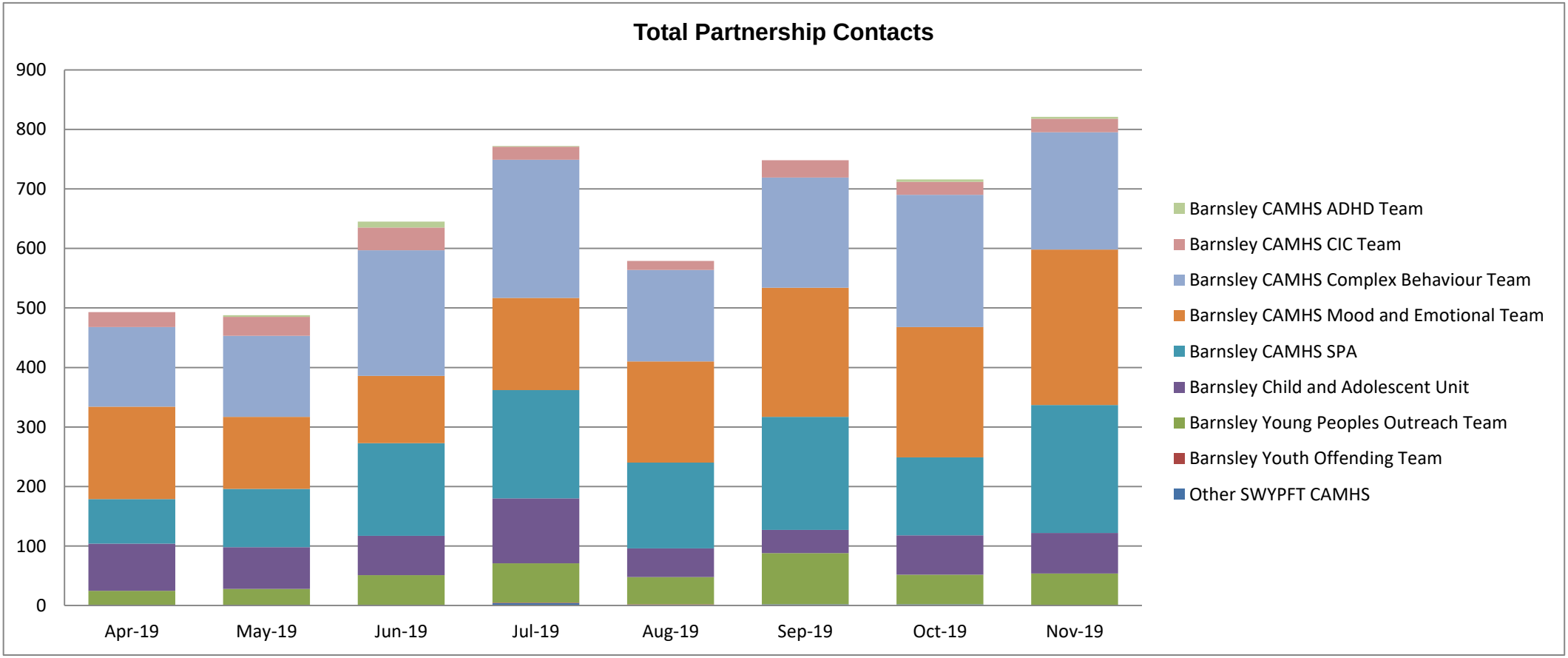
22 Choice appointments were attended, a total of 27 appointments were offered. There were also 2 DNAs and 3 appointments cancelled by patients.

Next available routine appointment as at 03/12/2019 is 27/12/2019. Appointments are now mainly held at New Street but clients are given the option for alternative location including home visits.

31 young people awaiting a Choice contact (26 booked and 5 waiting for opt-in contact).

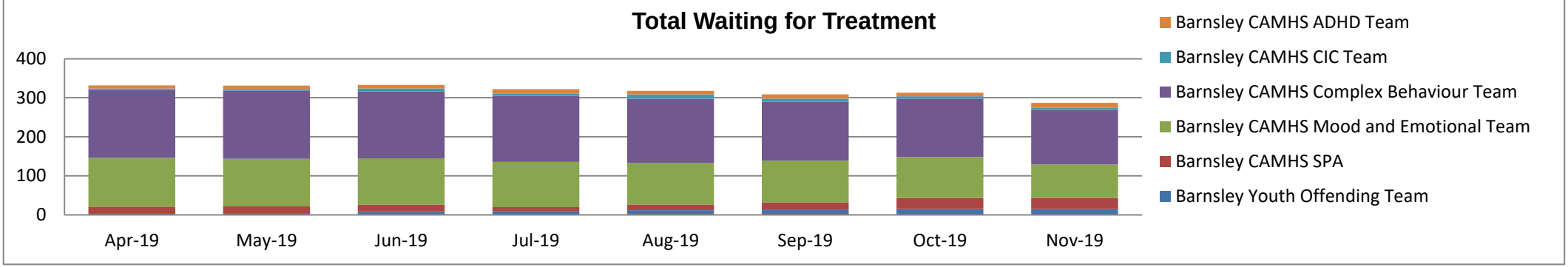
The SPA process has recently been reviewed and all clients referred into service are contacted via telephone to offer an appointment. This has led to an increase in the number of bookings and a reduced wait to opt-in.

Treatment (Partnership) Contacts

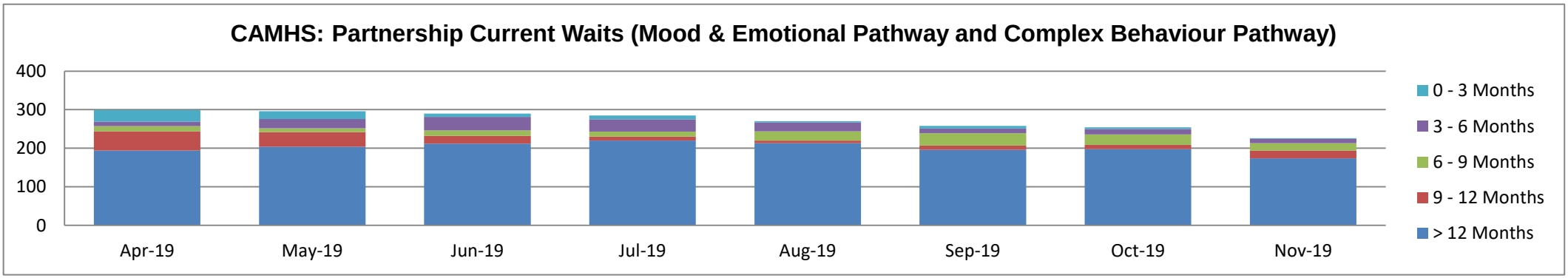


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS ADHD Team		3	10	1			4	3	21
Barnsley CAMHS CIC Team	25	32	38	22	15	29	22	23	206
Barnsley CAMHS Complex Behaviour Team	134	136	211	232	154	185	222	197	1471
Barnsley CAMHS Mood and Emotional Team	155	121	113	155	170	217	219	261	1411
Barnsley CAMHS SPA	75	98	156	182	144	190	131	215	1191
Barnsley Child and Adolescent Unit	79	70	66	109	48	39	66	68	545
Barnsley Young Peoples Outreach Team	24	27	50	66	46	86	50	54	403
Barnsley Youth Offending Team				1	1				2
Other SWYPFT CAMHS	1	1	1	4	1	2	2		12
Grand Total	**493**	**488**	**645**	**772**	**579**	**748**	**716**	**821**	**5262**

Treatment (Partnership) Contacts Cont.

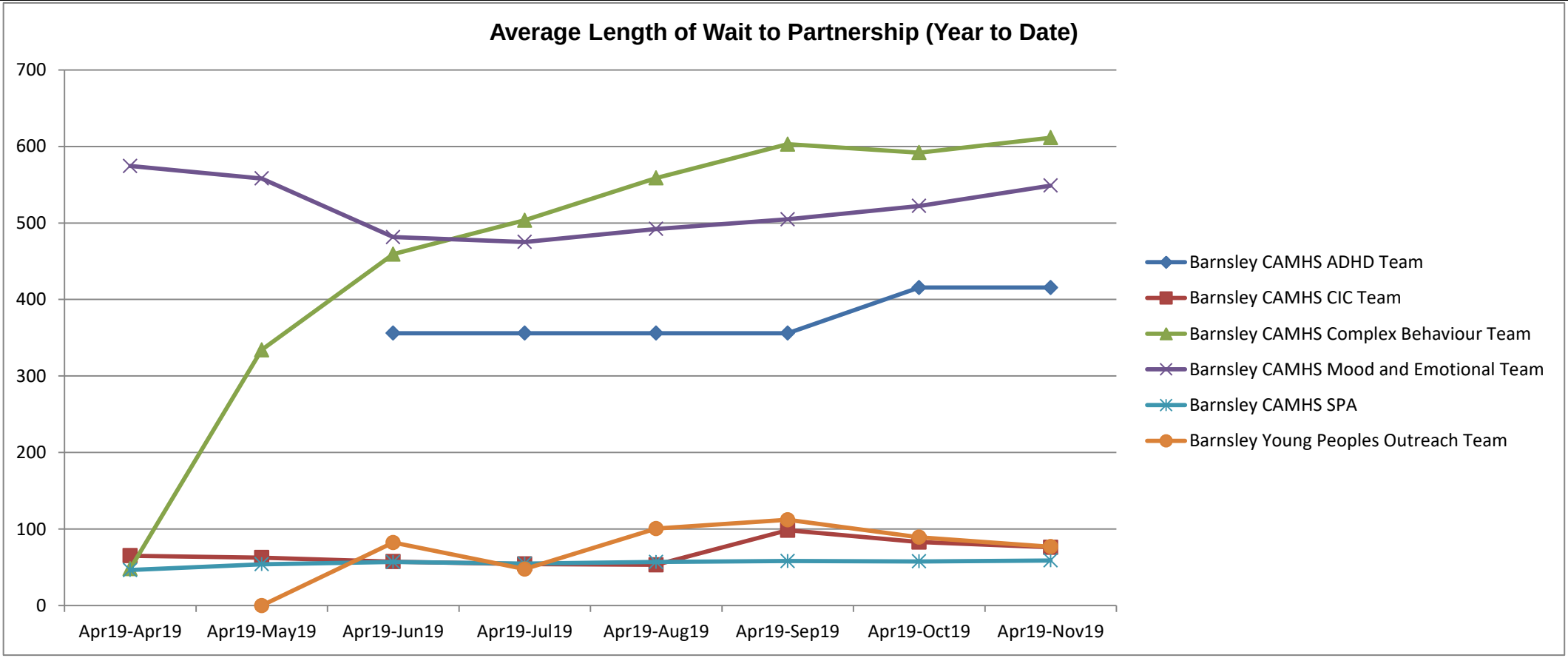


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Barnsley CAMHS ADHD Team	8	9	9	11	9	11	9	12
Barnsley CAMHS CIC Team	4	4	8	6	12	8	6	6
Barnsley CAMHS Complex Behaviour Team	174	174	171	169	164	151	150	140
Barnsley CAMHS Mood and Emotional Team	125	122	119	116	106	107	104	86
Barnsley CAMHS SPA	16	17	18	11	15	19	29	28
Barnsley Youth Offending Team	5	5	8	9	12	13	15	15
Grand Total	**332**	**331**	**333**	**322**	**318**	**309**	**313**	**287**



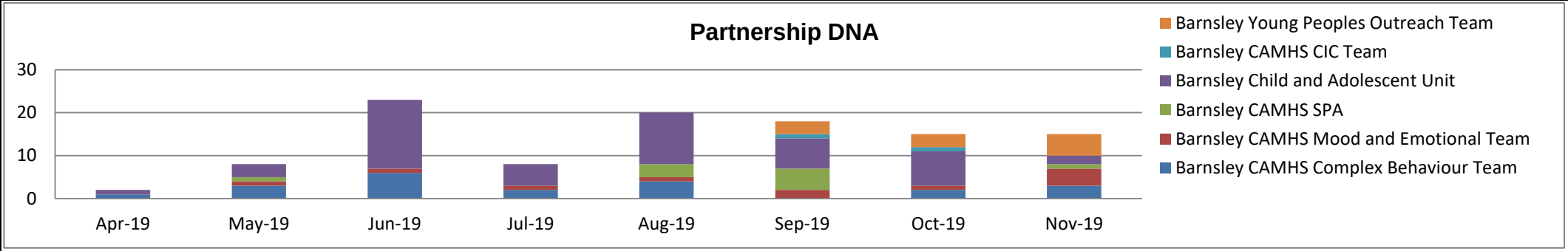
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
0 - 3 Months	30	20	9	10	3	7	4	2
3 - 6 Months	12	24	35	32	23	12	14	11
6 - 9 Months	13	10	14	13	24	32	27	19
9 - 12 Months	50	38	20	10	7	11	11	20
> 12 Months	194	204	212	220	213	196	198	174
Grand Total	**299**	**296**	**290**	**285**	**270**	**258**	**254**	**226**

Treatment (Partnership) Contacts Cont.

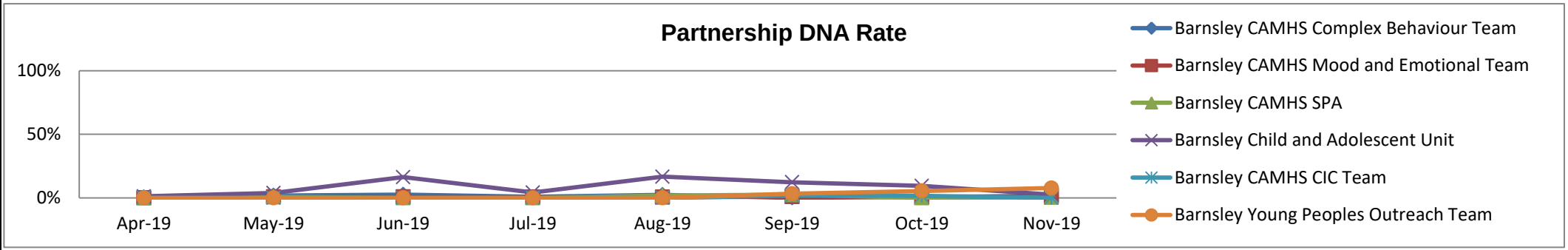


	Apr19-Apr19	Apr19-May19	Apr19-Jun19	Apr19-Jul19	Apr19-Aug19	Apr19-Sep19	Apr19-Oct19	Apr19-Nov19
Barnsley CAMHS ADHD Team			356	356	356	356	416	416
Barnsley CAMHS CIC Team	65	63	58	54	53	99	83	76
Barnsley CAMHS Complex Behaviour Team	48	334	459	503	559	603	592	611
Barnsley CAMHS Mood and Emotional Team	574	558	482	475	492	505	522	549
Barnsley CAMHS SPA	47	54	57	55	57	58	58	59
Barnsley Young Peoples Outreach Team		0	82	48	101	112	89	77
Overall Avg	**145**	**162**	**147**	**145**	**159**	**179**	**177**	**201**

Treatment (Partnership) Contacts Cont.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS Complex Behaviour Team	1	3	6	2	4		2	3	21
Barnsley CAMHS Mood and Emotional Team		1	1	1	1	2	1	4	11
Barnsley CAMHS SPA		1			3	5		1	10
Barnsley Child and Adolescent Unit	1	3	16	5	12	7	8	2	54
Barnsley CAMHS CIC Team						1	1		2
Barnsley Young Peoples Outreach Team						3	3	5	11
Grand Total	**2**	**8**	**23**	**8**	**20**	**18**	**15**	**15**	**109**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS Complex Behaviour Team	1%	2%	3%	1%	2%	0%	1%	1%	1%
Barnsley CAMHS Mood and Emotional Team	0%	1%	1%	1%	1%	1%	0%	1%	1%
Barnsley CAMHS SPA	0%	1%	0%	0%	2%	2%	0%	0%	1%
Barnsley Child and Adolescent Unit	1%	4%	16%	4%	17%	12%	9%	3%	8%
Barnsley CAMHS CIC Team	0%	0%	0%	0%	0%	2%	2%	0%	1%
Barnsley Young Peoples Outreach Team	0%	0%	0%	0%	0%	3%	5%	8%	3%
Grand Total	**0%**	**1%**	**3%**	**1%**	**3%**	**2%**	**2%**	**2%**	**2%**

Treatment (Partnership) Contacts Cont.

Description:

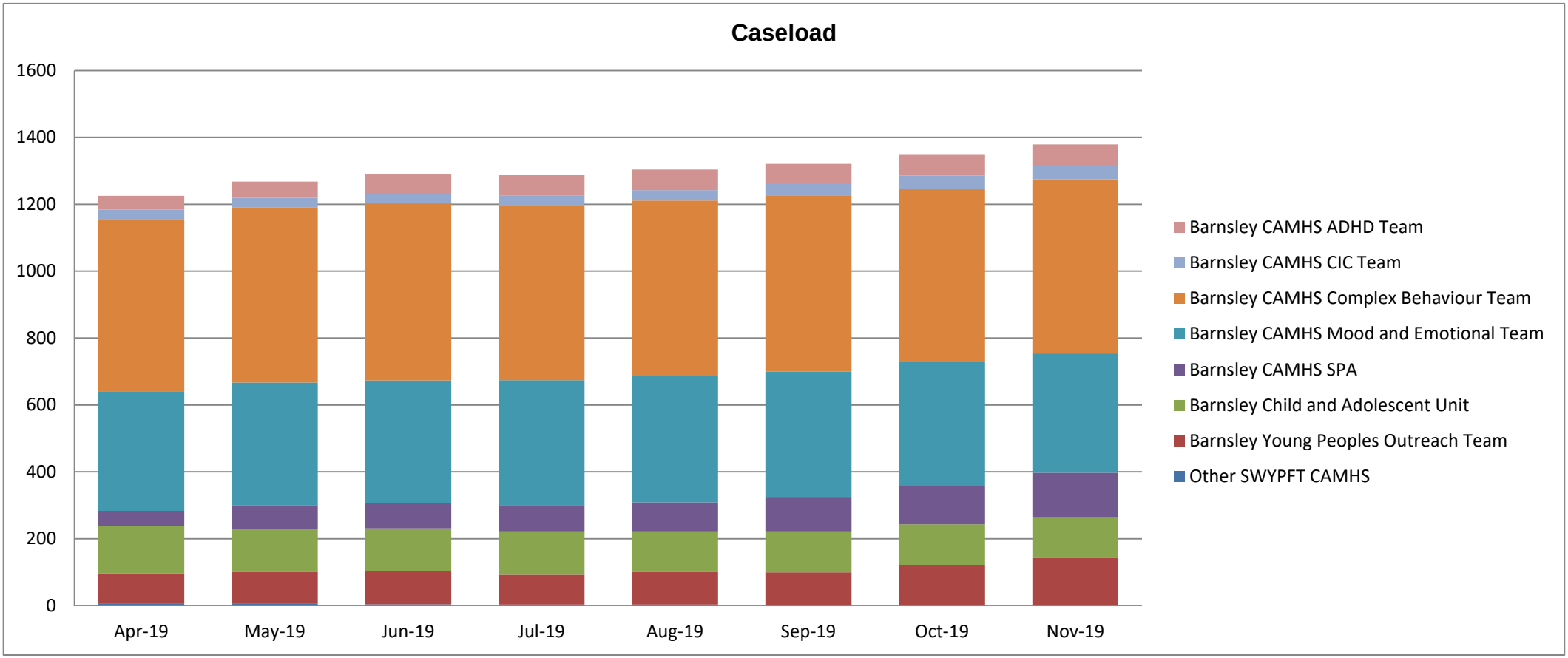
MDT processes are implemented across the service and the MDT allocate from waiting lists.

Comments:

Partnership contacts and DNA appointments are currently being under-reported due to recording issues on the clinical record system. The user confidence and competence problems still remaining across SWYPFT CAMHS will be escalated to the CAMHS SystmOne Improvement Group.

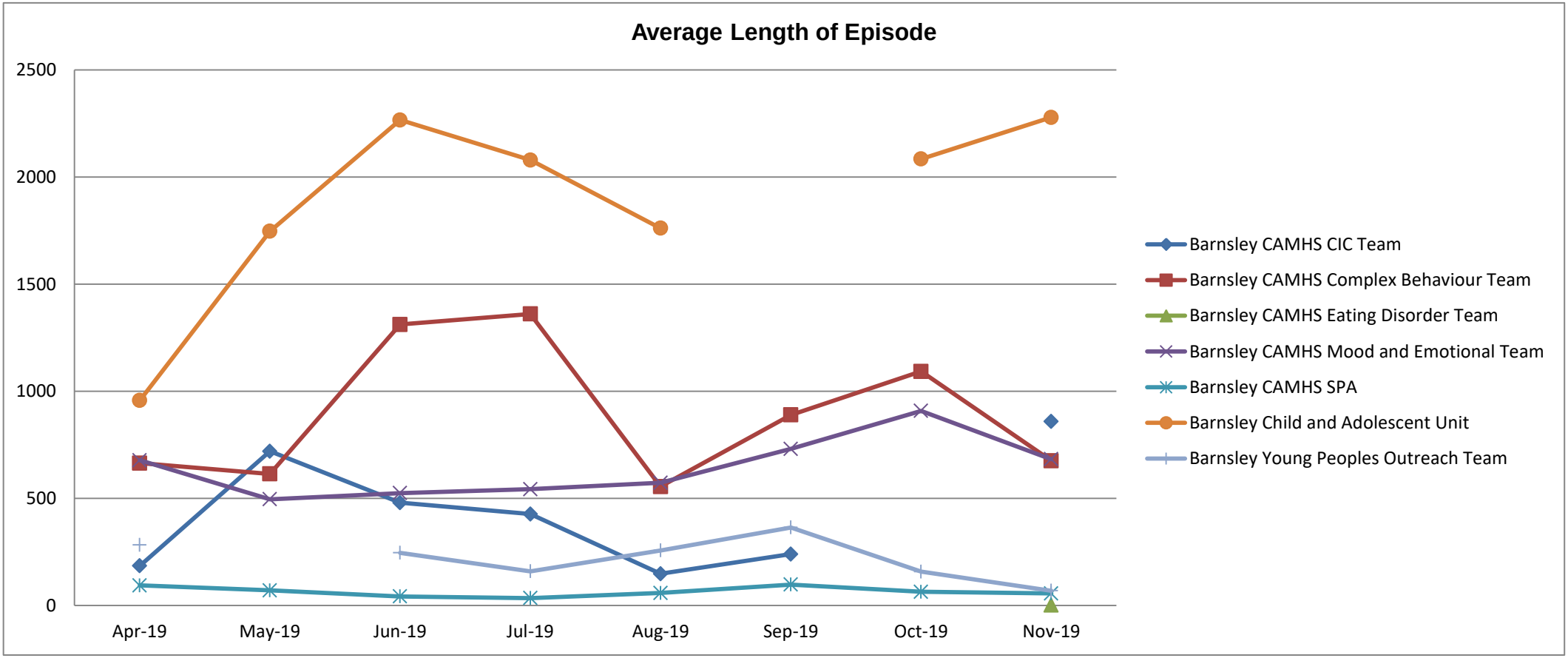
Due to system limitations the service is not able to log any group work appointments or appointments consisting of 2 or more clients.

Other Information



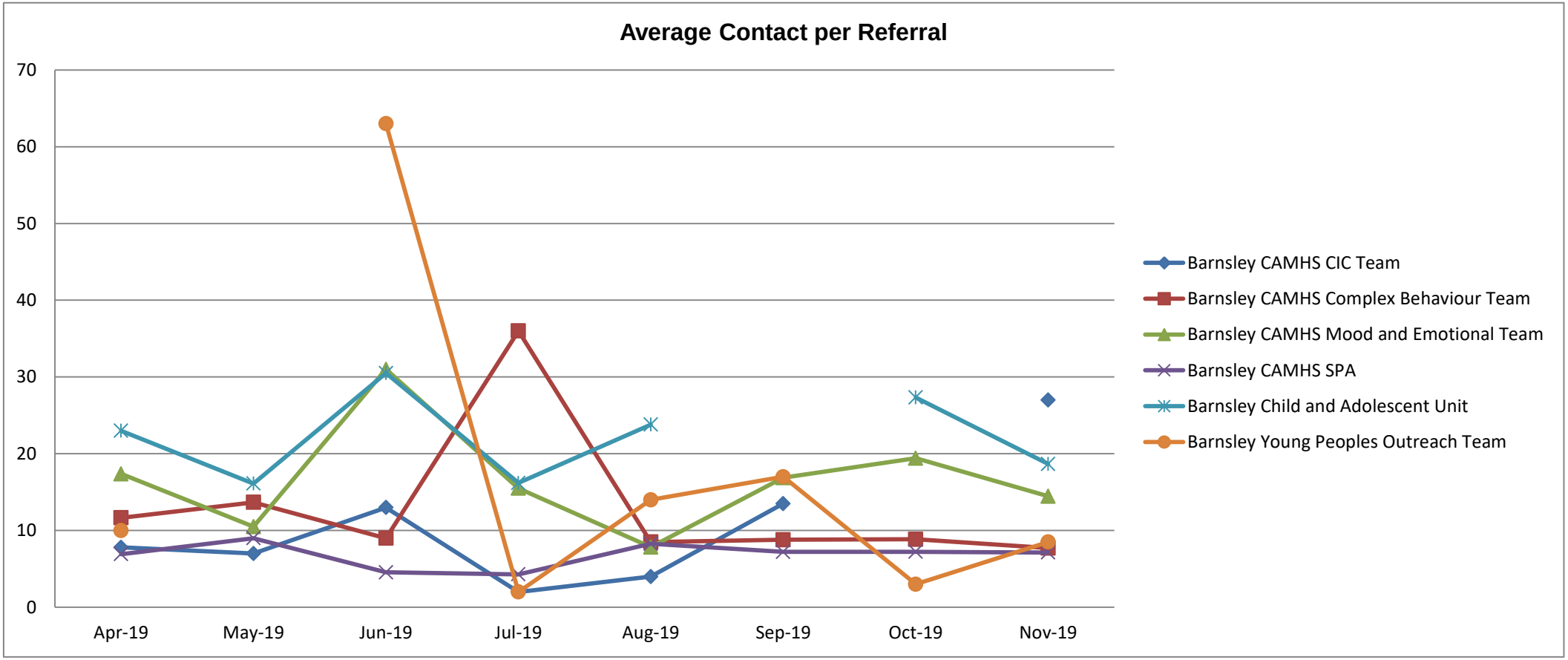
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Barnsley CAMHS ADHD Team	41	48	55	60	62	58	64	64
Barnsley CAMHS CIC Team	28	30	31	31	31	36	40	40
Barnsley CAMHS Complex Behaviour Team	517	523	530	522	524	527	516	521
Barnsley CAMHS Mood and Emotional Team	356	367	366	375	378	375	372	357
Barnsley CAMHS SPA	45	70	76	77	87	103	115	133
Barnsley Child and Adolescent Unit	142	130	128	130	122	123	121	121
Barnsley Young Peoples Outreach Team	91	95	99	89	97	97	120	141
Other SWYPFT CAMHS	5	5	4	3	3	2	2	2
Grand Total	**1225**	**1268**	**1289**	**1287**	**1304**	**1321**	**1350**	**1379**

Other Information



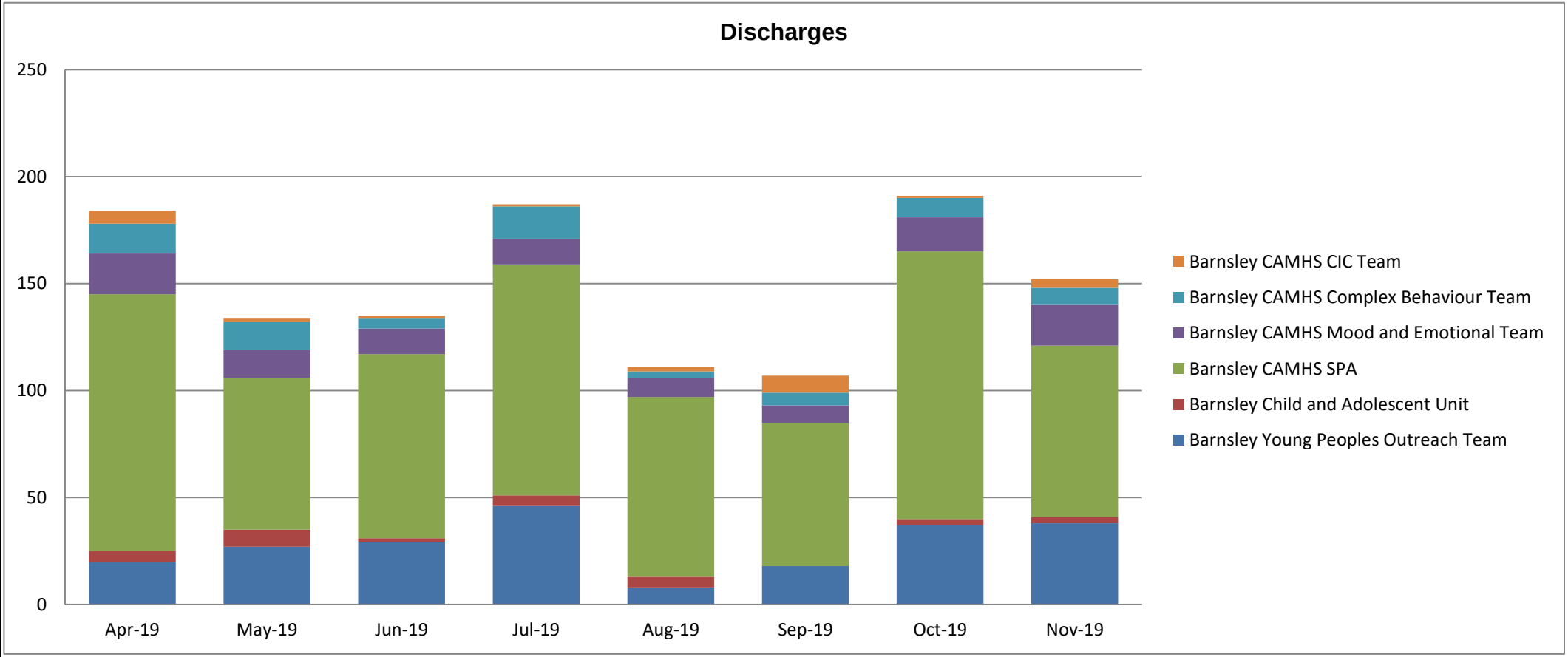
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Overall Avg
Barnsley CAMHS CIC Team	185	720	480	427	149	240		859	350
Barnsley CAMHS Complex Behaviour Team	665	614	1312	1361	555	890	1093	676	909
Barnsley CAMHS Eating Disorder Team								2	2
Barnsley CAMHS Mood and Emotional Team	678	496	525	543	573	731	909	683	658
Barnsley CAMHS SPA	94	71	43	35	59	98	64	57	62
Barnsley Child and Adolescent Unit	957	1747	2266	2079	1761		2084	2278	1793
Barnsley Young Peoples Outreach Team	283		246	160	257	365	159	69	212
Overall Avg	**444**	**567**	**366**	**572**	**284**	**332**	**469**	**442**	**437**

Other Information



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Overall Avg
Barnsley CAMHS CIC Team	8	7	13	2	4	14		27	11
Barnsley CAMHS Complex Behaviour Team	12	14	9	36	9	9	9	8	17
Barnsley CAMHS Mood and Emotional Team	17	11	31	16	8	17	19	14	16
Barnsley CAMHS SPA	7	9	5	4	8	7	7	7	7
Barnsley Child and Adolescent Unit	23	16	31	16	24		27	19	21
Barnsley Young Peoples Outreach Team	10		63	2	14	17	3	9	19
Overall Avg	**13**	**13**	**19**	**19**	**11**	**12**	**13**	**12**	**14**

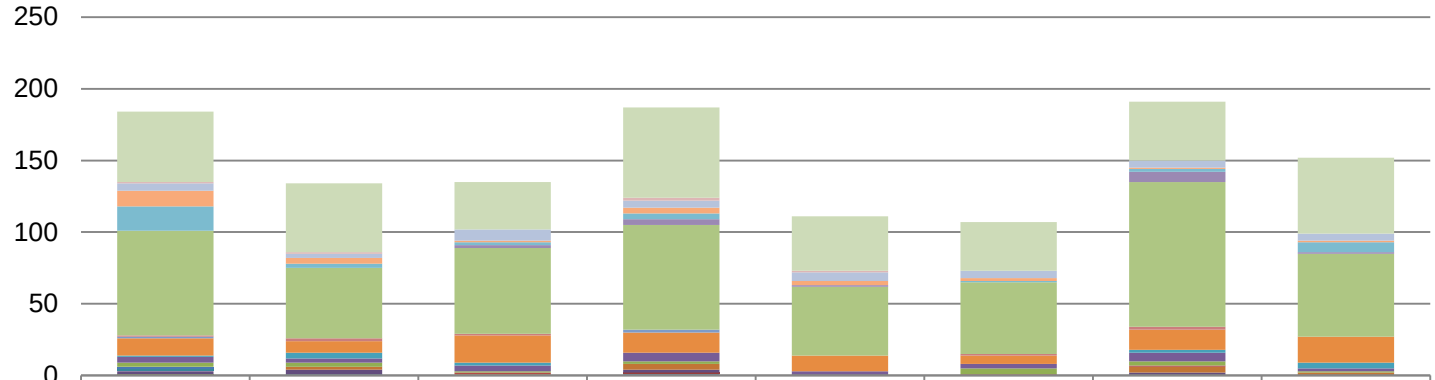
Other Information



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Grand Total
Barnsley CAMHS CIC Team	6	2	1	1	2	8	1	4	25
Barnsley CAMHS Complex Behaviour Team	14	13	5	15	3	6	9	8	73
Barnsley CAMHS Mood and Emotional Team	19	13	12	12	9	8	16	19	108
Barnsley CAMHS SPA	120	71	86	108	84	67	125	80	741
Barnsley Child and Adolescent Unit	5	8	2	5	5		3	3	31
Barnsley Young Peoples Outreach Team	20	27	29	46	8	18	37	38	223
Grand Total	**184**	**134**	**135**	**187**	**111**	**107**	**191**	**152**	**1201**

Other Information

Discharge Reasons



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Achieved Goals	49	48	33	63	38	34	41	53
Assessment not required (problem resolved)	1	1		2	1			
Failed to attend (repeated DNA, Cancel/CNA)	5	3	8	5	6	5	5	5
Failed To Attend At All	11	4	1	4	3	2	1	1
Inappropriate Referral	17	3	2	4		1	2	7
Inappropriate Referral (Advice/Liaison Given)			2	4	1		7	1
Inappropriate Referral (Signposted)	73	49	60	73	48	50	101	58
Moved Out of Area	1	2	1			1	2	
Not working towards goals	1			2				
Other	12	8	19	14	11	6	14	18
Patient Discharged Him/Herself Or Was Discharged By A Relative Or Advocate	1	4	2				2	4
Patient Discharged On Clinical Advice Or With Clinical Consent	4	3	4	6	2	3	6	2
Service user declined service	3	3	1	2		4	3	1
Service user discharged self			1				1	
Signposted to a Locala service	1							
Signposted to External Organisation/Agency		2	1	4		1	4	2
Single visit (no follow-up)	2							
Transferred to adult mental health service	2	3		2	1		2	
Transferred to other health care provider - not medium/high secure unit	1							
Transferred/Moved out of Area				1				
Young Person with capacity request discharge		1		1				

Other Information

Description:

Average length of episode is from initial contact to discharge based on discharges in the month.

Average number of contacts per referral is from referral to discharge and excludes inappropriate referrals, emergency referrals and those with zero or one contact.

Comments:

A review of the team breakdown is currently underway to more accurately report team caseloads.

The Child and Adolescent Unit team (previously used for SPA intervention) is now being used for clients proceeding with ADHD Medication prior to April 2019. We are currently in the process of moving all of the relevant clients into this team (which will be renamed in this report at some point to reflect its purpose). This will enable the service to have a more viable view of the amount of clients in service until their 18th birthday receiving ADHD related meds, and the potential impact on medication/prescribing costings.

The new ADHD team will eventually hold all clients that have started ADHD medication from 1st April 2019, also those clients waiting for ADHD Diagnosis. The clients waiting for ADHD Assessment will remain in the Complex Behaviour Team.

Barnsley CYP Mental Health Review

April 2019

NHS England and NHS Improvement

The National Context

Many of the issues and challenges highlighted in this document are common, to a greater or a lesser extent, to CYP systems across the country viz.

Variation

There is variation in the needs of children in different circumstances and at different stages of their development. There is variation in the availability and quality of services. And there is variation in the way different parts of the system are commissioned, funded and overseen. (CQC, 2017)

Fragmentation

The system as a whole is complex and fragmented. Mental health care is planned, funded, commissioned, provided and overseen by many different organisations, that do not always work together in a joined-up way. Poor collaboration and communication between agencies can lead to fragmented care, create inefficiencies in the system, and impede efforts to improve the quality of care.

Poor Data Quality and Availability

Significant gaps in the availability of data mean it is difficult to get a clear picture of what services are available to children and young people across the country.

Increased demand with long waits

Evidence suggests that the demand for mental health care for children and young people is increasing. What is less clear is whether the capacity of services is also changing, as there is no reliable data to tell us how many children and young people can be cared for across the mental health system.

What Good Looks Like

1. Seamless collaboration between organisations and between teams within organisations
2. Innovative and creative models informed by CYP IAPT principles and NICE pathways developed with all stakeholders including CYP and their families.
3. Easy access and minimal waits
4. Shared decision-making, formulation and choice of evidence-based intervention
5. Education and training for staff, families and young people
6. Use of Routine Outcome Measures (ROMs) to evaluate effectiveness, lead service improvement, inform interventions and help determine endings
7. Quality data recording and flow

These Key Lines of Enquiry (KLOEs) are linked to increasing access to CYP services and improving service quality, and they inform the IST diagnostic process.

Scope and Model

Population

The CCG have responsibility for developing the service specifications and KPIs and lead general relationship management and oversight in liaison with Barnsley Metropolitan Borough Council, with whom there is a Section 75 Agreement of which CYPMH funding is a part.

The Barnsley CCG population is 243,341, the 0-18 population is 52,888 and the estimated prevalence of CYP with a diagnosable mental health condition is 5,080.

The Model

The model commissioned and funded by Barnsley CCG for the delivery of the children and young people's service is as follows:

- The 0-18 specialist Children and Young People's Mental Health Services (CYPMHs), including crisis care, is provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
- Lower-level emotional health and wellbeing support is provided by a number of providers including MindSpace, SYEDA, ChilyPep, TADS, Family Centres and local authority Early Years services

The NHS England CYPMH access standard is intended to measure the impact of additional NHS investment (Future in Mind) on increased access to CYPMH services in the community. SWYPFT and MindSpace services are within the scope of the standard.

The IST Approach

The Mental Health Intensive Support Team (IST)

- Part of NHS England and NHS Improvement, a free resource to organisations providing NHS-commissioned care
- Work with local health communities that are facing particular challenges in delivering evidence-based treatment pathways and the CYP Access expansion standards

IST Approach – Diagnostic Review

- Agree scope and expectations with the provider(s) and commissioner
- Use quantitative, qualitative and benchmarking information to understand system performance
- Provide feedback and recommendations
- Further focused support as identified

Local Context

- Commissioners and providers welcomed the offer of support from the IST, cooperated openly and positively with the diagnostic process and are keen to engage with future IST support to accelerate improvement

Reasons for Engagement

- Value for money and productivity
- Waiting times in general, particularly for the ‘complex behaviour’ pathway
- Outcomes and waiting times for the ‘children in care’ pathway
- Effectiveness of the SPA, and how this links with GPs/primary care
- The relationship between MindSpace and SPA and, the MindSpace referral process more generally

Limitations: This summary report is provided to facilitate discussion but it should be noted that by the nature of a diagnostic review is that it is high level. The interpretation of IST findings should be followed up with more detailed local discussions.

It should be noted that only SWYPFT current flow data to MHSDS so most graphs and figures used in the report refer to SWYPFT only.

Good Practice

The IST observed a number of areas of good practice in the Barnsley CYPMH service:

- Service users and carers interviewed reported high levels of satisfaction with the treatment received from the specialist CYPMH service once commenced on a treatment pathway.
- Well regarded Early Help and family support provision (Barnsley Council)
- MindSpace and ChilyPep are providing responsive access to early intervention, health promotion, and service user/carer engagement and health promotion aspects of the Long Term Plan.
- MindSpace are developing personalised support plans in collaboration with students, which are distributed amongst teaching staff, to support students with mental health needs to engage in learning.
- Foster carers training programme (Flag)
- Active collaborations with non-NHS initiatives (e.g. Safety Net with Barnsley Football Club)
- Routine outcome measures are in use to evaluate service users' progress in MindSpace
- Job planning and management in MindSpace appears to be effective and productivity is high
- Waiting times to initial assessment have reduced within specialist CYPMH
- A range of evidence based treatments are available to users accessing specialist CYPMH
- SWYPFT staff spoke positively about the relationship with the interim general manager, and senior clinicians' reported feeling more involved in making changes to the way the service is delivered

Executive Summary and Key Recommendations

- System Working There are few written pathways, specifications or criteria for CYPMH services in Barnsley. As a result there is no shared understanding of which providers are commissioned to provide which services to CYP and whether there are gaps in the services
- Investment CCG investment is average amongst comparable CCGs. An increase in investment from 2019/20 brings the CCG in line with increases in Future in Mind funding but in previous years, although all FiM money has all been spent, overall CYP spend has risen by less.
- Waiting Lists Waiting times at SWYPFT are very long after initial assessment but not fully quantified. There is no plan to bring waits down, waiting list management processes in SWYPFT do not include all CYP waiting and clinical risk for CYP on the waiting list is not managed
- Demand and Capacity SWYPFT do not have an understanding of their current capacity, meaningful job plans are not in place and productivity is not managed in any meaningful way
- Access It appears likely that activity consistent with the 32% access standard is being delivered. This is not fully reported to MHSDS, however; commissioners do not routinely receive information on access and there are no specified activity levels in any provider contract
- ROMs Outcomes are used routinely in the MindSpace service and reported to commissioners. The culture of routine outcomes usage to support clinical discussions and service improvement is not well-developed in SWYPFT and systems are not in place to support this.
- Internal Reporting and Outcomes Processes Current IT systems in SWYPFT do not provide the service with the functionality required to manage all waits, use outcomes clinically and for service improvement and manage evidence-based treatment

Key Recommendations

- Urgently review and document service specifications and activity/outcomes schedules for each provider, and identify any gaps in provision
- Develop an appropriate system-wide forum to deliver and monitor required improvements in services
- Urgently develop waiting list reduction plans based on a clear understanding of capacity and demand
- Urgently implement a process/policy for overseeing the currently unmeasured clinical risk in the waiting list
- As a system, review the neurodevelopmental assessment and treatment pathway and the most appropriate place for medication review

A full set of recommendations is provided in subsequent slides. The IST can provide support developing and reviewing plans as well as implementation support where requested.

Recommendations

System Recommendations

- Commissioners and providers to jointly undertake work to develop service specifications as to what they are being commissioned to provide. Use this process to identify any gaps in services. Agreeing the eligibility criteria for the service and treatment pathways based on problem indicators will assist this.
- Based on these service specifications, commissioners and providers should agree a reasonable number of KPI targets relating to:
    - Access/activity, time to assessment and to treatment(s)
    - Clinical quality and improvement demonstrated via ROMs
    - Throughput/dose/length of stay
    - Productivity
- Commissioner and provider to utilise data from these KPIs to jointly undertake work to revise the pathway modelling based on accurate demand and capacity data
- Establish a joint forum across commissioners and both providers, with clinical and managerial representation to:
    - Hold accountability for the management of risks in quality and performance issues
    - Eliminate gaps between services as identified above
    - Develop evidence based treatment pathways with seamless transitions for service users, and improve the interface and advocacy with schools for people on the waiting list
    - Promote an identity as a single CYP system, with a shared understanding of the pathways, and oversee actions being taken to deliver effective integration/transitions between services
- Commissioners to work with providers across the system to review the neurodevelopmental assessment and treatment pathway to reduce the medication review burden and provide a seamless service. NICE guidance recommends a shared care protocol
- Providers and commissioners to work together to consider the wider community offer which will facilitate increased community resilience and support discharge planning from specialist services

Specific Recommendations

- Implement a waiting list management/Access policy including clear protocols to ensure accuracy, visibility, transparency at all levels so risk can be managed effectively
- Review all waiting lists to get a clear picture of everybody waiting for treatment at all stages of the pathway
- Implement a plan to move all waiting lists away from spreadsheets and into the EPR, and ensure that all waits are reported internally and to commissioners
- All providers to use problem descriptors, with systems to support recording. This should to inform evidence-based treatment pathways, dose, waiting list management and a clear definition of what constitutes meaningful treatment
- SWYPFT to specify ROMS for each individual pathway to inform care planning. This includes the entire subset of actions in regards to recording, understanding and reporting.
- MindSpace to implement a recognised assessment tool (such as the ‘current view tool’) where appropriate to structure initial contact and to ensure that they can demonstrate evidence based treatment being offered.
- SWYPFT to carry out job planning for all clinical staff in order to properly understand current available capacity
- Subsequent demand and capacity analysis/modelling for pathways to develop a credible, SMART waiting list reduction plan to include:
    - Clear trajectory and timescale for each pathway and
    - a review of estates to ensure the required clinical space is available
- Providers and commissioners to work together to define a pathway for engaging CYPMH service users with community CYP services to facilitate effective discharge planning from specialist services
- CYP participation in specialist CYPMH to be strengthened through existing avenues i.e. Chillypep/OASIS (young persons ambassadors)
- SWYPFT to implement pre-upload sign-off of access data and strengthen processes to check published data is accurate

System Working and Collaboration

NHS England and NHS Improvement

System Working

Good Practice Indicator: effective integrated relationships across local organisations to deliver timely and appropriate care

- Services do not have service specifications to define their access criteria, productivity and joint working expectations.
- There are not clearly defined eligibility criteria for all services, and access criteria that do exist are not clearly understood across the pathway.
- The introduction of SPA has not shown a reduction in the number of referrals allocated for assessment. It is planned that SPA will perform all of the assessments for CAMHS moving forwards. The service believes this will be at a neutral time cost based on experience from other boroughs, however this has not been formally modelled.
- There is regular engagement between the CAMHS SPA team and MindSpace via a weekly liaison meeting.
- There are gaps in the timely provision of support and treatment for young people who have been assessed as requiring specialist CAMHS involvement and are awaiting allocation within a treatment pathway.
- Presence on the CAMHS waiting list renders the young person unable to access support available from MindSpace, such as liaison with schools around support plans.
- Staff and carers of CYP using or waiting for specialist CAMHS reported poor support and adaptations for mental health needs from schools. Conversely, staff and a service user in MindSpace spoke positively about the impact of the service on the mental health support offered by the school.
- Service users who are not attending school (circa 400 young people), are not eligible for support from MindSpace. At the time of the IST visit a ‘support team’ service for these CYP was being planned.
- Staff within CAMHS reported challenges with discharging users from the service, owing to feeling that there were limited options for them to access services that would support maintenance of existing gains, and continued recovery outside of CAMHS.
- There is no CYP delivery group in place to oversee the integration of service provision across Barnsley.

Back to Key Recommendations

Contracting and Service Specification

Good Practice Indicator: outcomes and activity levels are used to incentivise easy access to appropriate, quality services

- There is no agreed service specification in place to describe the services commissioned from SWYPFT
- There is no agreed service specification in place for MindSpace, although the MindSpace service have themselves created documentation describing their offer, activity levels deliverable with current funding and outcomes framework
- No expected activity levels have been specified for SWYPFT or MindSpace and commissioners have no contractual levers to manage the contracts
- The IST heard from both SWYPFT and the commissioner that there was an understanding of which services should be provided by SWYPFT, which by MindSpace and where there may be a gap in between
    - The IST received inconsistent views about the scope for the SWYPFT service and no written criteria exist
- A 5 week assessment ‘target’ is worked to in SWYPFT. This is not a commissioner target and appears to represent misapplication of an understanding of queueing theory by the provider. Based on IST experience this is likely contributing to longer waiting times for treatment.
- The IST heard that the CCG formally requested a referral to treatment waiting list reduction initiative from SWYPFT in early 2019
    - At the time of the IST visit in April 2019 this project had not started, no trajectory had been requested and no timescale had been specified.
    - Although the terms of the waiting list reduction refer to referral to treatment, no definition of treatment has been agreed

Back to Key Recommendations

Investment

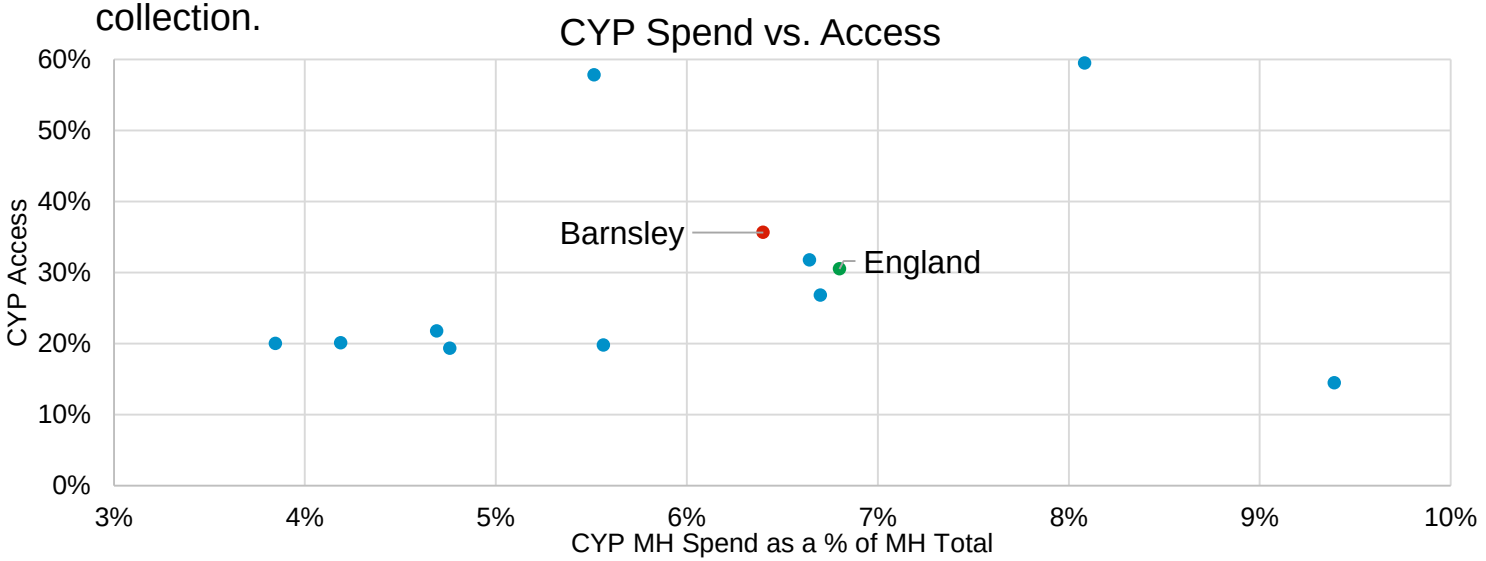
Investment priority level

The table compares Barnsley CCG with its 10 similar CCGs selected according to the Right Care methodology – 12 'dimensions' are used to identify comparator CCGs, taking into account deprivation, age, ethnicity and population density.

Analysis of NHS* CYP MH spend, based on nationally available information of 17/18 outturn, Shows Barnsley CCG spent £4,448k on CYPMH compared to £3,385k reported to IST.

The following analysis uses the £3,385k figure.

On this basis it appears that Barnsley CCG spent around the average of its total mental health spend on CYP mental health compared to its peers and close to the England average. The 30% access standard was delivered based on the SDCS collection.



CYP MH and ED (excl. LD) as a % total MH spend 17/18 (incl. LD & Dementia)		SDCS Access rate 17/18
England	**6.8%**	**30.5%**
Doncaster CCG	3.8%	20.0%
Warwickshire North CCG	4.2%	20.1%
St Helens CCG	4.7%	21.8%
Mansfield And Ashfield CCG	4.8%	19.3%
Durham Dales, Easington And Sedgefield CCG	5.5%	57.8%
Rotherham CCG	5.6%	19.8%
Barnsley CCG	**6.4%**	**35.6%**
Wigan Borough CCG	6.6%	31.8%
Wakefield CCG	6.7%	26.8%
Hartlepool And Stockton-On-Tees CCG	8.1%	59.5%
North East Lincolnshire CCG	9.4%	14.5%

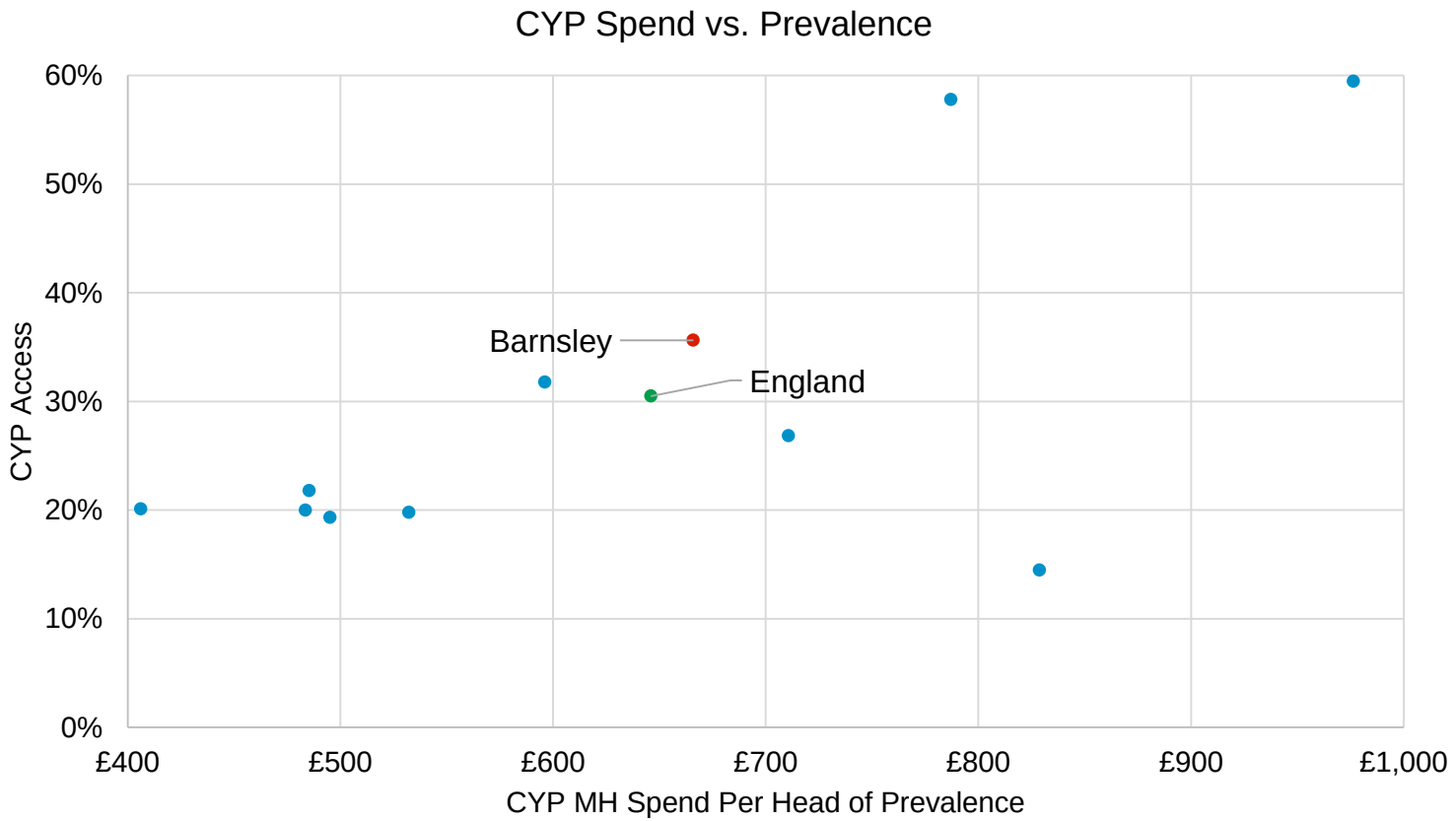
*These figures only cover NHS spending and exclude Local Authority investment.

Data Source: NHS England finance and NHS Digital SDCS data April 2017 – March 2018 https://files.digital.nhs.uk/EE/F486C9/CYP%20Access%20Reference%20Tables%202017-18.xlsx

Back to Key Recommendations

Investment against demand

Barnsley CCG was also very close to the England average and in the third quartile of the CCG peer group in its spend per prevalence in 17/18 which was at **£666 per head**.



	17/18 Spend per prevalence
England	**£646**
Warwickshire North CCG	£406
Doncaster CCG	£484
St Helens CCG	£485
Mansfield And Ashfield CCG	£495
Rotherham CCG	£532
Wigan Borough CCG	£596
Barnsley CCG	**£666**
Wakefield CCG	£711
Durham Dales, Easington And Sedgefield CCG	£787
North East Lincolnshire CCG	£829
Hartlepool And Stockton-On-Tees CCG	£976

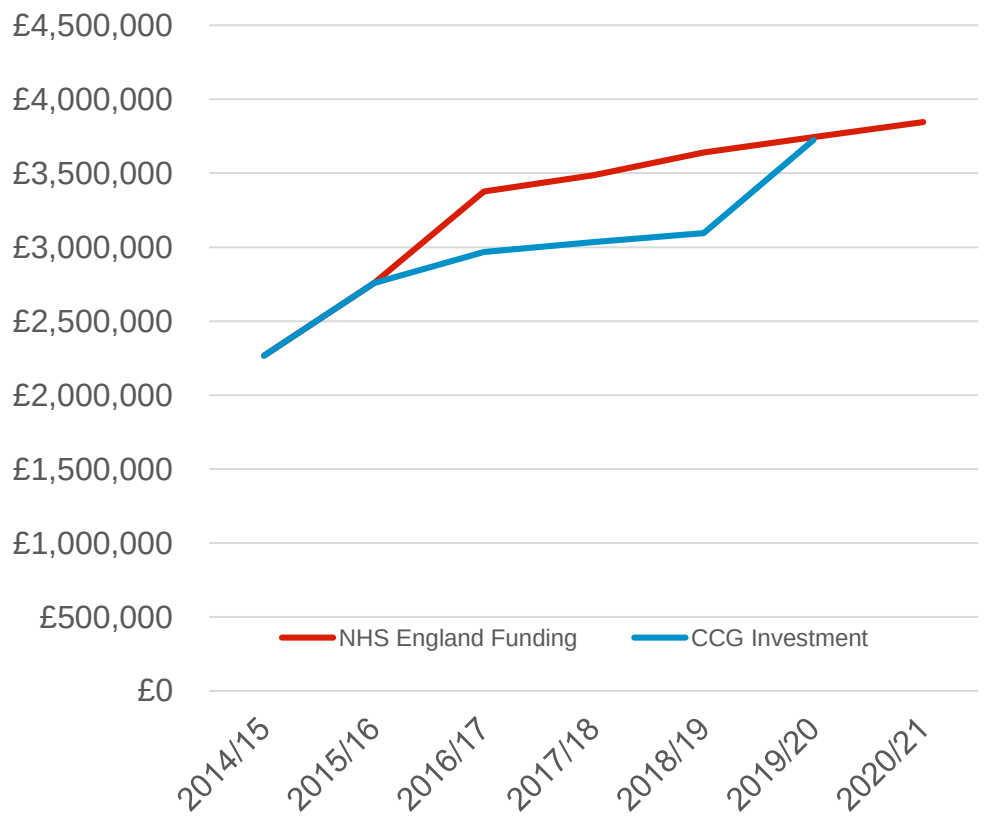
Data Source: NHS England finance and NHS Digital SDCS data April 2017 – March 2018 https://files.digital.nhs.uk/EE/F486C9/CYP%20Access%20Reference%20Tables%202017-18.xlsx

Back to Key Recommendations

Impact of New Investment

- Through Future in Mind, NHS England is investing further money through CCG baselines throughout the period of the Five Year Forward View from 2016/17 to 2020/21
- For Barnsley CCG, this increased allocation is outlined as below and includes investment growth for 2016/17 through to 2020/21

	2016/17	2017/18	2018/19	2019/20	2020/21
CCG Investment	£2,967,603	£3,035,323	£3,095,879	£3,724,017	
Growth From Previous Year	£209,603	£67,720	£60,556	£628,138	
NHSE New Funding	£619,280	£108,656	£154,586	£102,741	£102,489
NHSE Cumulative	£619,280	£727,936	£882,522	£985,263	£1,087,752
Cumulative Difference	-£409,677	-£450,613	-£544,643	-£19,246	



- All Future in Mind money has been invested by the CCG in new CYP MH projects such as the community ED team and schools work
- Overall investment in the system is forecast to grow significantly in 2019/20 but was below the increase in funding from NHS England in 2017/18 and 2018/19

*Includes £156k for eating disorders

Data Source: NHS England finance and local data provided by NHS Barnsley CCG

Back to Key Recommendations

Provider Expenditure

- Analysis of SWTPFT expenditure shows clinical staff spend to be consistent with expected levels (around 70% is the expected norm).
- Indirect costs and overheads are also in line with expectations for NHS providers.
- The total spend on staffing and direct costs at 80% is in line with levels seen in efficient services (75% - 80%).

Provider expenditure ('000's)

	2018/19
Staff-clinical	£2,280,876
Staff-Other	£162,129
Other direct costs	£131,454
Indirect costs & Local Estates	£158,937
Corporate overheads	£505,876
Total	**£3,239,272**

Provider expenditure analysis

	2018/19
% Actual workforce spend	70.4%
Total % spend on staff & direct costs	**70.4%**
Indirect costs & Local Estates	4.9%
Corporate overheads	15.6%
Total % spend on indirect costs & corporate overheads	**20.5%**

Back to Key Recommendations

Pathways and the Model

NHS England and NHS Improvement

Service Culture and Perception

Good Practice Indicator: CYP are involved in designing and planning services

- There is a young commissioners user involvement process via ChilyPep, and a voluntary parental peer support network being developed within MindSpace.
- There is limited service user and carer involvement in the design and delivery of specialist CAMHS, and users and carers are not routinely linked with peer support available in MindSpace and ChilyPep.
- However, there is a user forum in the process of being set up within CAMHS, which requires further development.

Good practice Indicator: no decisions about young people are made without their active involvement

- We heard that mental health wellbeing practitioners within MindSpace were using a goal based outcome approach with CYP to inform joint care planning.
- CAMHS clinicians informed us that Children and young people were involved in their care planning. Clinicians told use they routinely use goal based approaches in planning care. This however is impacted by the long waits between assessment and treatment.
- IST met with a young person receiving interventions from MindSpace who was able to give a clear example where he directly influenced his care plan.
- Service users' and carers' receiving support from MindSpace and CAMHS fed back that they felt involved in making decisions about their care, and staff talked about routine use of goal informed care plans.
- Gaps between service provision leaves some service users unable to access any support, which is a de facto decision they are unable to influence.
- Gaps in reporting on ROM exist in MindSpace and CAMHS, and it is not possible to extract clinician level data via dashboards to assure that PROM and PREM measurements are being used routinely within care provision.

Back to Key Recommendations

Service Culture and Perception

Good practice Indicator: CYP know where to get help and services are accessible and understandable

- MindSpace have a “user friendly” website for CYP Carers and professionals which gives clear links of how to access Mindspce and CAMHS. The website also offers detail of different types of problems a young person may experience with the appropriate signposting dependant in condition.
- We heard that MindSpace have developed a laptop icon for which school pupils can access the website directly.
- We heard from parents that they were not informed of a protocol for contacting CAMHS services if their child’s mental state deteriorated while awaiting a service.
- CAMHS staff told us that when service users do access the service, owing to the long waits their current treatment needs require reassessment and reformulation, and the expectations of service users and their carers are often beyond what they can deliver.
- A low proportion of CAMHS referrals are self referrals.
- Parents told us that they were given contact details for the CAMHS service, however weren't given information on when to contact the service, or access to any support while awaiting the core service.

Good Practice Indicator: CYP and/or parents/carers are offered help in accessible and comfortable settings

- The IST heard that there are insufficient rooms available to adequately accommodate service user activity at the New Street office.
    - During our visit we observed double occupancy of a therapy space adversely affecting the session time of a service user. Another service user described having sessions in a nearby McDonalds owing to lack of room availability.
    - The service feel that this was not due to room space and would only happen as part of an engagement/therapeutic strategy

Back to Key Recommendations

Leadership

Good Practice Indicator: there is a multi-disciplinary leadership team representing managers, admin, clinicians and practitioners

- There is a newly-established monthly leadership meeting within SWYPFT with membership from all clinical and operational leads. The agenda is largely driven by organisational priorities.
- The IST heard that there is limited time in the meeting to focus on CYPMH specifically challenges such as long waits for treatment

Good practice indicator: there is a collective approach with leaders working beyond organisation boundaries on challenges concern that are of mutual interest

- The Director of MindSpace is well engaged across regional and national networks to further develop service design and delivery.
- There is a newly established operational lead for CYPMH in SWYPFT who has started to put in place improved systems and processes. Examples given were around supervision, and ideas around implementing job planning.
- While we heard there is a clear governance structure where concerns over waiting times are escalated, we were told that there is not currently a SMART action plan in place to recover from the current position.
- An example being long waits being a red risk on the board risk register for 3 years.
- Clinical leads within the service told us they have not had direct engagement with board executives around developing plans to improve the current position, although SWYPFT subsequently highlighted a number of recent meetings involving CAMHS staff and SWYPFT Directors specifically to discuss service challenges and improvement strategies.

Back to Key Recommendations

Evidenced based Pathways

Good Practice Indicator: pathways and treatments should be evidence-based and delivered by an appropriately-trained workforce

- In MindSpace evidence-based treatments are being offered for a defined number of sessions, however are not using a recognised assessment tool such as the ‘current view tool’ and codifying identified needs using problem descriptors.
- Across CAMHS, service users are unable to access the appropriate evidence based treatment pathways due to long waits to access the service. Service users can wait in excess of two years for an appropriate intervention.
- We heard that once commenced on a treatment pathway CAMHS offer a range of evidence based interventions (e.g. CBT, IPT, brief solution focused therapy, play and art therapy, psychological assessment and formulation, psychiatry and safeguarding.
- Staff are appropriately trained to deliver specific interventions, however we were told that there were a lack of LD trained staff.
- Treatment pathways are currently not well defined. Problem descriptors are not used to inform treatment offer, and most evidence based interventions are not planned using a defined number of sessions.
- We were told by clinicians that it was not possible to offer specific treatment for a defined number of sessions due to also holding a care coordinator role.
- Clinicians’ described finding it difficult to identify when the treatment offered by the service had been completed, and service users were ready for discharge, due to a perceived lack of discharge options.
- The majority of senior medical capacity within the ADHD pathway is utilised on medication reviews, and the shared care protocol is not consistently implemented, posing a barrier to discharge of patients to primary care.

Back to Key Recommendations

Easy Access and Minimal Waits

NHS England and NHS Improvement

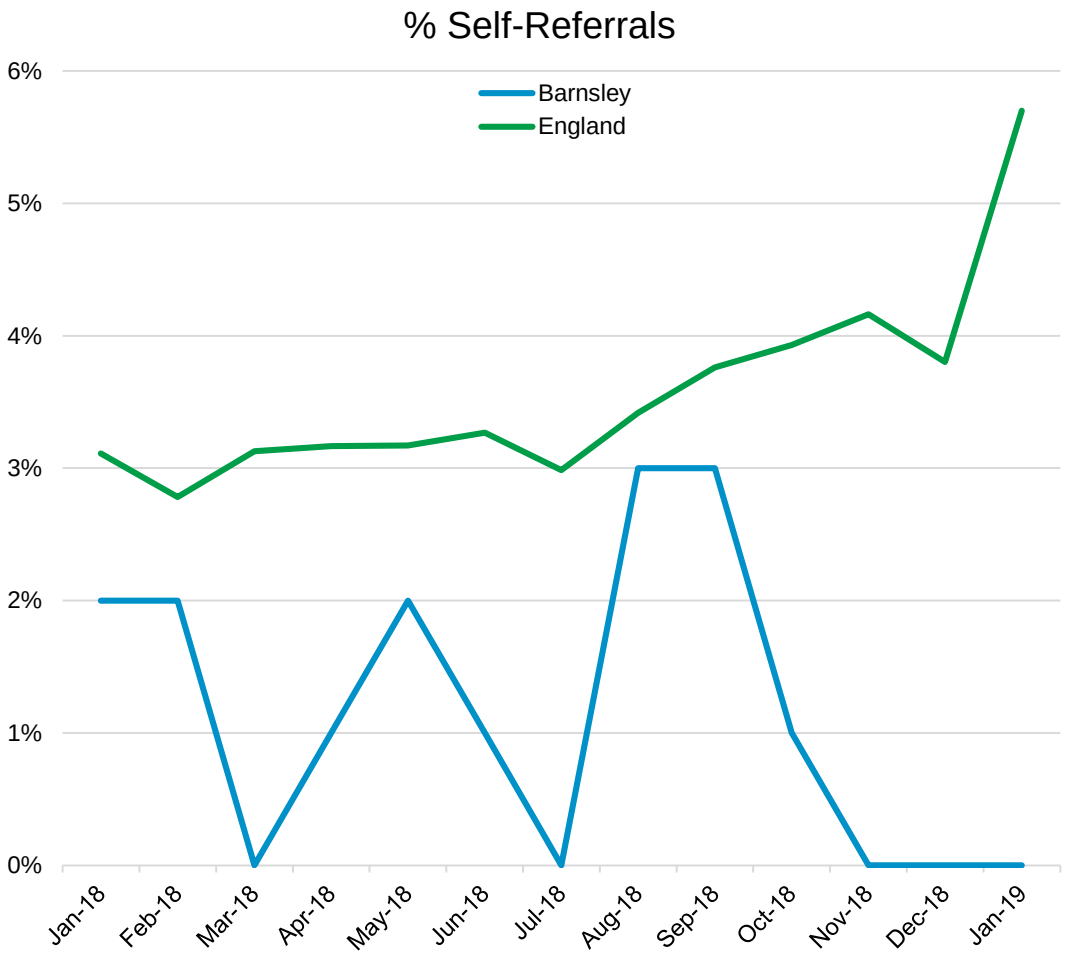
Access and Referral Routes

Good Practice Indicator: There is a Single Point of Access. There are Clear eligibility criteria and referral processes*

- Referral processes into SPA are clear, and reflected in a SOP
- The IST heard that SPA capacity is limited by following up poor quality referral information, and the volume of duty activity.
- Duty activity is soon to be transferred into the relevant treatment pathways, and SPA will conduct all new assessments. The service believes this will neutral in terms of time spent, however this has not been formally modelled.
- Eligibility criteria for services across the pathway are not recorded in service specifications, as such there are no reference documentation for services to refer to when making decisions.
- Most referrals are received by post and the IST were told that the use of e-mail was delayed by slow Information Governance processes in SWYPFT. E-mails are accepted and checked regularly.

Good Practice Indicator: Self-referrals accepted and encouraged

- Self referrals are accepted by SWYPFT, however are not being actively promoted.
- Self referrals are accepted and encouraged by MindSpace and are advertised via their website



* https://www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf

Back to Key Recommendations

Waiting List Management – Governance and Risk

Good Practice Indicator: systems are in place to manage risk for those waiting to access treatment

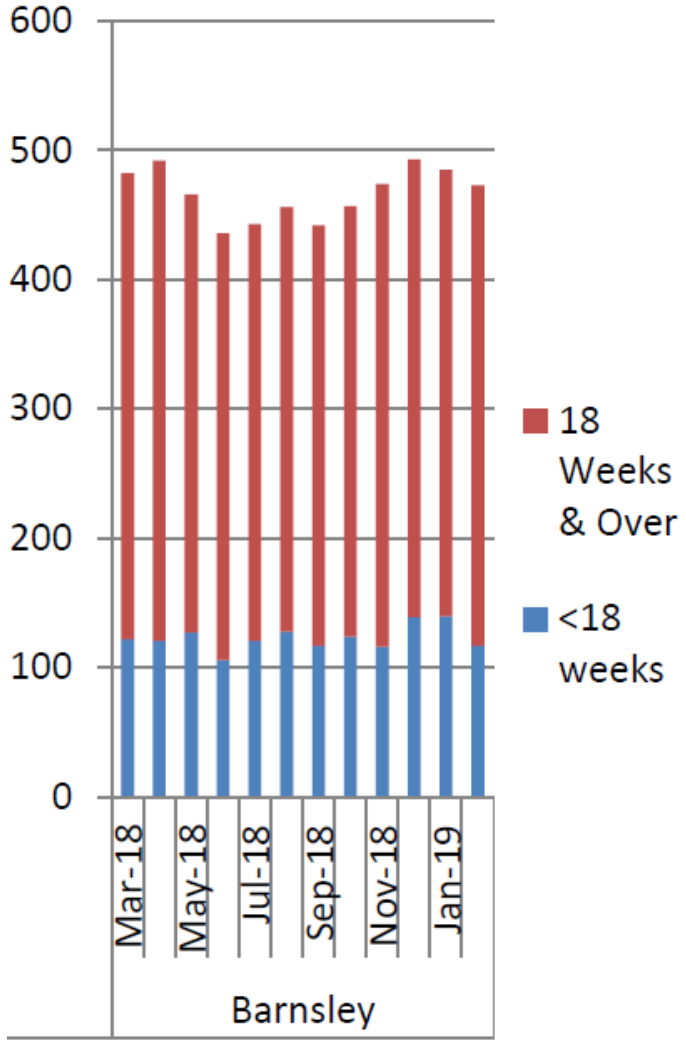
- There is no waiting list management policy in place within the SWYPFT service. Although the CCG have been told in writing that there is a formal process at SWYPFT to proactively review the clinical needs and risk profile of the CYP on the waiting list this is not the case.
- The deputy director of service told us that owing to the risks associated with the waiting list size and worsening length of waits, reports has been submitted to a Trust sub-board governance committee since 2015.
- Reports seen from November 2018 and April 2019 comprise position statements on waits, and various performance metrics. Vacancy data is omitted, however, and there is no assurance around the management of the clinical risks the waits create and no SMART action plans to address the position.
- Waiting list reduction money has been used to offer a time limited programme of group sessions to waiting CYP and parents. These are aimed at developing resilience, with a view to assessing whether further interventions from a service is still required.
    - Initial feedback from those who chose to attend the group was positive but take-up has been low.
- Staff felt that, having waited for long periods for 1-1 treatment, many families were unwilling to consider groups as an alternative. This was supported by a carer who told the IST that they declined the offer as it was ‘too little too late’
- We heard from staff that delivering groups in addition to their full time hours meant that they felt tired, and voiced that working 6 days a week would not be sustainable
- The service has begun expediting CYP whose families have contacted the service to report a deterioration in risk and mental state. The remaining list of CYP waiting have not been clinically-reviewed and the level of risk is unquantified.
- We heard that some children have had their treatment wait expedited following attendance at the resilience groups.
- Parents interviewed reported having been told that there would ‘be a wait to start treatment’ during assessment, but not the anticipated duration of this wait and that they did not receive information about making contact with the service if their child deteriorated

Back to Key Recommendations

Waiting List Management

Good Practice Indicator: systems and reports in place to monitor progress throughout the pathway

- Waiting times information produced by SWYPFT shows a consistent waiting list of around 500 CYP, with around 350 waiting over 18 weeks and a further 70-80 waiting for an initial assessment at any one time
- When we asked leaders within the SWYPFT service about their waiting lists, they were unable to provide consistent information on total waits, individual clinical pathway waits, or maximum waits
- There is a regular process to manage assessments to a five-week standard but no similar process for subsequent appointments. This is very likely to be exacerbating waiting times.
- The most recent report to the CCG reported 290 patients awaiting treatment, however the internal governance report on waits for the same period reported 473 patients waiting, which is a discrepancy of circa 200 patients. SWPFT have confirmed that 290 was submitted in error.
- Additionally, staff in CAMHS told us that there are approximately 360 CYP waiting for the complex needs pathway, and 259 for the mood and emotion pathway, totalling 619 patients waiting, however it was not possible to obtain written information during the review on the number of patients waiting for specific interventions or pathways
- There is no regular waiting list meeting after 'allocation' and no formal escalation process
- Waiting lists were not available on Rio for interventions subsequent to the first treatment appointment and staff reported numerous Excel waiting lists which are not monitored or visible outside the immediate teams
- It is understood that waiting list management on SystmOne is better but no plans were in place to migrate these spreadsheets at the time of the IST visit

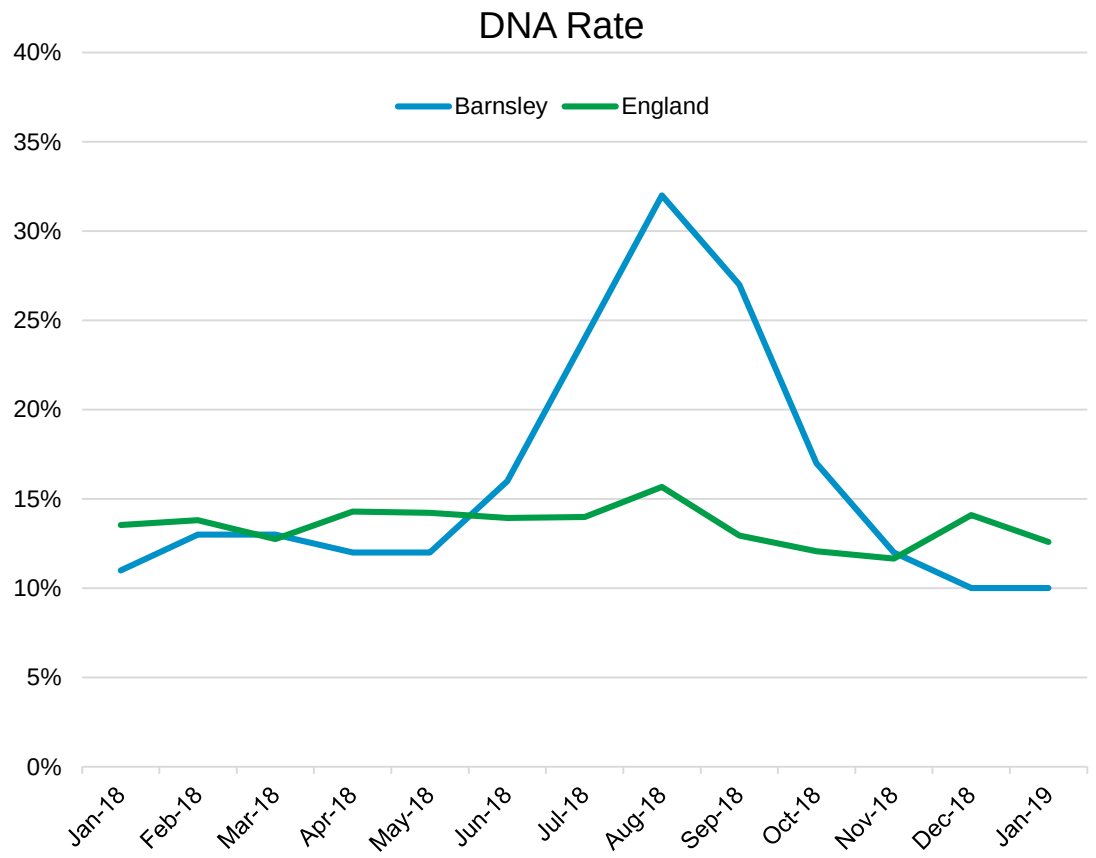


Back to Key Recommendations

Productivity

Good Practice Indicator: Productivity is managed effectively

- Clinician-level productivity data is not produced in SWYPFT
- Staff in SWYPFT reported that the job plans that had previously been developed were not fit for purpose and were planned for review
- As a result of changes to the EPR, it was reported that a loss of functionality has meant that not all SWYPFT activity is being systematically recorded
- The process for ensuring that staff are delivering activity at an expected level in in SWYPFT requires further development
- The IST heard that all staff in MindSpace have up to date job plans
- Staff in MindSpace are routinely monitored against their expected activity levels



Data Source: NHS Digital MHSDS data January 2018 – January 2019 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics

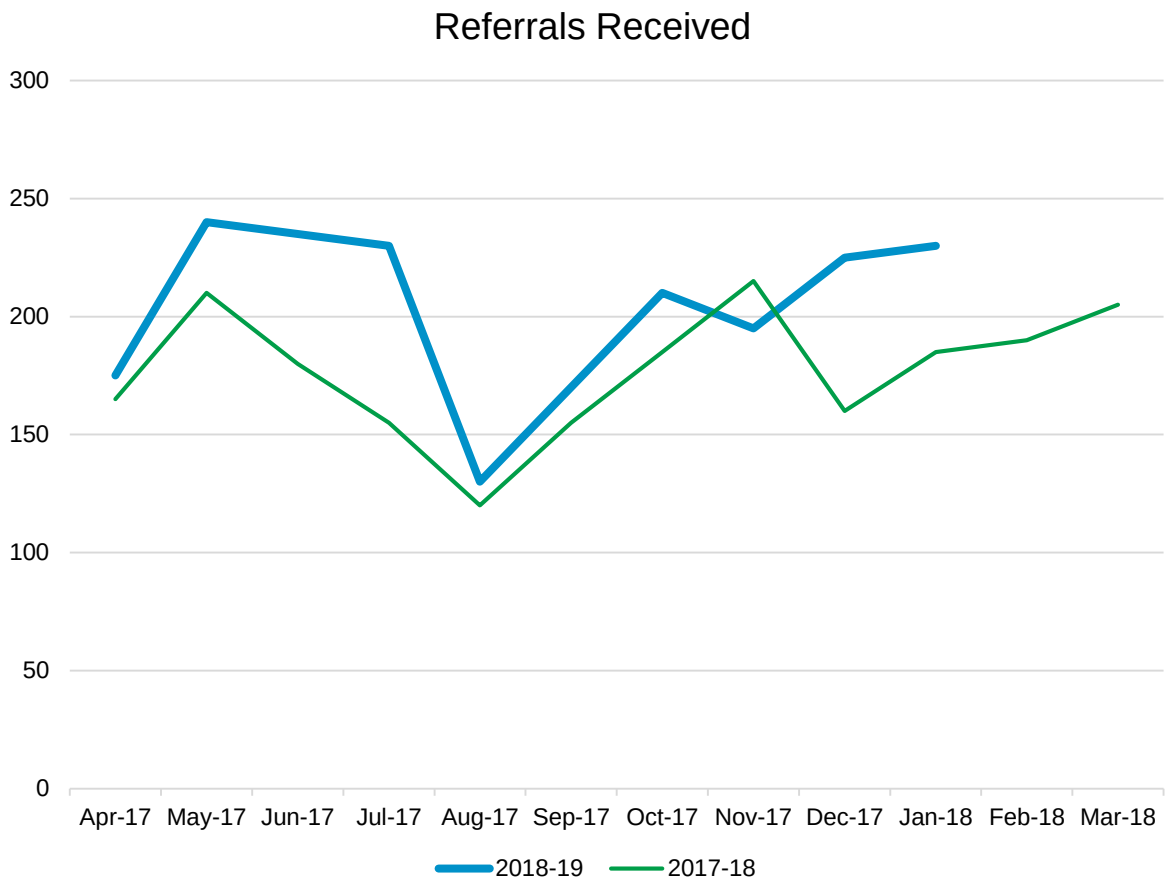
NB NHS Digital DNA figures include all contacts where the service user was under 18 *at the time of referral* and not at the time of the contact which may be at odds with local reporting

Back to Key Recommendations

Demand and Capacity

Good Practice Indicator: understanding of Demand and Capacity (D&C)

- The IST heard repeatedly that long waits are caused by insufficient capacity, but no data to demonstrate this was available
- Demand and capacity planning is not routinely undertaken
- The service has a good understanding of the assessment capacity (number of slots) but is not monitoring the number of treatment slots
- Treatment pathways and discharge protocols are not clearly defined, and job plans have not been standardised or updated to reflect changes in working patterns
- It was reported that there are issues with throughput linked to inconsistent approaches to discharges and lack of access to step down services



Data Source: NHS Digital MHSDS data January 2017 – January 2019 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics

Back to Key Recommendations

Routine Outcome Measures (ROMs)

NHS England and NHS Improvement

Outcomes and Quality Culture

Good Practice Indicator: appropriate ROMs are specified for interventions on each pathway and used at each session

- ROMs are being routinely applied within MindSpace, however it is not currently possible to report on these at a service level
- There is no standardised assessment tool in place in MindSpace to ensure that service users receive interventions and ROMs that are appropriate to their needs
- SWYPFT staff told the IST that they were using RCADS, SDQs and HONOSCA but that this was not done routinely

Good Practice Indicator: there is a supervision process where ROMs are routinely discussed

- There is no process in place for extracting clinician level information on the use of ROMs in supervision in SWYPFT or MindSpace
- Managerial vacancies have reduced the capacity for supervision within the SWYPFT treatment pathways

Good Practice Indicator: outcomes form part of the service specification

- Nothing is specified in the contracts with SWYPFT or MindSpace relating either to ROMs data completeness or outcomes, although anecdotal feedback from CYP and families is reported regularly to the CCG
- MindSpace do report ROMs information to the CCG at their own initiative

Back to Key Recommendations

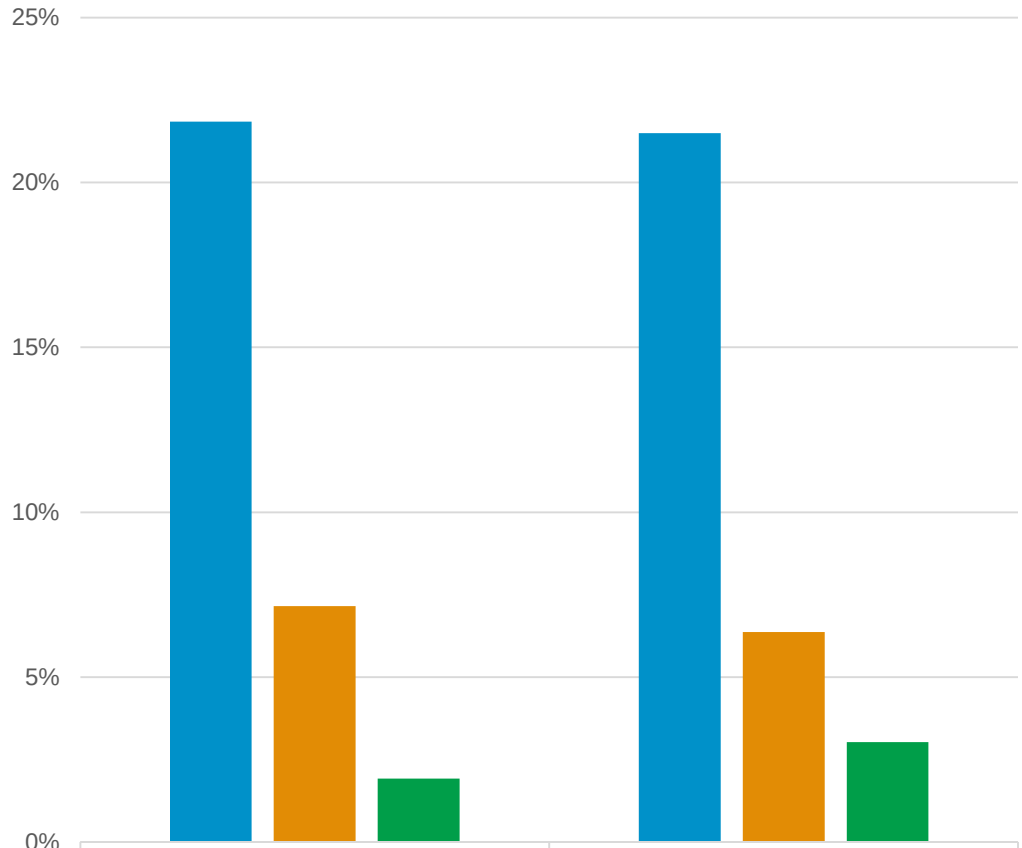
Outcomes and Quality Processes

Good Practice Indicator: systems are in place to facilitate the use of ROMs in session with CYP and to flow to the MHSDS

- As can be seen from the chart, right, SWYPFT as a provider do flow some ROMs information to MHSDS. No breakdown by team is available to show what of this is specific to the Barnsley service.
- Since moving to SystmOne there has been no facility to use ROMs in clinical sessions
- The IST heard that forms on SystmOne cannot carry out complex calculations so this will never be possible
- In MindSpace, ROMs are recorded sessionally
- These are stored in spreadsheets and not easily available to support discussion with CYP, or to facilitate supervision and service improvement

Good Practice Indicator: systems are in place to record specific interventions and to flow to the MHSDS

- SystmOne enables recording interventions for the Eating Disorders service
- For other pathways there is an incomplete list with key interventions missing e.g. DBT
- MindSpace record interventions and report regularly to the CCG



	England	SWYPFT
% Assessment Score	21.8%	21.5%
% Paired Scores	7.1%	6.4%
% Reliable Improvement	1.9%	3.0%

Data Source: NHS Digital MHSDS data April 2018 – December 2018 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics

Back to Key Recommendations

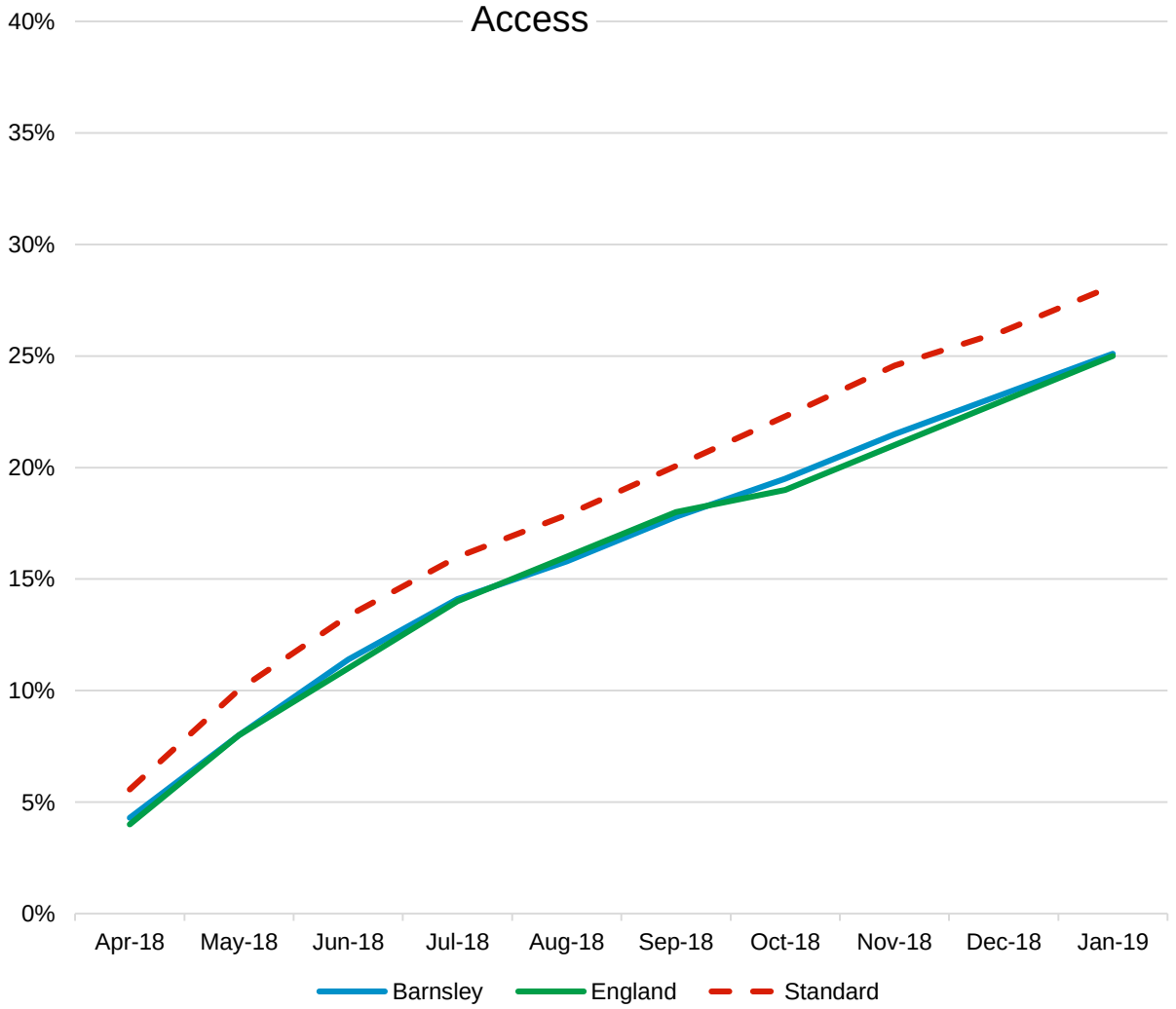
Data Recording and Reporting

NHS England and NHS Improvement

Data Flow and the Access Standard

Good Practice Indicator: It is a requirement under the standard NHS contract that all NHS-commissioned services must flow data to the Mental Health Services Dataset (MHSDS)

- SWYPFT have submitted access data to MHSDS for the whole of 2018/19
- MindSpace do not currently submit to MHSDS. There are plans in place to commence after May 2019 but no firm timescale.
- Both SWYPFT and MindSpace submitted to the 2017/18 SDCS collections and are planning to submit to the 2018/19 collection
- No recent estimate has been produced as to the level of treatment activity (as defined by the access standard) carried out by MindSpace
- The CCG are not confident in the completeness of the data across the system, although this is not regularly reviewed and this risk has not been raised formally
    - Subsequent to the IST visit, SWYPFT failed to submit any MHSDS activity for March 2019



Back to Key Recommendations

Internal Reporting

Good Practice Indicator: the service has a data lead in place and adequate informatics capacity to meet service requirements

- There is an 0.6WTE analyst role in the SWYPFT service. The IST heard that this is sufficient for data quality and day-to-day management but not to provide strategic support which is available through SWYPFT support service functions.
- There is an IT/data lead role in MindSpace but this is currently vacant and being recruited to
- Although data recording and reporting in MindSpace appears to be good this uses a somewhat manual spreadsheet-based system which may pose issues with MHSDS submission and future scalability

Good Practice Indicator: Routine reporting across key measures of quality, activity and productivity

- The focus of internal reporting at SWYPFT is the CCG KPI report. The IST heard that this is the only report referred to regularly within SWYPFT. This report gives a detailed view of referral numbers and types, as well as breakdowns of waiting lists to first and second contact and activity levels for first and subsequent contacts.
- Although DNAs and inappropriate referrals are reported, there is no other information in the report relating to productivity
- There is no information on either ROMs data quality or reliable improvement reported in SWYPFT
- Although it has never been requested from the CCG, MindSpace report regularly on activity, productivity and outcomes usage. This is good practice.
- No information on completeness or data quality for outcomes or interventions recorded in SWPYFT is available

Back to Key Recommendations

External Reporting

Good Practice Indicator: governance processes are in place to ensure service understanding and sign off of MHSDS data

- A SOP is in place to document the MHSDS upload process. This is good practice.
- The IST heard that MHSDS data is checked every month by staff in the information team and that NHS Digital 'Data Quality Notices' have been replicated internally to ensure that data is accurate prior to upload.
    - Subsequent to the IST visit, SWYPFT failed to submit any MHSDS activity for March 2019, suggesting that this process has room for further improvment
- An access dashboard is maintained within SWYPFT. The IST heard that this is checked against NHS Digital data but that this is due to one individual rather than an organisational policy. Although the figures reported are broadly similar, they do not match the published data
- Nobody from the CYP team has sight of or signs off access data prior to or after submission.
- Internal SWYPFT reports only use 'local' data and do not reference nationally-published data

Good Practice Indicator: routine data flow to commissioners as well as meeting national MHSDS requirements

- There is a monthly 'KPI Report' which forms the basis for performance discussions between SWYPFT and the CCG. This contains numerous useful measures of waiting lists and referral numbers.
- Although the IST heard repeatedly that long waits existed in numerous pathways subsequent to initial treatment, these waiting times are not reflected in the KPI report. A such, both SYPFT and commissioners have limited visibility and understanding of these waiting times.
- The CYP Access KPI is not part of the KPI report and the IST heard that the CCG were unaware of published performance until recent months

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Barnsley Education and In-School Counselling Report 1st April 2018 – 31st January 2019

Lead SYEDA contact: *Chris Hood, CEO*
Lead CCG contact: *Patrick Otway, NHS Barnsley CCG*

Education and Training

Introduction

South Yorkshire Eating Disorders Association (SYEDA) were commissioned by Barnsley CCG to be able to maintain a presence in Barnsley. The agreed activities were to deliver crucial education on eating disorders and related topics to young people; to deliver emotional resilience workshops to primary school children (year 6) as a complimentary addition to the Thrive programme; and to deliver courses on 'Understanding Eating Disorders' to key professionals such as school nurses. This report details the programme of activity for the 1 month period from 1st April 2018 – 31st January 2019. It details what has been delivered, the feedback gathered and an evaluation of this approach to the prevention and early intervention of eating disorders in young people. It will also provide information on activities planned for the remaining two months of the contract- see appendix 1

Charitable objectives

- To advance the education of children and young people in Barnsley in Eating Disorders and emotional wellbeing and resilience.
- To promote the early identification of disordered eating and eating disorders in young people in Barnsley.

From these charitable objectives, we focussed on these aims

- To deliver workshops, sessions and assemblies and training courses in an accessible and universal approach to not only support those most vulnerable, but to also advance the education to all young people in eating disorders and emotional wellbeing.
- To support those who are most vulnerable by signposting to support or identifying pathways to key professionals working with young people.

Education Offer

50 minute / 1 hour sessions - designed to fit in to one lesson. Interactive workshops exploring one topic.	Suitable for whole classes, available for Y6 onwards.
Whole morning / Whole afternoon sessions - An opportunity to get to grips with the topic.	Suitable for smaller groups, 12 maximum. Covers one topic.

After school sessions—a more relaxed and creative session, using activities, art and music to create something to keep, or to benefit the whole school.	Suitable for smaller groups, 12 maximum. Covers one topic.
Whole day sessions—with listening skills, self-care, supporting others within the role of a mental health champion.	Designed for mental health champions, adaptable for Y6 onwards. This session covers both our topics in one day.

Activity Report

Type of activity	**Number of sessions**	**Number attending**
10 Primary Schools. Topic: "Emotional Wellbeing and Resilience". *Please see attached sheet.*	12	338 Y6 Children 10 yrs. of age. In the sessions there were teaching assistants and teaching staff, an approximate total of up to 30 staff.
Awareness Raising Events This is including key professionals meetings and a Carers' launch event. *Please see attached sheet.*	7	Carers' Launch Event - Up to 12 other organisations working within Barnsley resulting in an exchange of information with Voluntary Action Barnsley and Beacon – South Yorkshire Carer Support.
1 Secondary school Topic: "Food and Feelings" (An Introduction to Eating Disorders for young people).	7	Y10 pupils plus teaching and support staff approx. 26 – 30 in each group up to 300 students –firm booking
Youth/Support Groups Topic: "Food and Feelings"	1	10 young people over 16yrs of age plus 3 adult workers.
	Total: 27	**Total YP:** 558

Schools/groups delivered to

- Lacewood Primary School
- OASIS (Chilypep group held at Horizon School)
- Joseph Locke Primary School
- Sacred Heart Catholic Primary School
- Hoylandswaine Primary School
- Thurgoland CE Primary
- Keresforth Primary School
- St Helen's Primary School
- St Michael and All Angels Primary
- Worsborough Common Primary School
- All Saints Academy (Primary)
- Netherwood Academy
- Carlton Academy – as yet bookings have not been made.

Planned Activity

Date	Where	Activity
Offered dates in February	Pathways	Understanding Eating Disorders Course
22nd or 29th January	All Saints School	Emotional Resilience, Year 6
Completed 15th November 2018	St. Helen's RC Primary, Hoyland	Emotional Resilience, Year 6
Completed 27th November	Worsbrough Common Primary, Barnsley	Emotional Resilience, Year 6
Date TBC	Penistone Grammar	Food and Feelings Sessions and UED in Young People Professional Session
Offered 14th, 21st, 28th Feb, 5th, 12th March	Kirk Balk Academy	Food and Feelings Sessions and UED in Young People Professional Session, with a view to then delivering Food and Feelings sessions to pupils
Date TBC	Horizon Community College	Food and Feelings Sessions and UED in Young People Professional Session
Date TBC	Dearne ALC	Food and Feelings Sessions and UED in Young People Professional Session
Fri: 18th, 25th Jan and 1st Feb & 15th 2019	Netherwood Academy	Food and Feelings x 7 sessions, Y10's
Date TBC, staff changes and only want times on non-working days	Barnsley College	Food and Feelings

What do children, young people and professionals think of the programme?

Worsborough Primary School Professional feedback	Evaluation: Strongly agreed that the session met all expectations, was well facilitated, questions were responded to very appropriately, the session was an effective way for individuals to learn and the students were actively engaged. 'The session was very interactive and informative which kept the children engaged' 'Becky/ the facilitator was really open and friendly towards the children and made them feel relaxed about participating' 'Becky/the facilitator was fab' 'I would love for Becky/ the facilitator to come back soon to speak to other children'
Young People's feedback	When asked 'What did you learn today'? 'About how to protect your body. How to look after yourself. Who I can trust. Thank you Syeda!!! You helped me.' ' I learned it is better to tell people about things than keep them to yourself' 'To eat properly. Have exercise. Talk to someone if you need help' When asked if there was anything SYEDA could change – ' No there isn't, Syeda is amazing'
Young people's feedback	'What did you learn?' 'That even if you are different you can still be as happy as the others. You don't just need to eat healthy to stay healthy' 'Not just to look after yourself but others too. Not to be ashamed of who you are'. 'I learned about different ways to keep fit and healthy so that you don't get poorly. I learned about different organisations that can help

	you going through a hard time'. ' I learned that you shouldn't always be on your phone and little things mean a lot' 'That being healthy is not just about eating healthy it's about exercise and feel positive and happy' ' I really like sharing all of our ideas' ' I learnt about a healthy life and the lady who did it was wonderful and the topic that we did today was really interesting about connecting and the other 4' Is there anything SYEDA could change? 'No, everything was great. I really enjoyed it'. 'I think it was brilliant and you shouldn't change anything' 'No, I think I have learnt a lot today, so thank you'.

Report

Research, National Guidance and Government Papers advocate early intervention, preventative work and a whole school approach to MH and Wellbeing: No Health without Mental Health (2011) Future in Mind (DOH, 2015) A whole School and College Approach (Public Health England, 2015). Our prevention focussed workshops explore the relationship between physical and mental health. They aim for young people to better understand their own relationships with food and exercise, and to appreciate and understand how everyone is different. We also look at wellbeing and developing healthy coping strategies and self-care strategies. Our workshops can be adapted to the needs of each class and develop activities to promote enjoyable engagement.

The education work we have delivered over the past 10 months has been well regarded and really effective. We have received positive feedback across the board and several schools have made comments that they would like us to return to teach other students. Our educational offer is multifaceted in that the workshops tackle stigma, raise awareness about mental health in general, but Eating Disorders in particular and raise important issues concerning for example, emotional literacy and resilience. The material covers the challenges many young people face that are not limited to the symptoms of their eating disorder but to the ill treatment of others as well.

With this funding we have delivered within the three main categories of education: Primary school sessions, secondary school sessions and professional courses on understanding eating disorders in young people.

Primary school is a time of learning and discovery, and a time when children are continually engaged in trial and error learning. They're learning emotionally, socially, and cognitively at a rapid pace, and in year 6 are starting to prepare for a new chapter in their life and education. Therefore it is timely to target this audience with a workshop on emotional resilience as this will come in useful with a transition to secondary school and into puberty, when our bodies start to change (all of which can be triggers for an eating disorder).

Secondary school and college are also a key time for learning and developing a sense of identity. There are a lot of pressures for a young person during this time including tests, developing relationships and the pressures pertaining to the use of the internet and social media specifically. Once again, several of these stressors can contribute to the development of an eating disorder. Eating disorder education can be a timely awakening that jars the consciousness of young people in

an early stage of an eating disorder. Through education a young person might recognise themselves or a friend as being on their way to having a serious disorder. Our early education is presented clearly and sensitively with regard to the developmental stage of the audience and stimulates awareness of eating disorders as the dangerous illnesses they are. These workshops can also help teens to recognise the understanding and compassion required of others to support healing in their friends.

Workforce development is a key area of prevention work for our charity. We have gained extensive experience in teaching professionals from teachers, to GPs, nurses, to Social Workers. The workforce being aware of the major causes, signs and symptoms of Eating Disorders equips them to identify young people who are developing a disordered relationship with food or negative body image sooner. We have plans to deliver to a team of Pathways staff and with thanks to Alicia Marcroft, Head of Public Health (Children and Young People), we have been able to target a large audience of nurses. Of course our reach is currently limited and we would like to be included in more workforce development plans in the future across sectors.

Suggestions

We delivered our educational offer in a range of schools across Barnsley which enabled us to reach a lot of young people. We were able to utilise existing relationships with Barnsley schools and colleges to gain access to the classroom for the purpose of delivering our education programme. However, a lot of marketing and promotion was required in order to make people aware of the offer and to build a trusting relationship for new schools to give us access to deliver a workshop. The longer we are able to operate in an area, the more we are able to build up relationships and cover new ground.

We would like to expand our reach to include all Barnsley schools and colleges. The 4 schools we developed an in-school clinic were primary targets for our education offer which we felt would complement and strengthen our counselling work with vulnerable students. Having contacted these schools via letter, email and setting up meetings, sadly no sessions or teacher training has been scheduled. As such, to ensure that there is a more long term impact on our involvement with these schools (Penistone Grammar, Kirk balk Academy, Horizon Community College and Dearne ALC) we would like the opportunity to build up these relationships and arrange for interventions for the next financial year. Similarly, some activities did not go ahead as arranged and it would be ideal to pursue these again with the schools.

It would also be useful to explore more in depth education work that students can gain a deeper understanding of eating disorders from. Targeting smaller, specific, or at risk groups may be more effective. For example we could work with mental health champions to deliver a full day of education and follow this up by supporting the group to deliver whole school Anti-Stigma Mental Health Campaigns. Similarly, we could develop a programme of psychoeducational group work that focuses on body image and self-esteem for vulnerable students. These approaches may make a more lasting impact. In addition, following Y6 students to their Secondary Schools to do further sessions may be beneficial and present a continuation of the supportive messages we delivered in their Primary schools. If this can be timed to coincide with PSHE lessons a more comprehensive and wrap around approach to delivering support and information can be achieved.

In conclusion, this is a valuable resource and Barnsley would hugely benefit from its continuation. Psychoeducation and information around the development of eating disorders are important methods for encouraging healthy growth and coping mechanism development in young people. These educational sessions are needed because often early stages of an eating disorder go

unrecognised by everyone, including the person with the disorder. Everyone eats, it is a necessary part of life and we each have a unique relationship with food. Plus, there are many ways of eating and not eating that are socially sanctioned for particular occasions.

- Information correct as of 21.1.19

<u>In-School Counselling</u>

'*Having the opportunity to offer students targeted early intervention around disordered eating and body confidence at Kirk Balk Academy has been fantastic*
The pressures of being a young person and fitting in with peers and the perceived perfection of social media impacts students' emotional well-being daily
SYEDAs work is specifically targeted to this area of work, and the work completed, although fantastic, has barely "scratched the surface" in terms of the number of students who would benefit and need this service
CAMHS is over stretched and students are often waiting for up to a year to access their support. Having SYEDA as a resource we can access on site has been amazing'.
Kind regards
Rachel Hague (kirk Balk pastoral lead)

Background

SYEDA was asked to pilot an in-school counselling service for young people experiencing difficulties with their relationship with food and eating from a psychological perspective.

Following guidance from Michelle Sault we contacted four secondary schools (Dearne ACL, Horizon, Kirk Balk and Penistone Grammar) to ascertain interest. All four schools responded positively and meetings were arranged with key personnel.

Given the comparative sizes of te four schools it was agreed to vary the frequency of our input as follows:

Horizon= weekly, Kirk Balk= Fortnightly, Penistone and Dearne = Monthly

It was agreed to launch the pilot in the new academic year on the 27th of September 2018. Each school agreed to work within the protocol to ensure consistency across the pilot- see appendix 2 .

We recruited a highly trained and professional counsellor with several years' experience of delivering counselling in a school setting and 4 years' experience of working with eating disorders.

Outputs to date

- Number of referrals = **15**, 2 inappropriate due to level of need and learning difficulties, both signposted to other services
- Gender (self-identified) = Male 5, female 10
- Age profile = 12=1, 13=2, 14=8,15=3, 16=1

- Presenting issues included; low self-esteem, restriction, negative body image, family member an in-patient with ED, family relationships impacting on mood, binge eating, bereavement
- Number of sessions accessed ranged from 1-12- regular attendance by all who accessed counselling

Dearne ACL did not identify anyone how they felt suitable so the figures above represent activities in the other 3 schools only. We increased the frequency of input at Penistone Grammar to fortnightly in light of Dearne's situation and to better respond to demand.

Comments from young people included:

'*I found the sessions really helpful and want to continue to come weekly'*

'I did not realise how my feelings and thought were affecting my relationship with food, I feel I have a better handle on it now'

'I have not binged for 2 weeks which I did not think was possible until now'

Quote from Hannah (counsellor):

'*I have found the work in Barnsley schools to be very complex. Students have presented with high levels of need in multiple areas. From speaking to the school staff, I have heard that the schools have a large amount of students who experience difficulties in the areas of body image, self-esteem and food. It is serve that I believe is vital for many young people who may become entrenched in negative thoughts and behaviours without a similar intervention'*

The service will continue to see students at et 3 schools until the end of March 2019

Appendix 12

Wednesday 11th April, 8.25-9.25am	*TBC:* Outwood Academy Carlton, Barnsley	Body Confidence workshop to 11-16 year olds	Mel Dyson
Wednesday 11th April, 9.25-10.25am	Outwood Academy Carlton, Barnsley	Body Confidence workshop to 11-16 year olds	Mel Dyson
Wednesday 11th April, 11.00-12.00pm	Outwood Academy Carlton, Barnsley	Body Confidence workshop to 11-16 year olds	Mel Dyson
Wednesday 11th April, 12.30-1.30pm	Outwood Academy Carlton, Barnsley	Body Confidence workshop to 11-16 year olds	Mel Dyson
Wednesday 11th April, 1.30-2.30pm	Outwood Academy Carlton, Barnsley	Body Confidence workshop to 11-16 year olds	Mel Dyson
Thursday 30th Aug	OASIS – Horizon School	Food and Feeling/UED	CHILYPEP
Thursday 25th October, time TBC	Horizon School, Barnsley	Food and Feeling/UED Workshop to students as part of a half day with Chilypep	Chilypep
Fri 5th Oct	Joseph Locke Prmary	Meeting heads to discuss sessions	G. Dransfield a
Fri 12th Oct	Sacred Hearts Primary	Emotional Wellbeing	A. Beed
Tues 16th Oct	Hoylandswaine Primary	Emotional Wellbeing	B. Huds
Thurs 18th Oct	Joseph Locke Primary	Emotional Wellbeing x2	G. Dransfield a
Wed 24th Oct	Barnsley	Carers' Launch event	
Tues 13th Nov	Thurgoland Primary	Emotional Wellbeing	Suzanne Brow
Tues 13th Nov	St Michael's and All Angels	Emotional Wellbeing	J. Holcroft
Thurs 15th Nov	St Helen's Hoyland	Emotional Wellbeing	E.Morrison
Tues 20th Nov	Keresforth Primary	Emotional Wellbeing	Charlotte Gau
Tues 27th Nov	Worsborough Primary	Emotional Wellbeing	Lisa Gray
Tues 22nd Jan 2019	All Saints Academy	Emotional Wellbeing	Kirsty Glyde

Future Activities

Organisation	Activity	Contact
Barnsley College	• February-Offering tutorials for awareness month	Laura Gray (now left) TBC
Barnsley College	• Sport Students tutorial on body image in sport and exercise	Bethany Smith TBC
Barnsley School Nurse Service x 2 1 – 7th Feb – Barnsley Town Hall 2 – 14th March – Barnsley Town Hall	• UED for School Nurses	Cathy Utley
Netherwood Academy x 7 1 x 2 18th Jan 2 x 2 25th Jan 3 x 2 1st Feb 4 x 15th Feb	• Eating Disorders x 7 for Y10's	Ruth Hancock
Barnsley Trainee GP session – Presentation – dates offered and yet to be confirmed	• Raising awareness about ED services in Barnsley	Diane Parker – GPSTP Administrator

Appendix 12

Barnsley Pathways – dates offered and yet to be confirmed	• UED and Ed services in Barnsley	SueStokes@PathwaysBArnsley.uk

Appendix 12

Appendix 2

SYEDA

Protocol for outreach working with Schools students for regular provision of counselling sessions on school premises

Current attending day: TBA

Location: room to be sourced and supplied by the school.

Contact links within school:

Designated Safeguarding Lead/ Main point of contact):

Email: ?

Session structure procedure:

The Syeda Counsellor will attend and provide counselling to young people who have been identified as experiencing difficulties with food and/or their body image and who are not in receipt of support from the local CAMHS Team for an eating disorder.

The Syeda Counsellor will arrive at the school via the main entrance and sign in and obtain the relevant visitors pass. The counsellor with base themselves in the allocated room and will see the young people at their allocated time.

The young people signposted for Syeda counselling support will either be identified by staff within the school or have approached staff themselves to seek support.

Once identified as potentially requiring support the young person will attend an initial short assessment session with the Syeda Counsellor before being seen for up to 6 sessions conducted on a weekly or fortnightly basis.

The Syeda Counsellor will meet with TBA, either before or after the sessions time and relevant information will be passed from both parties in order to maintain clear and open communication which safeguards the young person's wellbeing.

Sessions will be provided to each individual young person weekly/fortnightly and last for up to 6 sessions in total.

The Syeda Counsellor will be responsible for completing session notes after each individual session and this is kept in the School file which is kept in the confidential client notes cabinet at SYEDA's base.

Within this file is also kept an attendance register in which the name of every student that attends is documented alongside the length of the session, this is completed after each weekly attendance.

Within the sessions it is made clear to the students that what is discussed is confidential, however they are aware that if anything of risk/concern is disclosed, that this information will be passed on to the school (?) and they will manage this information as per their policies and procedures as the students are being seen on the school premises.

Appendix 12

Safeguarding and confidentiality

Any concerns that the Counsellor may have regarding a student; their wellbeing or the wellbeing of others will be communicated to ?, where ? is unavailable an alternative appropriate member of staff will be identified .Where a concern or update is deemed non-urgent the Counsellor will update ? via email as soon as they are able to.

During the first session the Counsellor will make each young person aware of the boundaries and limitations of confidentiality and inform them of the need to share information which relates to a risks posed to their wellbeing.

Where information relating to a young persons presentation is shared with the school, the school is then responsible for making a decision as to whether parents are contacted based upon their safeguarding procedures.

The Counsellor is asked on an individual basis as to whether their details (e.g. work contact number) can be passed to parents in order for them to make contact if they wish. On the occasions this has been asked, it has been agreed and the clinician has liaised with family, either by telephone or an arranged meeting at the school.

If the clinical risk/need is felt to be too great to be managed within the drop in sessions, this will be discussed with both the Clinical Manager at SYEDA and the named staff at School.

A decision will then be made about the most appropriate option for support and treatment at this time. This may include a self-referral to SYEDA directly or other agencies such as Sheffield Eating Disorders Service NHS (SEDS), MAST,CAMHS or GP involvement. There may also be a need to discuss the potential completion of an FCAF by the school if it is a complex case and the family also have needs

The content of the sessions is dependent on the needs and preferences of the students, however often discussions regarding thoughts, feelings and emotions take place, alongside discussions about stress and coping strategies.

C.wood

Clinical Manager

Syeda

May 2018

NICE National Institute for Health and Care Excellence

NICE guideline

Self-harm in over 8s: short-term management and prevention of recurrence

Clinical guideline

Published: 28 July 2004
nice.org.uk/guidance/cg16

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is partially replaced by CG133.

Overview

This guideline covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm.

Who is is for?

- Healthcare professionals
- Counsellors, psychiatrists, prison health staff, social workers, therapists pharmacists
- Police and professionals who work in the criminal justice and education sectors
- Directors of public health, NHS trust managers and managers in primary care trusts
- People who self harm and their families and carers

Key priorities for implementation

Respect, understanding and choice

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated charcoal

- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.

- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of

- self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

Assessment of needs

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

- Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

1 Guidance

This guideline makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed. For the purpose of this guideline, the term self-harm is defined as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself.

In the first part, the guideline makes recommendations that apply across the whole health community, wherever people who self-harm present for help, including good practice points to improve the integration of the different services involved. In the second part of the guideline, the recommendations directly address the care offered to people who self-harm presenting in primary care, in the community, or in secondary care. Throughout the guideline, the need to treat people who self-harm with compassion and understanding is emphasised.

The guideline is relevant to all people aged 8 years of age and older who have self-harmed. Where it refers to children and young people, this applies to all people who are between 8 and 16 years of age inclusive. However, it should be borne in mind that local services vary the upper age limit depending upon whether a young person is in full-time education or not.

1.1 Issues for all services and healthcare professionals

1.1.1 Users' experience of services

The experience of care for people who self-harm is often unacceptable. All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses this as a priority.

Respect, understanding and choice

1.1.1.1 People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

1.1.1.2 Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.

1.1.1.3 Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes.

1.1.1.4 When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words.

1.1.1.5 When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.

1.1.1.6 Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide people who self-harm with full information about the different treatment options available.

When relatives or carers are present

1.1.1.7 People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality and to allow discussion about issues that may relate to the relationship between the service user and carers.

1.1.1.8 Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety.

Specific issues regarding treatment and care

1.1.1.9 People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

1.1.1.10 Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.

1.1.1.11 When physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance.

1.1.2 Staff training and service planning

Self-harm is poorly understood by many NHS staff. All staff that come into contact with people who self-harm need dedicated training to improve both their understanding of self-harm and the treatment and care they provide. Effective collaboration of all local health organisations will be essential to develop properly integrated services.

Staff training

1.1.2.1 Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

1.1.2.2 People who self-harm should be involved in the planning and delivery of training for staff.

1.1.2.3 Emergency departments should make training available in the assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment.

1.1.2.4 Mental health services and emergency department services should jointly develop regular training programmes in the psychosocial assessment and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed.

Planning of services

1.1.2.5 Strategic Health Authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm.

1.1.2.6 Emergency departments, PCTs and local mental health services, in conjunction with local service users and carers wherever possible, should jointly plan the configuration and delivery of integrated physical and mental healthcare services

within emergency departments for people who self-harm.

1.1.2.7 Emergency departments catering for children and young people under 16 years of age, PCTs and local children's mental health services, in conjunction with local carers and service users, should jointly plan the configuration and delivery of integrated physical and mental healthcare services within emergency departments for children and young people who self-harm.

1.1.2.8 In jointly planning an integrated emergency department service for people who self-harm, service managers should consider integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department.

1.1.2.9 Emergency department and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day.

1.1.3 Consent to care

Issues of consent, mental capacity and mental ill health in the assessment and treatment of people who self-harm should be understood and addressed by all healthcare professionals involved in the care of this group of people.

1.1.3.1 All healthcare professionals who have contact, in the emergency situation, with people who have self-harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent.

1.1.3.2 Primary healthcare practitioners, ambulance staff, triage nurses and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed. Within the bounds of patient confidentiality, and subject to the patient's consent, staff should attempt to obtain relevant information from relatives, friends, carers and other key people, to inform the assessment.

1.1.3.3 In the assessment and treatment of people who have self-harmed, mental capacity should be assumed unless there is evidence to the contrary.

1.1.3.4 Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

1.1.3.5 If a person is assessed as being mentally incapable, staff have a responsibility, under common law, to act in that person's best interests. If necessary, this can include taking the person to hospital, and detaining them to allow assessment and treatment against the person's stated wishes.

1.1.3.6 Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to explain each new treatment or procedure and obtain consent before it is initiated.

1.1.3.7 Staff working with people who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm.

1.1.3.8 Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times.

1.1.4 Activated charcoal

For the majority of drugs taken in overdose, taking activated charcoal as early as possible, preferably within 1 hour of ingestion, can prevent or reduce absorption of the drug. Activated charcoal should be immediately available for rapid and appropriate use.

1.1.4.1 Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

1.1.4.2 All healthcare professionals who are able to offer activated charcoal to people who have self-poisoned should ensure that they know how and when this should be administered. This should include:

- knowing for which poisons activated charcoal should and should not be used
- the potential dangers and contraindications of giving activated charcoal

- the need to encourage and support service users when offering activated charcoal.

1.2 The management of self-harm in primary care

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm, and their relatives, could also help in prevention. In remote areas, access to TOXBASE (the national database of the National Poisons Information Service [NPIS]) may be necessary.

1.2.1.1 When an individual presents in primary care following an episode of self-harm, healthcare professionals should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

1.2.1.2 All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user.

1.2.1.3 In the assessment and management of self-injury in primary care, healthcare professionals should refer service users for urgent treatment in an emergency department, if assessment suggests there is a significant risk to the individual who has self-injured.

1.2.1.4 In most circumstances, people who have self-poisoned and present to primary care should be urgently referred to the nearest emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned, making accurate risk assessment difficult.

1.2.1.5 If there is any doubt about the seriousness of an episode of self-harm, the general practitioner should discuss the case with the nearest emergency department consultant, as management in secondary care may be necessary.

1.2.1.6 Consideration should be given to the service user's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate person where there is a risk of further self-harm

or reluctance to attend other care centres, or the service user is very distressed.

1.2.1.7 In remote areas at considerable distance from an emergency department or where access is likely to be delayed, consideration should be given to initiating assessment and treatment of self-harm in the primary care setting, following discussion with the nearest emergency department consultant. This should include taking samples to test for paracetamol and other drugs, as indicated in TOXBASE.

When urgent referral to an emergency department is not necessary

1.2.1.8 If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services.

1.2.1.9 Assessment of the service user's needs should be comprehensive and should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment.

1.2.1.10 Following assessment and treatment of self-harm in primary care, the outcome of the risk and needs assessment, and full details of the treatment provided, should be forwarded to the appropriate secondary mental health team at the earliest opportunity.

1.2.1.11 Healthcare professionals who may have to assess and/or treat people who have self-harmed should ensure that they are properly trained and competent to undertake assessment and treatment as necessary.

Service users at risk of self-poisoning in primary care

1.2.1.12 In service users who are considered at risk of self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose, and should consider prescribing fewer tablets at any one time.

1.2.1.13 Consideration should be given to preventing or reducing the prescription of co-proxamol, especially for people who are at risk of self-poisoning.

1.2.1.14 As medication intended for relatives is often used in self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose when prescribing medication to relatives who live with a person who is considered at risk of self-poisoning. They should also consider prescribing fewer tablets at any one time. Care must be taken, however, to preserve confidentiality appropriately.

1.3 The assessment and initial management of self-harm by ambulance services

Ambulance staff have an increasingly important role in the assessment and early treatment of self-harm, a role that needs to be well supported through effective collaboration with other professional groups.

1.3.1.1 When ambulance staff attend a person who has self-harmed, they should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

1.3.1.2 Ambulance staff should be trained in the assessment and early management of self-harm. Training should particularly address the different methods of self-harm and the appropriate treatments, the likely effects if untreated, and issues of consent and mental capacity, as these apply both to adults, and to children and young people.

1.3.1.3 In cases where, following an act of self-injury, the service user does not require emergency treatment in the emergency department, ambulance staff should consider, having taken full account of the service user's preferences, taking the service user to an alternative appropriate service, such as a specialist mental health service. The decision to do so should be taken jointly between the ambulance staff, the service user and the receiving service.

1.3.1.4 Ambulance Trusts, the emergency department and Mental Health Trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self-harmed, where this is appropriate and does not increase the risks to the service user.

1.3.1.5 In cases of self-poisoning, ambulance staff should obtain all substances and/or medications found at the scene of an emergency call, whether thought to be involved in the overdose or not, and pass these to staff upon arrival at the emergency department.

1.3.1.6 Unless the service user's clinical condition requires urgent treatment that should not be delayed, ambulance staff should record relevant information about the service user's home environment, social and family support network, and history leading to self-harm, as well as the service user's initial emotional state and level of distress. This information should be passed to emergency department staff.

1.3.1.7 When transporting people who have self-harmed to an emergency department, wherever possible, ambulance staff should take into account the service user's preferences when more than one emergency department facility exists within a reasonable distance, unless doing so significantly increases the risk to the service user, or when one department has specialised in the treatment of people who have self-harmed.

1.3.1.8 When a person who has self-poisoned presents to the ambulance service within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, ambulance staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

1.3.1.9 Activated charcoal may also be considered between 1 and 2 hours after ingestion as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

1.3.1.10 In the emergency treatment of opioid overdose when using intravenous naloxone, ambulance staff should adhere to the guidelines established by the Joint Royal Colleges Ambulance Liaison Committee. Particular attention should be given to the possible need for repeated doses of naloxone and frequent

monitoring of vital signs, because the effects of naloxone are short-lived in comparison with the effects of most opioids and service users frequently relapse once the effect of naloxone has worn off. All people who have overdosed with opioids should be conveyed to hospital, even if the initial response to naloxone has been good.

1.3.1.11 The ambulance services should ensure that there is rapid access to TOXBASE and the NPIS so that their crew can gain additional information on substances and/or drugs ingested in cases of self-poisoning in order to assist in decisions regarding urgent treatment and the transfer of patients to the most appropriate facilities.

1.3.1.12 When people who have self-harmed are considering refusing further treatment, ambulance staff should assess mental capacity and provide information about the potential consequences of not receiving treatment when attempting to gain valid consent. When consent is withheld, the guidance on consent and capacity in this guideline should be followed.

1.3.1.13 PCTs, in conjunction with acute and mental health trusts, should consider the level of support needed for the delivery of an adequate pre-hospital care system for self-harm. Specific consideration should be given to the provision of telephone advice to ambulance staff from crisis resolution teams, approved social workers and Section 12 approved doctors, regarding the assessment of mental capacity and the possible use of the Mental Health Act in the urgent assessment of people who have self-harmed.

1.3.1.14 Ambulance Trusts should regularly update ambulance staff about any change in local arrangements for services available for the emergency treatment of people who have self-harmed.

1.3.1.15 Ambulance Trusts should routinely audit incidents of overdose, both to ensure that interventions are being used consistently and effectively, and to monitor adverse incidents.

1.4 The treatment and management of self-harm in emergency departments

The emergency department provides the main services for people who self-harm. Emergency department staff should assess risk and emotional, mental and physical state quickly, and try to

encourage people to stay to organise psychosocial assessment.

1.4.1 Triage

1.4.1.1 When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

1.4.1.2 Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment.

1.4.1.3 Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner. Do not use the Australian Mental Health Triage Scale to predict future suicide or repetition of self-harm.

1.4.1.4 Triage nurses working in emergency departments should be trained in the use of mental health triage systems.

1.4.1.5 All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

1.4.2 People waiting for physical treatments

1.4.2.1 A psychosocial assessment should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed, or the patient is unconscious or otherwise incapable of being assessed.

1.4.2.2 People who have self-harmed should be provided with clear and understandable information about the care process, both verbally and as written material in a language they understand.

1.4.2.3 If a person who has self-harmed has to wait for treatment, he or she should be

offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

1.4.3 People who wish to leave before assessment and/or treatment

1.4.3.1 For a person who has self-harmed and presents to services, but wishes to leave before psychosocial assessment has been undertaken, assessment of mental capacity and the presence of mental illness should be undertaken before the person leaves the service. This assessment should be clearly recorded in his or her notes. The assessment should be passed on to the person's GP and to the relevant mental health services as soon as possible to enable rapid follow-up.

1.4.3.2 People who have self-harmed and present to services and wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental illness is established, should be referred for urgent mental health assessment. Appropriate measures should also be taken to prevent the person leaving the service.

1.5 Medical and surgical management of self-harm

Self-poisoning can be treated by reducing absorption, increasing elimination and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with tissue adhesive, whilst more complicated injuries will need surgical assessment and possibly exploration.

1.5.1 General treatment for ingestion

1.5.1.1 Gastrointestinal decontamination should be considered only for people who have self-harmed by poisoning who present early, are fully conscious with a protected airway, and are at risk of significant harm as a result of poisoning.

1.5.1.2 When a person who has self-poisoned presents to the emergency department within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, emergency department staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

1.5.1.3 When a person who has self-poisoned is fully conscious and able to protect his or her own airway, activated charcoal may also be considered between 1 and 2 hours after ingestion, as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

1.5.1.4 Multiple doses of activated charcoal should not be used in the management of self-poisoning to reduce absorption, or to promote elimination of poisons, unless specifically recommended by TOXBASE or following consultation with the National Poisons Information Service (NPIS).

1.5.1.5 Emetics, including ipecac (ipecacuanha), should not be used in the management of self-poisoning.

1.5.1.6 Cathartics as a specific treatment should not be used in the management of self-poisoning.

1.5.1.7 Gastric lavage should not be used in the management of self-poisoning unless specifically recommended by TOXBASE or following consultation with the NPIS.

1.5.1.8 Whole bowel irrigation should not be used in the management of self-poisoning, unless specifically recommended by TOXBASE or following consultation with the NPIS.

Collecting samples and interpreting results

1.5.1.9 Staff involved in the emergency treatment of self-poisoning should collect appropriate samples for analysis; usually this will be a sample of blood, although samples of urine, vomit or sometimes gastric contents may be indicated following discussion with the NPIS. If possible, samples of the suspected poison should also be collected.

1.5.1.10 Hospital laboratory staff should provide emergency department staff with regular updates about which toxicology tests are available, both locally and at the nearest specialised toxicology laboratory. These should include information

on the correct methods of collecting, handling and storing samples, and how samples should be transferred to the laboratory.

1.5.1.11 Where emergency department staff are unsure about the value of undertaking a toxicology assay or about whether an assay is available locally, advice should be sought from TOXBASE, the local hospital laboratory, a specialised toxicology laboratory or the NPIS.

1.5.1.12 When emergency department staff are unsure about the interpretation of assay results, advice should be sought from the local hospital laboratory, specialised toxicology laboratory or the NPIS.

Information and laboratory services available to clinicians treating self-poisoning

Emergency department staff should have easy access to TOXBASE, be fully trained in its use, and know how and when to contact the NPIS.

1.5.1.13 TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. TOXBASE should be the first point of call for poisons information.

1.5.1.14 The NPIS telephone number should be permanently and easily available to clinical staff involved in the emergency treatment of self-poisoning. The NPIS should normally be contacted only directly after clinicians have accessed TOXBASE or if there is concern about the severity of poisoning in a particular case.

1.5.1.15 Clinical staff involved in the emergency treatment of self-poisoning should be given training to better understand human toxicology, in order to make best use of TOXBASE and the NPIS telephone service. Emergency departments, in conjunction with local hospital laboratories or regional toxicology units, or NPIS units, should ensure all staff receive regular training.

1.5.1.16 In cases where the suspected poison is a substance for which little toxicology data exists, clinical and laboratory data about exposure and absorption should be passed to the NPIS to help in the development of TOXBASE and other poisons information databases.

1.5.1.17 For further information about the management of overdose with substances covered by this guideline and for the specific management and treatment of overdose with substances not covered in this guideline, clinicians should consult TOXBASE or discuss the individual case with the NPIS.

Paracetamol screening

1.5.1.18 Plasma paracetamol concentrations should be measured in all conscious patients with a history of paracetamol overdose, or suspected paracetamol overdose, as recommended by TOXBASE. They should also be taken in patients with a presentation consistent with opioid poisoning, and in unconscious patients with a history of collapse where drug overdose is a possible diagnosis. Plasma paracetamol levels should be measured for risk assessment no earlier than 4 hours and no later than 15 hours after ingestion, as results are not reliable outside this time period.

1.5.2 Management of paracetamol overdose

1.5.2.1 Following gut decontamination with activated charcoal as recommended in this guideline, TOXBASE should be used to guide the further management of paracetamol poisoning. TOXBASE should be easily available to all clinicians treating paracetamol poisoning.

1.5.2.2 Intravenous acetylcysteine should be considered as the treatment of choice for paracetamol overdose (although the optimum dose is unknown). If acetylcysteine is not available or cannot be used, for example in people who abuse intravenous drugs where intravenous access may be difficult, or for people with needle phobia, then TOXBASE should be consulted.

1.5.2.3 In the event of an anaphylactoid reaction following administration of intravenous acetylcysteine, procedures outlined in TOXBASE should be followed.

1.5.2.4 In cases of staggered ingestion of paracetamol, the procedures outlined in TOXBASE should be followed in conjunction with discussion with the NPIS.

1.5.3 Flumazenil in benzodiazepine overdose

If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help reduce the

need for admission to intensive care. Although widely used, flumazenil is not currently licensed for the treatment of benzodiazepine overdose in the UK.

1.5.3.1 When a positive diagnosis of self-poisoning with a benzodiazepine has been made, the possibility of mixed overdose should be considered, and investigated if necessary, at the earliest opportunity, especially if the patient's clinical progress suggests that he or she may later require admission to intensive care.

1.5.3.2 In patients who are unconscious or showing marked impairment of consciousness, with evidence of respiratory depression likely to lead to admission to intensive care with endotracheal intubation, and in whom self-poisoning with a benzodiazepine is suspected, flumazenil should be considered as a therapeutic option to avoid intubation and artificial ventilation. The decision to administer flumazenil should be based upon a comprehensive assessment including a full clinical and biochemical assessment of the patient's respiratory status, and his or her ability to protect his or her own airway. Clinicians should, however, avoid the use of flumazenil in: patients who may have ingested proconvulsants, including tricyclic antidepressants; those who have a history of epilepsy; and patients who are dependent upon benzodiazepines.

1.5.3.3 When using flumazenil in the treatment of benzodiazepine poisoning, clinicians should use small doses, comparable to those used in other contexts, and administer slowly, to avoid the emergence of the more serious adverse reactions associated with the use of flumazenil.

1.5.3.4 Given the relatively high incidence of adverse psychological events experienced by patients following administration of flumazenil, the minimum effective dose should be used and only for as long as it is clinically necessary.

1.5.3.5 When using flumazenil in the treatment of benzodiazepine poisoning, care should be taken to ensure that patients who become agitated should be closely monitored and warned of the risk of re-sedation, especially if the patient expresses the desire to leave the treatment setting.

1.5.3.6 Flumazenil should be used in the treatment of benzodiazepine overdose only when full resuscitation equipment is immediately available.

1.5.3.7 Only clinicians who have been explicitly trained in the use of flumazenil for the treatment of benzodiazepine poisoning, as described in this guideline, should undertake to administer flumazenil in this context.

1.5.4 Treatment and management of poisoning with salicylates

1.5.4.1 Following gut decontamination with activated charcoal, where this is indicated by this guideline, the further treatment of self-poisoning with salicylates should follow the current guidance outlined in TOXBASE.

1.5.5 Treatment of opioid overdose

1.5.5.1 Naloxone should be used in the diagnosis and treatment of opioid overdose associated with impaired consciousness and/or respiratory depression.

1.5.5.2 The minimum effective dose of naloxone should be used to reverse respiratory depression caused by opioids without causing the patient to become agitated. This is especially important in people who are dependent upon opioids.

1.5.5.3 When reversing the effects of opioids, especially long-acting opioids such as methadone, the use of an intravenous infusion of naloxone should be considered.

1.5.5.4 When reversing the effects of opioid overdose using naloxone in people who are dependent upon opioids, naloxone should be given slowly. Preparations should be made to deal with possible withdrawal effects, especially agitation, aggression and violence.

1.5.5.5 When using naloxone in the treatment of opioid poisoning, regular monitoring of vital signs (including the monitoring of oxygen saturation) should be undertaken routinely until the patient is able to remain conscious with adequate spontaneous respiration unaided by the further administration of naloxone.

1.5.6 General treatment for self-injury

The treatment of self-injury should be the same as for any other injury, although the level of distress should be taken into account, and therefore delays should be avoided. Tissue adhesive is effective and simple to use for small superficial wounds.

1.5.6.1 In the treatment and management of injuries caused by self-cutting, appropriate physical treatments should be provided without unnecessary delay irrespective of the cause of the injury.

1.5.6.2 In the treatment and management of people with self-inflicted injuries, clinicians should take full account of the distress and emotional disturbance experienced by people who self-harm additional to the injury itself, in particular, immediately following injury and at presentation for treatment.

1.5.6.3 In the treatment and management of superficial uncomplicated injuries of greater than 5 cm in length, or deeper injuries of any length, wound assessment and exploration, in conjunction with a full discussion of preferences with the service user, should determine the appropriate physical treatment provided.

Superficial wound closure

1.5.6.4 In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, the use of tissue adhesive should be offered as a first-line treatment option.

1.5.6.5 In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, if the service user expresses a preference for the use of skin closure strips, this should be offered as an effective alternative to tissue adhesive.

1.6 Support and advice for people who repeatedly self-harm

1.6.1 Advice for people who repeatedly self-poison

Service users who repeatedly self-poison, and their carers where appropriate, may need advice about the risks of self-poisoning.

1.6.1.1 Harm minimisation strategies should not be offered for people who have self-harmed by poisoning. There are no safe limits in self-poisoning.

1.6.1.2 Where service users are likely to repeat self-poisoning, clinical staff (including pharmacists) may consider discussing the risks of self-poisoning with service users, and carers where appropriate.

1.6.2 Advice for people who repeatedly self-injure

Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure.

1.6.2.1 For people presenting for treatment who have a history of self-harm, clinicians may consider offering advice and instructions for the self-management of superficial injuries, including the provision of tissue adhesive. Discussion with a mental health worker may assist in the decision about which service users should be offered this treatment option.

1.6.2.2 Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss harm minimisation issues/techniques. Suitable material is available from many voluntary organisations.

1.6.2.3 Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss appropriate alternative coping strategies. Suitable material is available from many voluntary organisations.

1.6.2.4 Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue.

1.7 Psychosocial assessment

Everyone who has self-harmed should have a comprehensive assessment of needs and risk; engaging the service user is a prerequisite.

1.7.1 Engaging the service user

1.7.1.1 Healthcare workers should undertake the assessment of needs and risk for people who have self-harmed as part of a therapeutic process to understand and engage the service user.

1.7.2 Assessment of needs (specialist mental health professionals)

1.7.2.1 All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social,

psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

1.7.2.2 The comprehensive assessment of needs should be written clearly in the service user's notes.

1.7.2.3 To encourage joint clinical decision making, service users and the assessor should both read through the written assessment of needs, wherever possible, to mutually agree the assessment. Agreement should be written into the service user's notes. Where there is significant disagreement, the service user should be offered the opportunity to write his or her disagreement in the notes. The assessment should be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

1.7.3 Assessment of risk (specialist mental health professionals)

1.7.3.1 All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

1.7.3.2 The assessment of risk should be written clearly in the service user's notes. The assessment should also be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

1.7.3.3 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' (NICE clinical guideline 133).

1.7.3.4 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' (NICE clinical guideline 133).

1.7.3.5 Consideration should be given to combining the assessment of risks into a needs assessment framework to produce a single integrated psychosocial assessment process.

1.7.4 Training

1.7.4.1 All health professionals, including junior psychiatrists, social workers and psychiatric nurses, who undertake psychosocial assessment for people who have self-harmed should be properly trained and supervised to undertake assessment of needs and risk specifically for people who self-harm.

1.8 Referral, admission and discharge following self-harm

Referral, treatment and discharge following self-harm should be based on the overall assessment of needs and risk.

1.8.1.1 The decision to refer for further assessment and/or treatment or to discharge the service user should be taken jointly by the service user and the healthcare professional whenever this is possible. When this is not possible, either as a result of diminished mental capacity or the presence of significant mental illness, this should be explained to the service user and written in their notes.

1.8.1.2 Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto the service user's GP and to any relevant mental health services as soon as possible to enable follow-up.

1.8.1.3 The decision to discharge a person without follow-up following an act of self-harm should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto their GP and to any relevant mental health services.

1.8.1.4 In particular, the decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.

1.8.1.5 Temporary admission, which may need to be overnight, should be considered following an act of self-harm, especially for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug

and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity thereafter.

1.9 Special issues for children and young people (under 16 years)

Children and young people who self-harm have a number of special needs, given their vulnerability. Physical treatments will follow similar principles as for adults.

1.9.1.1 Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

1.9.1.2 Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed.

1.9.1.3 All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary.

1.9.1.4 For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person.

1.9.1.5 A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm.

1.9.1.6 Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person.

1.9.1.7 Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues.

1.9.1.8 In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act.

1.9.1.9 During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team and social services and education staff as appropriate.

1.9.1.10 All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues.

1.9.1.11 Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should:

- be trained specifically to work with children and young people, and their families, after self-harm
- be skilled in the assessment of risk
- have regular supervision
- have access to consultation with senior colleagues.

1.9.1.12 Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed.

1.9.1.13 For the further management of young people who have self-harmed, see 'Self-harm: longer-term management' (NICE clinical guideline 133).

1.10 Special issues for older people (older than 65 years)

When older people self-harm, treatments will be much the same as for younger adults, but the risk of further self-harm and suicide are substantially higher and must be taken into account.

1.10.1.1 All people older than 65 years of age who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to the potential presence of depression, cognitive impairment and physical ill health, and should include a full assessment of their social and home situation.

1.10.1.2 All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults.

1.10.1.3 Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and levels of risk.

1.10.1.4 In all other respects, the assessment and treatment of older adults who have self-harmed should follow the recommendations given for adults.

1.11 Psychological, psychosocial and pharmacological interventions

Referral for further assessment and/or treatment should be based upon a comprehensive psychosocial assessment, and should be aimed at treating a person's underlying problems or particular diagnosis rather than simply treating self-harming behaviour, although intensive therapeutic help with outreach may reduce the risk of repetition. Whatever the treatment plan, primary care and mental health services should be informed.

1.11.1.1 Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an

assessment of risk, and should not be determined solely on the basis of having self-harmed.

1.11.1.2 Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, including the likely benefits and disadvantages, in a spirit of collaboration, before treatments are offered. The provision of relevant written material with time to talk over preferences should also be provided for all service users.

1.11.1.3 The mental health professional making the assessment should inform both mental health services (if they are involved already) and the service user's GP, in writing, of the treatment plan.

1.11.1.4 For the further management of people who have self-harmed, see 'Self-harm: longer-term management' (NICE clinical guideline 133).

2 Research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. The Guideline Development Group's full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Mental Health.

- Research, using appropriate survey and rigorous qualitative methods, should be conducted about the meaning of self-harm to people from different ethnic and cultural groups. This should include the exploration of issues of intentionality.
- A study using an appropriate and rigorously applied qualitative methodology should be undertaken to explore user experiences of services.
- Qualitative research methods, such as Q sort and Interpretive Phenomenological Analysis, should be used to better understand staff attitudes to self-harm and their psychological and social origins.
- A study of appropriate design reporting all relevant patient outcomes (mortality, morbidity, numbers lost to the service, patient satisfaction) should be undertaken to assess the impact of the introduction of the Mental Health Triage Scale.
- Further research into treatments specific to people who self-harm should evaluate the differential responses of different patient subgroups, using a broad range of outcomes, especially those relevant to service users, such as quality of life.
- An adequately powered RCT reporting all relevant outcomes should be undertaken to determine the clinical and cost effectiveness of intensive interventions combined with assertive outreach for people who self-harm. The study should address patient characteristics (such as age, gender, diagnosis, frequency and method of self-harm, past history of abuse) and therapists' characteristics (such as age, gender, training, professional discipline, parental status). Outcomes should include loss from services, admission rates, satisfaction, repetition of self-harm, quality of life, and employment status.
- An appropriately designed and adequately powered study should be undertaken to clarify the optimum dose level at which acetylcysteine should be used (for both oral and intravenous administration) in the treatment of paracetamol poisoning, reporting all relevant biochemical and clinical outcomes, including liver function, liver failure and adverse reactions. Consideration should be given to patient characteristics such as co-ingested substances,

- including alcohol.

Update information

July 2018: Recommendation 1.4.1.3 was updated to make it clear the Australian Mental Health Triage Scale should not be used to predict future suicide or repetition of self-harm.

November 2011: The following recommendations were replaced with recommendations from self-harm: longer-term management (NICE clinical guideline CG133): recommendations 1.7.3.3 and 1.7.3.4 on assessment of risk, 1.9.1.13 on special issues for children and young people, and 1.11.1.4 on psychological, psychosocial and pharmacological interventions.

Recommendation 1.11.1.5 on psychological, psychosocial and pharmacological interventions has been withdrawn.

Finding more information and resources

You can see everything NICE says on self-harm in over 8s in our interactive flowchart on self-harm.

To find out what NICE has said on topics related to this guideline, see our web page on mental health and behavioural conditions.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

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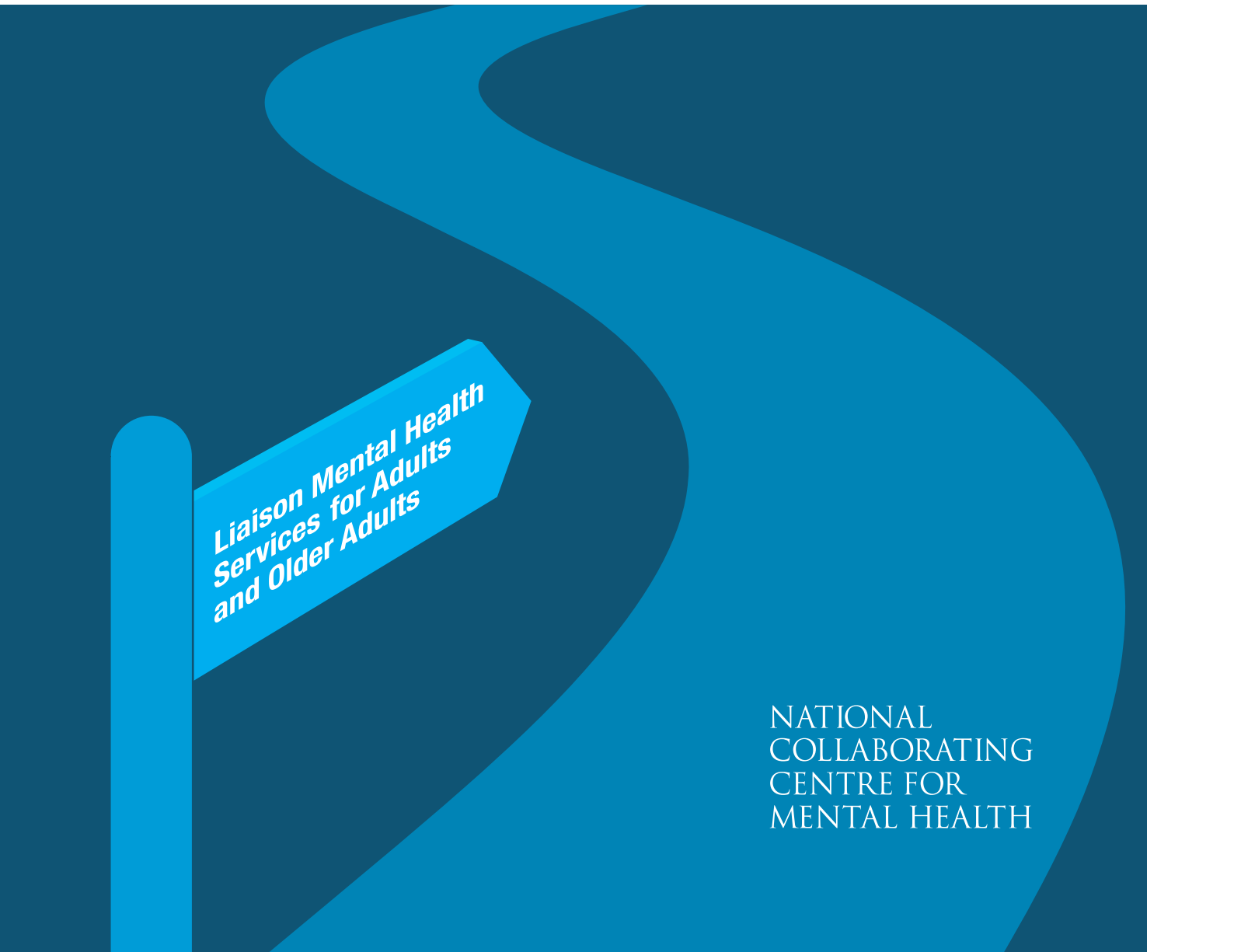
NICE National Institute for Health and Care Excellence

NHS England

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – **Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance**



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance

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Foreword

The Independent Mental Health Taskforce Five Year Forward View (February 2016) made it clear that improving access to high-quality mental health care must now become a national priority. The Achieving Better Access to Mental Health Services programme has been developed by NHS England, the National Institute for Health and Care Excellence and the National Collaborating Centre for Mental Health to introduce standards for mental health care and ensure that these can be properly measured across the country. The aim? To begin a major national implementation programme to make sure people with mental health problems get prompt access to evidence-based NICE-recommended care, on a par with the care provided for physical health problems. Nowhere within mental health care is the issue of parity more important than in the provision of urgent and emergency care for people experiencing a mental health crisis.

Proper funding for mental health crisis care and its full integration within NHS urgent and emergency care was one of the commitments made in the Five Year Forward View for Mental Health. With the publication of Implementing the Five Year Forward View for Mental Health (July 2016), and this implementation guidance for *Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care*, commissioners and service providers now have some powerful tools at their disposal to improve crisis care for people of all ages across the country.

Liaison mental health services already play a valuable role in supporting people in a crisis, as well as adults and older adults who have both mental and physical health problems in a general hospital setting. They can help people to avoid lengthy stays in hospital and can speed up discharge. We now want to make sure people who experience a mental health crisis have received a response from an urgent and emergency mental health service within an hour, and that within four hours they have received the appropriate support to meet their needs and an evidence-based package of care is in place.

Improving liaison mental health provision has been a long-standing goal for the NHS and is a 'must do' in the most recent two-year planning guidance for 2017-19. In April 2016, as part of the CCG Improvement and Assessment Framework 2016/17, CCGs were also asked to ensure that agreed and funded plans are in place to aim for a core 24 (24 hours, 7 days a week) service by 2020/21.

The pathway set out in this guide will help NHS commissioners and providers to ensure that liaison mental health services can meet these standards and deliver on their improvement plans. If these goals are achieved, adults and older adults presenting in crisis in emergency departments and on physical health general wards will have access to high-quality NICE-recommended care, any time of the day or night, every day of the week.

This implementation guide is one of a series for urgent and emergency mental health care that also covers 'blue light' services (for all ages), community-based crisis response services (for adults and older adults) and children and young people's crisis services. Together they will form a crucial part of the overall implementation plan for transforming urgent and emergency mental health care in England.

Never before has timely access to high quality mental health care been accepted as so necessary by the whole health and social care community. Now we, as commissioners, providers, health and social care workers and partners across the whole urgent and emergency care pathway, must rise to this challenge and meet these expectations.

Professor Tim Kendall
National Clinical Director for Mental Health

Key statements

These statements were developed by the Expert Reference Group based on what they considered to be the key messages for this implementation guide. They have been worded from the perspective of a person experiencing a mental health crisis to highlight the need to develop urgent and emergency mental health services with the person at the centre.

- When I visit hospital experiencing a mental health crisis and I require help and support, this is treated with as much urgency and respect as a physical health emergency and I am able to get a response no matter what time of the day it is, or which day of the week.
- When I experience a mental health crisis in an emergency department or on a general hospital ward, I receive a timely and compassionate response from trained and competent professionals in liaison mental health. If I am an older adult I will receive specialist support from a team skilled in working with older people. I am treated with kindness, compassion and dignity and in accordance with my legal rights.

EBTP STANDARD
Any person experiencing a mental health crisis should receive a response from the liaison mental health service within a **maximum of 1 hour** of the service receiving a referral.

- My physical and mental health needs should not be seen as separate from each other and I receive effective care for both in a general hospital setting.
- Within one hour of a liaison mental health service being contacted, I have received a response and know that help is on its way.
- Within four hours of arriving in an emergency department or being referred from a ward, I receive a response and support that meets my needs. Depending on my situation:
  - *I have had a full assessment of my physical, psychological and social needs, and an urgent and emergency care plan is in place, and*
  - *I am on my way to another service or location, if needed, or I have been accepted for follow-up care by another service*

    OR
  - *I have started assessment under the Mental Health Act.*
  - *If I feel better within four hours, I can go home.*

EBTP STANDARD
Within **4 hours** of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence-based care package (informed by NICE) in place.

- When I am on a general hospital ward and require an urgent response from a liaison mental health service, I receive a full assessment within 24 hours. If I am an older adult I will receive specialist support from a team skilled in working with older people.
- Liaison mental health services have access to appropriate staff either on the team or through contractual arrangements to ensure that there are no delays to the start of a Mental Health Act assessment, should I require one.
- If the difficulties I am facing during a mental health crisis cannot be resolved where I am, I am provided with appropriate support to access and travel to an appropriate and safe place where help is available.
- If I need longer-term support to manage my mental health problems, this is arranged.

Contents

1 Introduction

1.1 Background

This guide builds on a number of policy drivers, reviews and publications including The Mental Health Crisis Care Concordat,[1] the Care Quality Commission (CQC) report Right Here, Right Now,[2] the Urgent and Emergency Care Review[3] and the Five Year Forward View for Mental Health.[4] Together these made an overwhelming case for improving urgent and emergency mental health services, including liaison mental health services.[a] The additional funding announced in the Spending Review and detailed further in Implementing the Five Year Forward View for Mental Health[5] will be used to improve coverage and availability of urgent and emergency mental health care, so that by 2020/21 all general hospitals will have a liaison mental health service and at least 50% will meet the standard for adults and older adults of a core 24 service as a minimum. This will be supported by £120 million additional central funding by 2020/21.

1.2 Purpose and scope of this document

This guide supports implementation of the ambitions set out in the Five Year Forward View for Mental Health to introduce evidence-based treatment pathways across mental health services. It states: '*by 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24'*[b] service standard as a minimum' to ensure provision of liaison mental health services in all general hospitals.

This guide covers the first 24 hours of urgent and emergency mental health care following referral or presentation. The pathway and associated standards should be applied equally regardless of the nature of the mental or physical health problem and any disabilities (including learning disabilities) of the person presenting in a mental health crisis.

The primary aim of this document is to provide guidance on establishing, developing and maintaining urgent and emergency liaison mental health services for adults and older adults in emergency departments (EDs) and general hospital wards. It is acknowledged that liaison mental health teams provide a wider range of services than urgent and emergency mental health care. However, these activities are beyond the remit of this guide and will be addressed in forthcoming implementation guides on integrated mental and physical health services in 2017.

This guide is aimed at commissioners and providers of services for adults and older adults. It is recognised that some adult services provide an urgent and emergency mental health response to young people aged 16 to 18 years. See Part 4 in this series (listed below) for the implementation guidance for urgent and emergency mental health services for children and young people.

This document is one in a series of ***Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care*** implementation guides, which includes:

Part 1: Implementing the Evidence-based Treatment Pathway for 'Blue Light' Services Providing an Urgent and Emergency Mental Health Response for All Ages (forthcoming)

[a] *Also commonly known as 'liaison psychiatry' or 'psychological medicine', the term 'liaison mental health' is used in this guide to reflect the multidisciplinary nature of liaison teams.*

[b] *Core 24 is a liaison mental health service model provided 24 hours, 7 days a week; it is commonly provided across urgent and emergency care pathways.*

Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults

Part 3: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Community Mental Health Services for Adults and Older Adults (forthcoming)

Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming)

Evidence-based treatment pathways and recommendations for services that provide acute mental health care and planned care liaison mental health will be covered in forthcoming implementation guides.

This guide has been organised into four further chapters as described below:

Chapter		Purpose of the chapter
2	**What is a mental health crisis and why is rapid access to a liaison mental health service so important?**	• To provide personal perspectives on mental health crises • To provide key facts regarding mental health crises • To describe the important functions of liaison mental health services in responding to mental health crises
3	**What are liaison mental health services?**	• To provide a description of liaison mental health services and their benefits • To describe the skill mix necessary to deliver care in line with NICE guidance and to ensure that the specific needs of older adults are met • To describe optimal service models
4	**The evidence-based treatment pathway**	• To summarise the NICE quality standards and guidelines relevant to liaison mental health services • To describe all aspects of the pathway, including clock starts and stops • To clarify the approach to measurement for the recommended response times and the delivery of care in line with NICE guidance • To describe the recommended approach to routine measurement of outcomes (clinician and service user reported) • To clarify data collection and reporting requirements
5	**Key commissioning considerations and service development**	• To provide a step-by-step process that local commissioners and providers can follow, working collaboratively with stakeholders, to ensure sustainable delivery of the evidence-based treatment pathway

Additional resources have been brought together in the accompanying *Appendices and Helpful Resources* pack. This pack includes:

- appendices
  - *relevant NICE guidance and outcomes measurement*
  - *the full pathway*
  - *Expert Reference Group members*
- positive practice examples and models
- links to helpful web-based resources.

1.3 How was this document developed?

NHS England has commissioned NICE to provide a package of implementation support for evidence-based treatment pathways for mental health, including implementation guidance. NICE has asked the National Collaborating Centre for Mental Health (NCCMH)[c] to develop this guide. The NCCMH established an Expert Reference Group including topic experts from the following areas:

- commissioning and public health
- service providers including health and social care professionals from primary and secondary mental and physical health care services and service managers
- academics and health educators
- people and carers with lived experience
- specialist expertise in older adult mental health.

See Appendix C in the *Appendices and Helpful Resources* pack for a full list of members.

In developing this guide, the Expert Reference Group and NCCMH technical team followed a manual for developing implementation guides[d] and were primarily informed by relevant NICE quality standards and guidelines supplemented by data on current service provision. The Expert Reference Group used its knowledge, expertise and judgement to determine the recommendations set out in this guide.

[c] *The NCCMH, a partnership between the Royal College of Psychiatrists and University College London, was one of the national collaborating centres first established by NICE in 2001 to develop clinical guidelines.*

[d] *Forthcoming on the NICE website.*

1.4 The evidence-based treatment pathway

For the purposes of this guidance, 'emergency' and 'urgent' are defined as follows:

An **emergency** is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.

An **urgent** situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.

Urgent and emergency mental health care is a response that health and care service providers deliver 24 hours a day, 7 days a week (24/7) to people who are experiencing a mental health crisis.

This guide sets out an evidence-based treatment pathway (EBTP) for people presenting in general hospital settings in mental health crisis who require urgent or emergency mental health care.

The pathway includes recommended standards (called 'EBTP standards'), which require delivery of an evidence-based package of care informed by National Institute for Health and Care Excellence (NICE) guidance.

1.4.1 Emergency pathway

The evidence-based treatment pathway introduced in this guide requires that people who need urgent and emergency mental health care receive an evidence-based package of care informed by NICE guidance within four hours of presenting in an ED or referral from a ward.

- An urgent and emergency liaison mental health service should respond to the person within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment (see Section 4.2.2)

- Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for follow-up care by a responding service, or*
  - *have been discharged because the crisis has resolved*

    OR
  - *have started a Mental Health Act assessment.*

1.4.2 Urgent pathway

As well as an emergency response to crisis referrals, liaison mental health services should provide an urgent care pathway, with a full assessment taking place within 24 hours of referral. An urgent response is described in Section 4.3.

- An urgent and emergency liaison mental health service should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed and resources required for the assessment
- The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. The principles of assessment described in the emergency pathway (see Section 4.2.2) apply to the urgent care pathway.
- Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for a follow-up appointment by a responding service, or*
  - *have been provided with advice or signposted, where appropriate.*

If at any point the person's mental health deteriorates, or it is deemed they require an emergency response, including a Mental Health Act assessment, the emergency pathway should be followed.

1.5 Expectations of commissioners

Commissioners are responsible for ensuring that local service development plans are created and implemented in collaboration with people with mental health problems and their families or carers, as well as local mental health providers, public health providers and partner organisations. This should include voluntary and third sector organisations, drug and alcohol service commissioners and providers, and local authorities (social care, housing, debt, benefit advice, employment and education) to provide a framework for collaborative action. Development plans should focus on delivering the recommendations in the Five Year Forward View for Mental Health.

Improving provision of liaison mental health has been in the NHS planning guidance for the past three years, and is now set out among the nine 'must dos' for the NHS in the two-year planning guidance for 2017-19. From April 2016, as part of the CCG Improvement and Assessment Framework 2016/17, clinical commissioning groups (CCGs) were further asked to ensure that agreed and funded plans are in place to aim for core 24 service level by 2020/21, as well as conducting a self-assessment of current provision against selected key lines of enquiry.[e] The availability of high-quality liaison mental health services informs CQC inspections of general hospitals, and these EBTP standards will also be taken into account as NHS Improvement develops future iterations of its Single Oversight Framework.

[e] *The key lines of enquiry for liaison mental health are set out on page 68: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf*

In 2016 and 2018, NHS England is making available central transformation funding to help accelerate provision of liaison for the general hospitals with 24/7 EDs that are closest to the minimum core 24 level. This funding was first announced following the November 2015 Government Spending Review.

The reduction of inequalities in access and outcomes should be central to the development of urgent and emergency mental health services. Local commissioners should make explicit in their plans how they have taken into account the duties placed on them under the Equality Act 2010[6] and their duties with regard to reducing health inequalities as set out in the Health and Social Care Act 2012.[7] Service design and communications should be appropriate and accessible to meet the needs of diverse communities (see Guidance for Commissioners on the Equality and Health Inequalities Duties).

2 What is a mental health crisis and why is rapid access to a liaison mental health service so important?

> *I am scared, disorientated, and cannot manage even simple day-to-day tasks. People talk to me, but what they are saying does not make sense, and they cannot understand me. I am very alone, and it gets harder and harder to ask for help. The world is too close, too full of meanings. My mind is glowing.*
>
> *Source: A person with lived experience, 2016*

2.1 What is a mental health crisis?

A mental health crisis is a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.

There are various possible causes or triggers of a crisis. For example, many people experience adverse life events that include a psychological, physical or social element, which leads to a need for an urgent or emergency response from mental health services. All crises will be different in their cause, presentation and progression. It is important to identify the trigger (for example, abuse, trauma or homelessness[8]), associated risks and options for ongoing care, and respond to the crisis according to the individual's need and circumstances.

2.2 Attending the ED when in a mental health crisis

> *I'm not attention seeking or being manipulative when I self harm. I've suffered in my past and I'm coming asking you for help. I'm seeking attention, yes, because I've hurt myself and I need medical attention.*
>
> *Please remember to dress my self harm even if I have overdosed. Often you forget because I'm not well enough to point it out.*
>
> *If I have overdosed I would like a bed to lie in, not forced to sit in a chair.*
>
> *Please remember to validate my emotions. I'm feeling so sad, often ashamed and I often feel suicidal. Yes, it is awful. Yes I've been trying so hard and I feel so vulnerable, just tell me you can see that.*
>
> *Remember to use pain relief for people who need it. Don't carry out procedures without it.*
>
> *Please refer me to liaison psychiatry, don't just let me leave. People who self harm can go on to complete suicide – they need help.*
>
> *It would be amazing if all hospitals had people trained to help people who self harm 24/7 as liaison psychiatry doesn't often operate those hours. Instead people are left to wait until morning tired and in crisis.*
>
> *You don't have to tell me if I leave you will call the police. I'm not a criminal and I'm not that person who runs away. We are all individuals.*
>
> *Source: Dignity and Self-Harm #WMHD*

2.3 How liaison mental health services can help people in a mental health crisis

Given that adults and older adults with mental health problems are three times more likely to attend an ED and five times more likely to be admitted to a general hospital as an emergency,[9] a liaison mental health service must be an essential component of any high-performing general hospital. This has been recognised by the CQC, which recommends that liaison mental health services should be commissioned to meet the needs of the local population, giving consideration to the peak times that adults and older adults in crisis are likely to present in EDs. The CQC is evolving its method of inspecting mental health care in general hospital settings.[2] The primary functions of a liaison mental health service within the context of responding to mental health crises are to:

2.3.1 Identify, assess and respond to mental health crises

- Assess needs
- Respond to the mental health crisis in line with the EBTP standard
- Have on-site access to current clinical (including mental health care) records
- Have access to a consultant psychiatrist with significant experience in responding to mental health crises, including specialists with expertise in older adult mental health
- Have access to a range of health and social care staff with significant experience and competences in responding to mental health crises
- Work with general hospital staff to ensure the person is safe and supported while waiting for, and during, an assessment
- Have protocols in place with social care teams to provide swift access to Mental Health Act assessments.

2.3.2 Treat the symptoms of the mental health crisis

- Provide access to NICE-recommended urgent and emergency care, including NICE-recommended treatment for self-harm.

2.3.3 Provide access to ongoing support

- Offer follow-up care within the service (or refer to another service if clinically appropriate). This has been shown to improve patient care and reduce ED re-attendance rates[10 11]
- Signpost to other support, including voluntary sector and community groups.

2.3.4 Provide service-level support

- Ensure effective and transparent pathways by establishing links with other emergency, health and social care services, including those provided by the voluntary sector
- Provide training to other healthcare professionals who may need to respond to mental health crises (for example, training ED and general hospital ward staff on local protocols, legal frameworks, mental health awareness, and responding compassionately and appropriately). Wherever possible, mental health awareness training should be co-produced and co-delivered with people with lived experience
- Enable data, record and information sharing across mental health services, general hospitals, primary care and other health and social care services to ensure:
    - *rapid, appropriate and safe treatment*
    - *timely and effective community-based follow-up*
    - *that patients' up-to-date histories and preferences are known.*

3 What are liaison mental health services?

Liaison mental health services are specialist services providing mental health care in a physical health setting. They support the work of clinicians working in general health pathways, enabling EDs and wards in general hospitals to assess and manage mental health problems as they present or arise among people being cared for in the general health pathway. While liaison mental health teams provide a range of services to people (which can include follow-up care), this guide is concerned with the aspect of liaison mental health services that provides unplanned, non-elective urgent and emergency mental health care in general hospitals. Referrals come from EDs, medical assessment units and clinical decision units, and may also be made from any other ward within a general hospital.

Liaison mental health is traditionally concerned with the care of a person who presents with both mental and physical health symptoms regardless of presumed cause. In the context of a mental health crisis, liaison mental health services commonly see people when they are experiencing or have experienced any of the following:

- self-harm leading to medical or surgical treatment
- suicidal ideation
- the consequences of alcohol and drug use, including when co-occurring with a mental health problem
- dementia or delirium
- a severe mental illness, such as schizophrenia, bipolar disorder or severe depression, or a personality disorder
- social vulnerability that may have a mental health problem or trauma as a component or root cause, for example, homelessness or domestic abuse.

A liaison mental health service also plays a critical role in enhancing the care provided by the general hospital system, in which expertise in mental health care is still too often lacking. It does this by:

- providing education and support to general hospital staff, both formally and informally
- helping to ensure the same attention is paid to people's mental health and physical needs while they are in hospital
- identifying underlying mental health problems for people primarily presenting with physical health problems
- supporting the efficient running of the hospital through prompt and well-coordinated discharge, increasing the safety of patients and staff, and ensuring a good experience of care.

3.1 Current provision of liaison mental health services

There is wide variation in the degree of provision of liaison mental health services across the country.[12] In the most recent national survey commissioned by Health Education England of liaison mental health services (mid-2016), 174 (98%) of 177 EDs in England responded.[13] While 52% of teams that responded reported that their service had better provision than the previous year, 15% reported that their service was worse-resourced.[13] Some services lack the staff to cope with the overwhelming number of referrals, leading to some people reportedly being turned away.[14]

3.1.1 24-hour services

Most[f] liaison mental health teams report that they provide a 24/7 service, but only around 10% do so with a level of staffing sufficient to provide a core 24 or greater service, meaning that the level of care provided out of hours does not meet the EBTP standards set out in this guide, and 45% of services do not have staff on site at all out of hours.[13] This is despite evidence that people are more likely to experience a crisis outside normal working hours. An audit by the Royal College of Emergency Medicine showed that people are most likely to present to an ED with a mental health problem between 5pm and midnight,[15] and the CQC Right Here, Right Now report[2] found that the peak hours for admissions to general hospitals via an ED were between 10pm and 7am (these admissions were for people with a mental health crisis resulting from drug and alcohol use, self-harm, schizophrenia or mood disorders).

This suggests that in order to provide accessible and timely care for all, services need to be available all day, every day. In the same way that it is essential to ensure the provision of 24/7 care for people with urgent and emergency physical health needs, people experiencing a mental health crisis should also be able to receive 24/7 care that meets their needs.

3.1.2 Distinct specialty

Currently, there are areas in which crisis resolution and home treatment teams (CRHTTs) provide in-reach to general hospitals for people with urgent and emergency mental health needs. However, liaison mental health teams are unique in being fully integrated with ED and general hospital pathways, rather than delivering an in-reach function from a neighbouring mental health base.

Many of the benefits from specialist liaison teams arise from their ability to care for such a wide range of people with the most complex needs in general hospitals.

Where services are provided with crisis team in-reach to general hospitals, they tend to focus on self-harm or acute mental health presentations in EDs only. These teams would not usually provide the mental health support described in Section 2.3 to the wider range of people with undiagnosed or complex common mental health needs in general hospitals.

3.1.3 On-site service

The pathway set out in this guide (see Section 4) recommends that liaison mental health teams should be available to respond to mental health crises within one hour, and then to conduct a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan and refer for onward treatment, transfer or discharge within four hours. To achieve these response times, personalised risk assessment and information gathering need to start as soon as the person presents to the ED reception or triage point. In practical terms, this means the liaison service must have a base in or near to the ED.

Busy community-based CRHTTs providing in-reach to general hospitals are highly unlikely to be able to meet these response times. Attempting to do so is likely to compromise their core function of providing a 24/7 community-based urgent and emergency mental health response, and providing intensive home treatment as an alternative to mental health acute inpatient admission.

The evidence base for general hospital liaison and CRHTTs shows that these are rightly distinct teams that have different functions and different skills. Therefore, services that are commissioned as a hybrid do **not** meet the minimum core 24 service level set out in this guidance (see Section 3.3.1).

In order to achieve the core 24 service standard, liaison mental health teams should at a minimum achieve the following criteria:

- They are commissioned to operate 24/7, as an on-site distinct service in the general hospital
- They have the skill mix and staffing level to operate a 24/7 rota effectively (see Section 3.4.1 for further detail)

[f] 55% of those who responded to the HEE survey.

- They provide a response within one hour to emergency referrals from wards or the ED and within 24 hours for urgent referrals from inpatient wards.

3.2 Benefits of liaison mental health services

Historically, many liaison mental health services have been commissioned from CCG mental health budgets because the provider has typically been the local NHS mental health provider. However, there is increasing recognition that this arrangement fails to reflect the fact that the quality and productivity benefits achieved through investment in liaison mental health services are realised almost exclusively in the general hospital setting.[12] Future models of payment for all urgent and emergency care are likely to include liaison mental health services as a core component, recognising that liaison services must be an integral part of any high quality integrated urgent and emergency care response. Commissioners should recognise this in their approach to service development and investment plans and commissioning arrangements. (See Section 5.7).

3.2.1 Benefits for people experiencing a mental health crisis

Adults and older adults presenting with a mental health crisis in EDs and general hospital wards, and their families and carers, will benefit from 24/7 access to liaison mental health services, more specifically a swift and compassionate assessment of their mental health needs and:

- a reduction in inappropriate general hospital inpatient admissions
- improved discharge planning and coordination resulting in shorter lengths of stay and reduced general hospital re-admissions for adults and, particularly, older adults (who account for 80% of inpatient hospital stays) who are admitted[11]
- an overall improved experience of services resulting from care provided by well-trained and knowledgeable general hospital staff who are not necessarily trained as mental health specialists but can more readily recognise mental health needs
- clearer referral routes and a better understanding of how to ask for help in their local area.

3.2.2 Benefits to service providers

Evaluations of liaison mental health services[10] have demonstrated that:

- Effective collaborative working by inpatient, liaison and community mental health services helps to avoid lengthy inpatient stays and delayed transfers of care
- Effective working with social care and housing services assists in reducing discharge delays by helping people move to a stable environment in the community
- General hospital staff are able to better support people with mental health problems, through training, support and formal and informal networks
- Providing 24/7 liaison mental health services enhances responsiveness; services such as the Birmingham Rapid Assessment, Interface and Discharge (RAID) model and the North West London Optimal model provide a rapid response and have shown significant reduction in length of stay, re-attendances at EDs and emergency general hospital admissions.[16]

3.2.3 Economic benefits of liaison mental health services

There is an established body of research[17] suggesting that liaison mental health services are cost effective and generate savings. These are mainly related to a reduction in the length of stay of older adults admitted to general hospital wards, many of whom have significant mental health needs linked to dementia, depression or anxiety. Recent evaluations of service models found that:

- The RAID model at the City Hospital in Birmingham identified savings of £3.55 million; 90% of these savings related to older people, with around half resulting from a

reduced length of stay in a general hospital, and half from reduced rates of readmission;[18] this equates to a saving of £4 for every £1 invested in the service.[18] Other hospitals in Birmingham that introduced RAID services realised savings of £3 for every £1 spent.[18]

- When a similar model to RAID was introduced across four hospitals in east London, there were also substantial savings of between £1.4 million and £1.7 million across 3,052 hospital beds.[19] These were realised primarily through reductions in inpatient length of stay, particularly for older adults
- A substantial return on investment in liaison mental health services has consistently been demonstrated and commissioners. The Centre for Mental Health estimated this at an initial level of £3 for every £1 of investment, stabilising over time at £2.50.[18] High quality, integrated liaison mental health services also have a positive impact on averting avoidable pressures on the wider health and social care system.

3.3 Liaison mental health service models

Despite wide variation in service configuration, a number of models developed over recent years have shown a demonstrable impact,[10 20] including the RAID model, the North West London Optimal model and the Leeds Liaison Service. Consensus has emerged around three main service model descriptions: 'core 24', 'enhanced 24' and 'comprehensive'. There is also the 'core' model, which describes a basic level of service for hospitals that do not have a 24/7 ED.[20]

3.3.1 Core 24

Where the hospital has a 24/7 ED, then it should have a core 24 service level as a minimum to ensure 24/7 mental health cover. The core 24 model provides the following functions on a 24/7 basis. This includes consultant psychiatrists being available 24/7 (on-call out of hours) to:

- Provide a response to mental health crises in EDs and inpatient wards within one hour and to all urgent ward referrals within 24 hours
- Complete a full biopsychosocial assessment and formulation and contribute to treatment and collaborative care plans
- Offer brief evidence-based psychological interventions[g] as inpatient or short-term outpatient follow-up
- Work with general hospital teams to reduce length of stay in general hospitals and improve follow-up care, particularly for older adults
- Provide advice and support to general hospital staff regarding mental health care for their patients
- Provide specialist care for older adults.

This model provides urgent and emergency, as well as unplanned, care pathways (that is, non-elective admissions to general hospitals). The North West London model forms the basis of the core 24 model.[20]

3.3.2 Enhanced 24

As well as providing all of the features of the core 24 model, the enhanced 24 model provides more specialist care, offering enhanced expertise in addictions and drug and alcohol use, and mental health problems in people with learning disabilities. An enhanced 24 service will have a higher level of consultant psychiatrist input and be able to provide increased follow-up care. The RAID model was developed as a pilot for enhanced 24 in City Hospital, Birmingham.

[g] *These will be covered in more detail in a forthcoming programme on integrated care for mental and physical health (planned care liaison mental health services and psychological therapies for people with or without long-term physical conditions or with medically unexplained symptoms).*

3.3.3 Comprehensive

Comprehensive model services are usually suitable for large secondary care centres with regional and supra-regional services. In addition to delivering core 24 services, they provide enhanced expertise and input to planned care pathways spanning all inpatient and outpatient areas, including assessment and treatment for conditions such as chronic pain and medically unexplained symptoms. The comprehensive model has greater numbers of senior staff, including consultants, senior nurses and psychologists. (The service once offered by Leeds and York Partnership NHS Foundation Trust formed the basis of the comprehensive model of care.)

3.3.4 Core

The core model delivers the same functions as a core 24 service, but operates during reduced hours. This may be, for instance, a nine-to-five service in an urgent care centre that does not operate out of hours.

3.4 The workforce

Having the right workforce with the right skills is essential to delivering care in line with NICE guidance. The key staff roles, functions and necessary competences for a liaison mental health service to deliver urgent and emergency mental health care are described below. Table 2 shows key competences for liaison mental health staff and further information is provided within the Psychiatric Liaison Accreditation Network (PLAN).[21]

Key competences for children and young people's liaison mental health services can be found in the forthcoming implementation guide (*Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People*).

3.4.1 Workforce for core 24, enhanced 24 and comprehensive service models

One of the key differences between the levels of service described above relates to workforce capacity, skill mix and competences.

A team with a robust skill mix should include sufficient numbers of practitioners from a range of regulated professions and support workforces (clinical and administrative/business support).

Core 24

- This model has adequate staff to cover a 24/7 rota
- This model has fewer medical staff than any of the other models
- Consultant psychiatrists should have expertise in common presentations, for example mental health problems in older people and drug and alcohol use
- Proportionately, this model has the highest number of nurses within it. The out-of-hours rota is nurse-led, with on-call consultants accessible during these hours.

Enhanced 24

- This model has more consultants per number of beds, with specialisms in working with older people, adult mental health and addictions
- Consultant psychiatrists are available on-call on a 24-hour basis
- Band 7 nurses lead sub-teams that are organised by consultant specialism.

Comprehensive

- Due to economies of scale, staffing of the medical and nursing workforce for this model is proportionately lower per bed than for the core 24 and enhanced 24 services.

Table 1 provides sample staffing levels for the models in this guide. Different service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and ED footfall. By way of illustration, the comprehensive model in Table 1 is set for a hospital of around 2000 beds.

Table 1: Staffing approaches with different service models[22]

Staff	Core 24	Enhanced 24	Comprehensive (illustrative for a 2000-bed hospital)
Consultants	2	4	5
Other medical	2	2	2
Nurses	6 band 7	3 band 7	2 band 8b
	7 band 6	7 band 6	17 band 6
			10 band 5
Other therapists	4	2	16
Team manager	1	1	
Clinical lead	0.4	0.4	1
Admin and business support	3	3	13

Commissioners and providers should consider other roles that could be utilised in liaison mental health services, including clinical support workers and new roles such as nursing associates.

All considerations regarding indicative staffing and skill mix levels for liaison mental health services should be flexible and take into account the forthcoming Health Education England national mental health workforce strategy and the forthcoming Department of Health Mental Health Core Skills Education and Training Framework.

3.4.2 Other staffing

> *Adult social services should ensure they have effective workforce management and succession planning in place to enable ongoing sufficiency of AMHPs and good workload management.*
>
> Source: The College of Social Work

There is a legal requirement for approved mental health professionals (AMHPs) to carry out Mental Health Act assessments and make applications for admission to mental health hospitals that are supported by the medical recommendations from the section 12 approved doctor.

Liaison mental health services should have access to appropriate staff either on the team or through contractual arrangements to ensure that there are no delays to the start of a Mental Health Act assessment should one be required.

Consideration should be given to the availability of independent mental health advocates (IMHAs) and independent mental capacity advocates (IMCAs), and people should be informed how to access them.

3.4.3 Integrated governance

Liaison mental health teams are only able to maximise their impact when fully integrated governance arrangements (involving senior clinical staff) are in place with EDs and other general hospital departments. This will help with the development of relationships, processes and shared learning between liaison mental health teams and EDs and ward teams, including to improve quality and safety. There are opportunities for shared learning from adverse incidents, such as people leaving EDs and delays in pathways. In practice, integrated governance could be achieved through, for example, regular meetings involving professionals from both mental health and acute medicine, with clear reporting lines to hospital boards and links to other relevant in-hospital professional groups.

Liaison mental health services should have joint ownership and governance arrangements between acute trusts, mental health trusts and other local providers including senior clinical and operational leadership from those providers. This should improve partnership working by the liaison service and local providers of community, primary, social care, housing, public health (including drug and alcohol use) and voluntary sector services.

Table 2: Competences of the liaison mental health team

Role	Key competences
Common to all roles	• Up-to-date knowledge of relevant legal frameworks (for example, Mental Health Act and Mental Capacity Act) • Ability to complete personalised risk assessments, including for self-harm and suicide prevention • Up-to-date knowledge of the general hospital system • Knowledge and skills around the care and treatment of older adults, people with drug or alcohol use problems, people with learning disabilities and people with physical health problems • Skills in providing training and support to general hospital staff around mental health problems • Knowledge of local services for people who use drugs or alcohol, including social care and voluntary sector services.
Medical	• Expertise in pharmacological treatments • High level of competence in biopsychosocial assessment • High level of leadership • Specialist training in working with older adults and people who use drugs or alcohol (in enhanced 24 or comprehensive services)
Nursing	• High degree of clinical leadership, providing clinical expertise and supervision • Specialist training in working with older adults and people who use drugs or alcohol • Ability to work autonomously and complete biopsychosocial assessments See the competence framework for liaison mental health nursing[23]
Drugs and alcohol	• Skills in addiction treatment, including comprehensive assessments, care planning, medically-assisted alcohol withdrawal, detoxification, psychological interventions and relapse prevention support • Skills in brief intervention • High level of competence in assessment of co-occurring drug or alcohol use and mental health problems • Specialist training in drug or alcohol use in line with National Occupational Standards (NOS) Skills for Health • Ability to train, advise and supervise others in co-occurring drug or alcohol use and mental health problems • High level of skills in engaging, liaising and co-ordinating across organisational boundaries See the Dual Diagnosis Competency Framework[24] or the Leeds Dual Diagnosis Capability Framework[25]

Role	Key competences
Older adults	• Specialist expertise in old age psychiatry • Knowledge of particular presentations and treatments of mental health problems in relation to coexisting physical health problems • Ability to identify social factors in the presentation of mental health problems in older adults • Expertise in the assessment and management of those presenting with delirium • Specialist expertise in dementia identification, assessment and diagnosis
Developmental and learning disabilities	• Expertise in developmental and learning disabilities • Knowledge pertaining to complex needs and completing comprehensive assessments

4 The evidence-based treatment pathway

4.1 Evidence-based treatment

There is no single NICE guideline or quality standard for urgent and emergency mental health that defines NICE-recommended treatment and care in liaison mental health services, but the Expert Reference Group considered the following to be directly relevant:

- Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
- Borderline Personality Disorder: Recognition and Management (NICE clinical guideline 78)
- Dementia: Support in Health and Social Care (NICE quality standard 1)
- Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
- Self-harm (NICE quality standard 34)
- Service User Experience in Adult Mental Health Services (NICE quality standard 14)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE clinical guideline 136)
- Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings (NICE guideline 10)

The relevant statements and recommendations from the NICE quality standards and guidelines that define NICE-recommended care for liaison mental health services are listed in Table 3 and Table 4.

The type of outcomes measures that should be used and the methods for measuring them can be found in Appendix A in the *Appendices and Helpful Resources* pack.

Table 3: NICE quality standards

Quality statement
Service User Experience in Adult Mental Health Services (NICE quality standard 14)
1. People using mental health services, and their families and carers, feel optimistic that care will be effective.
2. People using mental health services, and their families and carers, feel they are treated with empathy, dignity and respect.
3. People using mental health services are actively involved in shared decision-making and supported in self-management.
5. People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6. People can access mental health services when they need them.
7. People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8. People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9. People using mental health services who may be at risk of a crisis are offered a crisis plan.

Quality statement
Service User Experience in Adult Mental Health Services (NICE quality standard 14)
10. People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
15. People using mental health services feel less stigmatised in the community and NHS, including in mental health services.
Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
1. Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.
2. Health and social care staff opportunistically carry out brief screening and brief interventions for hazardous and harmful drinking as an integral part of practice.
Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
7. Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.
Self-harm (NICE quality standard 34)
1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.
2. People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.
Dementia: Support in Health and Social Care (NICE quality standard 1)
8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.

Table 4: NICE guidelines

Recommendations
Service User Experience in Adult Mental Health (NICE clinical guideline 136)
1.5.6. Health and social care providers should provide local 24-hour helplines, staffed by mental health and social care professionals, and ensure that all GPs in the area know the telephone number.
1.5.10. Consider the support and care needs of families or carers of service users in crisis. Where needs are identified, ensure that they are met when it is safe and practicable to do so.
1.5.11. Health and social care providers should support direct self-referral to mental health services as an alternative to accessing urgent assessment via the emergency department.
Violence and Aggression (NICE guideline 10)
1.5.1. Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.
1.5.2. Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

In addition, other NICE guidelines on specific mental health problems may be relevant and are available on the NICE website and in the *Appendices and Helpful Resources* pack.

4.2 Emergency care pathway

For full pathway diagram, see Appendix B.1 – Appendix B.8 in the *Appendices and Helpful Resources* pack.

The EBTP standard for a person experiencing a mental health crisis states that they should receive an evidence-based package of care informed by NICE guidance within four hours.

- An urgent and emergency mental health service should respond to the person within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment
- Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should:
    - *have received a full biopsychosocial assessment if appropriate, and*
    - *have an urgent and emergency mental health care plan in place, and*
    - *as a minimum, be en route to their next location if geographically different, or*
    - *have been accepted and scheduled for follow-up care by a responding service, or*
    - *have been discharged because the crisis has resolved*

      OR
    - *have started a Mental Health Act assessment.*

The pathway describes the delivery of evidence-based interventions for adults and older adults with a range of needs. At all stages, the principles of personal choice, capacity and collaboration should be embedded to improve recovery and experience of care and there should be an integrated health and social care response to the person experiencing a mental health crisis.

In order to meet the EBTP standard, as well as the wider ED performance standards set out in the NHS Constitution,[26] general hospitals will need a robust pathway (which includes the liaison mental health functions set out in this pathway) to ensure emergency referrals are made at the earliest opportunity after a person arrives in the ED. This will also require ED staff, particularly those conducting triage assessments, to be competent in identifying possible mental health problems in people who are attending the ED. Liaison mental health teams can help ensure this by providing support and training to ED staff.

See Figure 1: Summary of the pathway for an emergency response from liaison mental health services.

4.2.1 EBTP CLOCK STARTS – Identification

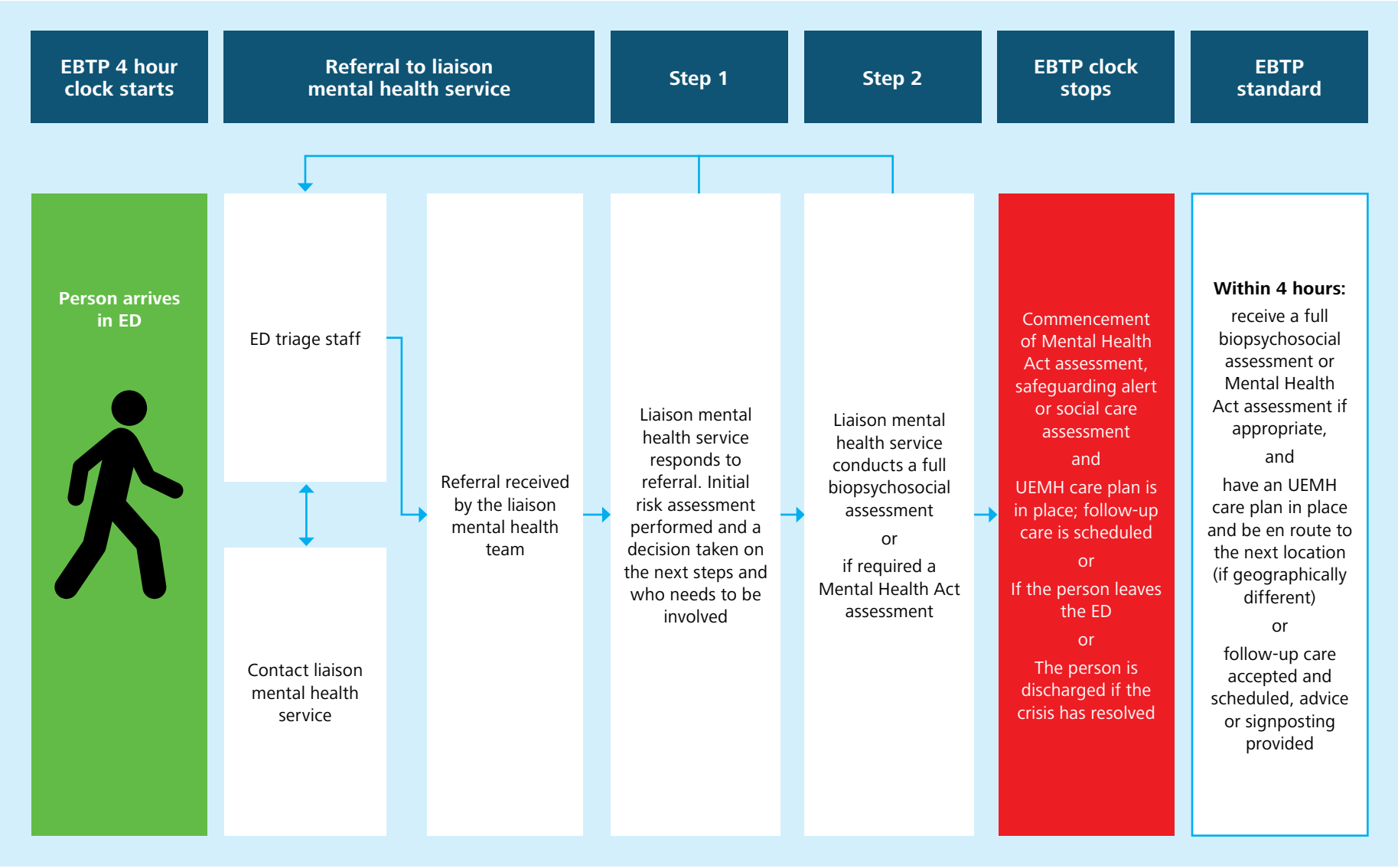
The EBTP CLOCK STARTS when: (1) the person arrives at an ED, or (2) the person is referred to the liaison mental health team from a ward. The liaison mental health service should be notified at the earliest opportunity when a need is identified.

A basic review should be conducted by ED triage staff or appropriate staff on the ward. This should be undertaken with compassion and understanding and include:

- a physical assessment; a decision as to whether they need emergency physical care should be taken as a priority (see Appendix B.2 and B.3 in the *Appendices and Helpful Resources* pack)
- a personalised risk assessment, including a decision as to the appropriate action needed should the person leave the ED while waiting for review by the liaison mental health team
- observations on behaviour and mental state.

If there is a lack of clarity about whether an urgent or emergency mental health response is needed, staff should call the liaison mental health team for advice. This will put the liaison mental health service on alert. See Section 4.4.2 for guidance on the difference between referrals and alerts.

Figure 1: Summary of the pathway for an emergency response from liaison mental health services



Key: UEMH = urgent and emergency mental health

4.2.2 Step 1 – Response

The liaison mental health team should **respond to a referral within one hour**. A response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.

- The liaison mental health team reviews the person face to face to:
  - *establish initial mental state*
  - *establish with the person whether they are experiencing a mental health crisis*
  - *obtain a general history of mental and/or physical health problems*
  - *obtain any existing care or crisis plan and/or advance decision or statement*
- Patient records, including primary care records, drug and alcohol records and any other records from specialist services, should also be reviewed
- If the liaison mental health team confirms with the person that they are experiencing a mental health crisis, they should arrange appropriate support while the person is waiting for a full biopsychosocial assessment or an assessment under the Mental Health Act if appropriate. This should include an agreed level of contact with health or social care staff, and a point of contact within the department
- If the person is severely intoxicated or demonstrating behaviour that challenges, the liaison mental health team should not assume that their mental state is a consequence of drug and alcohol use without adequate assessment and should:
  - *ensure that appropriate support is available for the person's physical care*
  - *consider whether the person has the capacity to agree to an assessment or to self-discharge (and whether it would be safe for them to do so)*
- The liaison mental health team should decide whether a full biopsychosocial assessment or an assessment under the Mental Health Act is appropriate
  - *If a full biopsychosocial assessment is required, it should start without delay. The priority is to ensure the person has been assessed and a NICE-recommended care package is in place for onward care or discharge, where appropriate.* ***The clock does not stop when the full biopsychosocial assessment starts.***
- The liaison mental health team should decide whether there are safeguarding concerns. If there are, they should raise a safeguarding alert, following their local safeguarding processes.

4.2.3 Step 2 – Assess

The EBTP CLOCK CONTINUES as the liaison mental health team assesses the person and decides on the appropriate outcome.

- The person, and their family/carers where appropriate, should be kept informed of plans while waiting for an assessment
- The assessment should start as soon as practicably possible
- The assessment should take place in an appropriate and safe environment[27] where any physical health concerns can still be addressed
- During a full biopsychosocial assessment, if the liaison mental health team suspects or identifies physical health concerns, such as intoxication or overdose, the liaison mental health team should refer the person back to the ED triage staff
- While conducting a full biopsychosocial assessment, if it is decided that a Mental Health Act assessment is needed, the full biopsychosocial assessment should be paused and the attendance of an AMHP and section 12 approved doctor(s) arranged to undertake the Mental Health Act assessment
- During the full biopsychosocial assessment, a need for an assessment under the Mental Health Act may be identified. If an assessment under the Mental Health Act is required (adhering to the Mental Health Act Code of Practice), the following should be considered:
  - *if the person is already admitted as an inpatient on a general hospital ward, it should be considered whether a holding power (section 5(2) of the Mental Health Act) is necessary*

- *the appropriate professionals should be informed as soon as a location for the assessment is confirmed (for example, if there is no AMHP available on site one needs to be called)*
- *whether use of a section 136 is needed involving the police; if so, the assessment should take place in a designated health-based place of safety[h] if possible and practicable.*

4.2.4 EBTP CLOCK STOPS – Agreed treatment plan in place

The EBTP CLOCK STOPS when the mental health crisis is resolved and the appropriate follow-up arranged OR a Mental Health Act **assessment starts.** The assessment should be done as quickly as possible, but without compromising good clinical practice. It should be remembered that the consequences of a Mental Health Act assessment are potentially the loss of liberty or the saving of life.

- The duration of the assessment and the cause of any delays in either starting or completing the assessment should be recorded as these data from AMHPs can be used to improve the quality of services
- The following should be covered in a full biopsychosocial or Mental Health Act assessment:
  - *the person's wishes and feelings about their treatment and care including, where relevant, any advance decision or statement*
  - *the factors that may have contributed to the mental health crisis*
  - *the physical, psychological and social consequences of the crisis*
  - *the presence and severity of coexisting mental and physical health problems, including coexisting drug or alcohol use problems*
  - *current risk (physical and/or mental health including self-harm) and whether inpatient stabilisation or intensive home treatment is needed*
  - *a person's history including whether they are currently receiving any treatment for mental or physical health problems and any social factors that may be impacting on their mental health*
  - *the person's level of consumption of drugs and/or alcohol*
  - *the level of motivation of the person and, if appropriate, their family/carers, to engage in appropriate treatment, including:*
    - *aspects of motivation that may not be immediately apparent or are hidden by feelings of despair and hopelessness*
    - *whether the person feels that they will be able to engage in treatment*
    - *any protective factors with regard to future crises, for example, personal/social relationships, and the strengths, resilience and capacity of families/carers to support treatment in the community*
- Based on the assessment and discussions with the person's family, if appropriate, and health and social care professionals relevant to the care of the person, the liaison mental health team should ensure that:
  - *An urgent and emergency mental health care plan is in place if the person is to be discharged and a copy given to the person before they leave (and, if the person agrees, to their family/carer). This plan should include:*
    - *details of who to contact at any time if the crisis reoccurs*
    - *an outline of appropriate care for the person if the crisis reoccurs*
    - *any advance decision or statement that the person wishes to add*
    - *contact details for the service and individual with whom follow-up care is arranged*
    - *contact details of services that may help the person to address factors that are thought to have contributed to the crisis, for example Citizens Advice or the local housing association.*

[h] *See Part 1: Implementing the Evidence-based Treatment Pathway for 'Blue Light' Services Providing an Urgent and Emergency Mental Health Response for All Ages (forthcoming, 2016).*

See Appendix B.5 in the *Appendices and Helpful Resources* pack for the process for ensuring an urgent and emergency mental health care plan is in place

- *The appropriate facilities are available for the person after discharge from the liaison mental health service. Alternative discharge locations may include:*
  - *their residence, or the residence of a family member or friend, if appropriate*
  - *crisis house (or similar facility)*
  - *a bed on an appropriate ward*

See Appendix B.6 in the *Appendices and Helpful Resources* pack for the process for ensuring an appropriate discharge location is available before the person leaves the department

- *All services that need to be involved in follow-up care are notified and have accepted the person into their care (see Appendix B.8 in the Appendices and Helpful Resources pack).*

4.3 Urgent care pathway

For the pathway see Appendix B.9 and B.10 in the *Appendices and Helpful Resources* pack.

As well as a rapid response to emergency referrals, liaison mental health services should provide an urgent care pathway, with a full assessment taking place within 24 hours of referral.

- An urgent and emergency liaison mental health service should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed and resources required for the assessment
- The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. The principles of assessment described in the emergency pathway (see Section 4.2.2) apply to the urgent care pathway.
- Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for a follow-up appointment by a responding service, or*
  - *have been provided advice or signposted, where appropriate.*

If at any point the person's mental health deteriorates, or it is deemed they require an emergency response, including a Mental Health Act assessment, the emergency pathway should be followed.

It should be borne in mind that:

- An urgent referral would usually be received from a ward in a general hospital, and relate to an emergent or deteriorating mental health problem that is not considered a crisis requiring an emergency response
- The majority of urgent referrals are likely to be for older adults (including dementia), and the response should be carried out by staff with training in working with older people
- If general hospital staff are unsure whether or not an emergency or urgent response is required, they should consult the liaison mental health team
- If an emergency mental health need is identified, the liaison mental health service should follow the emergency pathway (see Section 4.2.2). Clinical judgement should be used to establish on which pathway a person starts
- Follow-up care may be provided by the liaison mental health service over a number of sessions. This may take place in an inpatient or outpatient setting

See Figure 2: Summary of the pathway for an urgent response from liaison mental health services.

4.4 Pathway principles

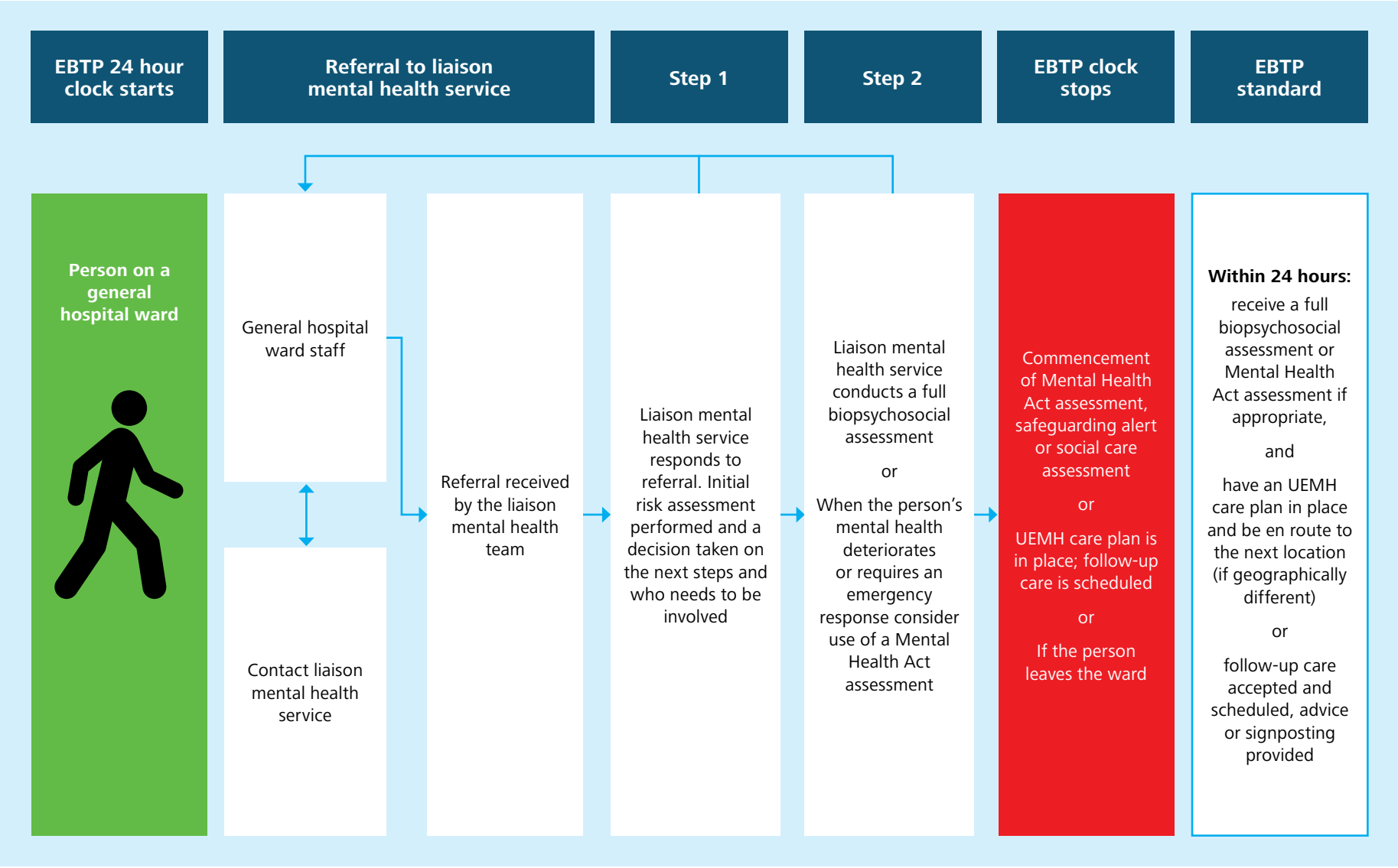
The evidence-based treatment pathway set out in this guidance is designed to inform responses to mental health crises, and it is expected that individual clinical decisions will need to be made to provide a response that is tailored to the person's circumstances and presentation. The pathway describes the most common situations, but it is expected that some people will not follow this pathway if they have different needs.

4.4.1 Providing age-appropriate treatment

Children and young people

Some adult services provide an urgent and emergency mental health response to young people aged 16 to 18 years or provide an all-age response that reflects the organisation of urgent and emergency services locally. If an adult or all-age liaison mental health service provides an urgent and emergency mental health response for children and young people under the age of 18 years, there should be a well-defined 24/7 pathway for this age group. This will ensure that the majority receive a response from staff with experience, competence and training in working with children and young people, particularly if a full biopsychosocial assessment is required. See *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming).*

Figure 2: Summary of the pathway for an urgent response from liaison mental health services



Key: UEMH = urgent and emergency mental health

Staff whose specialist experience and training does not include children and young people's mental health should be provided with additional training to support their work with children and young people and they should be able to access specialist staff within the team for professional consultation and on-call consultation, if appropriate.

Older adults

It should be noted that a large proportion of the caseload of liaison mental health services tends to be older adults with mental health problems and dementia on inpatient wards, and indeed the majority of the financial benefits of liaison services are accrued through assessment and treatment of older adults. Nearly two-thirds of people aged 65 or older in general hospitals have a significant mental health need (mainly depression, delirium or dementia).[28] A liaison mental health team should therefore include staff with specialist expertise in working with older people, in order to support the specific needs that come with age.

If the person has reduced awareness of the environment, impaired cognition and is experiencing behavioural or emotional disturbances, it is important to rule out a physical health condition, particularly delirium, when the person is in the ED. Although services may be aware that a person has a diagnosis of dementia, a mental health crisis should not be dismissed automatically.

4.4.2 Using referrals and alerts

Referrals and alerts can be made via a range of methods (for example, in writing, by telephone, email or face-to-face) including when a member of the liaison mental health team observes a person in the ED who they suspect is experiencing a mental health crisis.

- A referral is any formal request for clinical assistance from the liaison mental health service where it is reasonable to assume that the correct outcome for the person's health is an advancement to the next stage of the pathway (for example, from referral to assessment). A referral may be formal (such as an electronic form) or informal (such as a phone call)
- An alert is any informal request for assistance to the liaison mental health service where a healthcare professional could reasonably assume that the next stage of the pathway is impossible at the current time (for example, the person is unconscious)
- When receiving an alert, the liaison mental health team should attend in person or make contact with the referring team. Liaison mental health teams include the necessary expertise in caring for people with comorbid mental and physical health problems and they work in parallel with medical teams. They should therefore be proactively involved in the person's treatment and be ready to provide mental health input as soon as the person is able to be seen. This should not be just a request to be notified when the person is declared medically cleared, which can often lead to undue delays in the pathway.

4.4.3 Mental capacity

Professionals working with people experiencing a mental health crisis should understand legislation relevant to capacity, consent and information sharing as outlined in the Mental Capacity Act[29] and Mental Capacity Act Code of Practice[30] and refer to these for further guidance on this topic. Mental health professionals should pay particular attention to sections 1 to 6 of the Mental Capacity Act in order to understand legal duties as well as limitations. Guidelines on capacity and information sharing should always be followed and considered at all times throughout the pathway.[31] If a person does not have capacity, additional support will be needed in order to conduct an assessment. Capacity may be lacking not only due to a mental health problem but may also be impaired because of severe delirium or anaesthesia.

4.4.4 Safeguarding

Professionals working with people experiencing a mental health crisis should always have the person's wellbeing and safety in mind. All professionals have a duty to raise a safeguarding alert when they are concerned about a vulnerable person.[32] [33] Safeguarding should be considered as part of the full biopsychosocial assessment and throughout care, and any safeguarding concerns should be addressed in a timely manner following local safeguarding protocols.

For adults, the Care Act 2014 should be observed and the Social Care Institute for Excellence (SCIE) has published information for implementing reform in line with the Care Act.[34]

If there is a concern around safeguarding (this may relate to the person themselves or any dependants in their care), then professionals have a duty to raise a safeguarding alert, following local processes for doing so.

Safeguarding children and young people is covered in *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming).*

4.4.5 Transport

For the pathway see Appendix B.7 in the *Appendices and Helpful Resources* pack.

If someone needs to be transported from the general hospital to another location, this should always be done in a manner that preserves dignity and privacy and allows for management of their safety and that of others. The liaison mental health team should assist in arranging transport based on a personalised risk assessment in discussion with ambulance personnel and police if necessary. If appropriate, a mental health professional should provide support for the journey. Ambulances should take no more than one hour to respond to a transport request. If other transport is needed, the person should start their journey within one hour of the request for transport being received.

Where a person is discharged, the liaison mental health team should assist in arranging transport, preferably with the person accompanied by a friend or family member if they are available and the person agrees.

4.4.6 Managing intoxication due to drug or alcohol intake

For the pathway, see Appendix B.4 in the *Appendices and Helpful Resources* pack.

As a general principle, intoxication, any drug or alcohol problems, or coexisting mental health and drug/alcohol problems, must not prevent people in crisis from accessing physical or mental health services.[35]

People with mental health problems who are intoxicated may first present to EDs, which can be a challenge to ED and liaison mental health staff. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness showed that 54% of people who die by suicide had a history of either alcohol or drug use or both.[36] In 2014 there were approximately 3,000 alcohol-related admissions to EDs every day.[4]

One of the challenges is the difficulty recognising an underlying mental health problem if the person is in withdrawal or is intoxicated (for example, if they are unconscious or semi-conscious, have severely impaired cognition, perception or judgement and/or other symptoms that warrant urgent and emergency care). Furthermore, both intoxication and withdrawal may be associated with transient suicidality or psychosis, which will warrant an urgent and emergency mental health intervention.

The general principle when managing people who are intoxicated is to ensure that they are kept safe physically, and assessed clinically as having sufficient mental capacity to access urgent and emergency mental health care if there is a reasonable suspicion of mental health needs. Equally, not everyone who is intoxicated should be assumed to need mental health care. However, if the person is severely intoxicated or in withdrawal, a medical response is needed regardless of the person's drug or alcohol use history or whether a mental health problem is suspected.

- The outcome of the physical assessment would indicate if the referral to the liaison mental health service should be made and

whether referral to a drug or alcohol service is required. The EBTP clock starts when a person first arrives in an ED, but will only applied if a person is subsequently referred to a liaison mental health service

- A person who is intoxicated or going through severe withdrawal may need to be detained in hospital for their own safety, following a best interest decision
- If a Mental Health Act assessment is needed, the AMHP and section 12 doctor should consider the risk to the person if assessment is delayed.

4.4.7 Managing people who leave (or are likely to leave) before an assessment

If a Mental Health Act assessment has been arranged and the need for urgent and emergency mental health care is still in place, then the EBTP clock does not stop if the person leaves the ED or ward and is reported to the police as a 'missing person'.

If there are concerns that the person is likely to leave before an assessment and there are concerns regarding immediate harm, all efforts should be made to support the person.

The following should also be considered:

- Whether there is reason to suspect the person lacks mental capacity and powers to hold under the Mental Capacity Act can be used
- Whether it is appropriate to contact the police to consider the use of Mental Health Act section 136 (if the person is in a place to which the public has access, such as the ED)
- Whether Mental Health Act holding powers should be used:
    - *If a person is already receiving physical health treatment, the doctor in charge of their care can apply section 5(2) holding powers*
    - *If a person is already receiving mental health treatment, a registered mental health nurse can apply section 5(4) holding powers.*

If no urgent and emergency mental health care is required and the person leaves the general hospital of their own accord, the EBTP CLOCK STOPS and the conditions under which they left should be recorded. The liaison mental health team should consider whether further referral and/or follow up is necessary (for example, referral to a community mental health team).

4.4.8 Supporting a person when they no longer need urgent and emergency care

Not all crises indicate a need for mental health service involvement, but where support is required, presenting problems can subside at different rates. Once the crisis starts to subside, the person can appear more settled and it is not uncommon for people to not want or need any further follow-up by specialist mental health services.

The person's wishes together with clinical judgement should decide whether further care is required. If the person feels there is no longer a need for urgent and emergency mental health care, and there is no immediate risk to their safety, their rights and wishes should be respected, and the clock would stop at this point.

4.4.9 Collecting data

Complete, timely and accurate data collection and subsequent submission to national NHS datasets should be viewed as an integral part of the pathway and the responsibility of all service providers. Appropriate data collection helps improve service quality overall and is essential for services involved in follow-up care. In August 2016, the National Mental Health Dementia and Neurology Intelligence Network at Public Health England launched a crisis care profiling tool and data catalogue, which lists metrics and datasets relevant to mental health crisis care. The data catalogue is for commissioners, policy makers, planners and service providers and includes links to data sources. The aim of the data catalogue is to enable services to identify data that is available on crisis care and to ensure that there are effective services in place. As improvements are made to national datasets, the profiling tool will also be updated and improved.

4.5 Measuring and reporting performance against the pathway and standards

4.5.1 Submission of data items

From April 2017, liaison mental health services that are provided by mental health trusts will be expected to submit the following data items in the Mental Health Services Data Set to begin measurement of times and interventions related to this pathway. These will need to record:

- the time of the referral received by the liaison mental health team
- the time of the initial response by the liaison mental health team
- that a full biopsychosocial assessment has taken place
- that an urgent and emergency mental health care plan has been agreed and is in place
- the time that the person is either:
    - *en route to their next location if geographically different, or*
    - *has been accepted and scheduled for follow-up care by a responding service, or*
    - *has been discharged because the crisis has resolved*

    OR
- the time that a Mental Health Act assessment started.

Further guidance will be issued by NHS Digital about this new data collection in due course.

In time, we expect that the clinician-reported outcomes measures (CROMs) and patient-reported experience measures (PREMs) set out in Section 4.5.2 will also be collected via national datasets, but further testing will be taking place as part of the quality assessment and improvement programme (see Section 4.5.3) that will begin from mid-2017.

The above requirements will only measure part of the evidence-based treatment pathway from when the liaison mental health team receives the referral.

ED waiting times as set out in the NHS Constitution should continue to be submitted for all people who attend EDs, including people who present with mental health needs, via the A&E National Statistics collection and the A&E HES Dataset.

A new Emergency Care Data Set is currently in development, with the intention of improving the quality of data about ED activity. In the interim, we encourage liaison mental health services to contribute to improvements in local primary and secondary mental health ED diagnostic coding. Work is underway to determine how the full evidence-based treatment pathway will be measured through national datasets, and guidance will be issued in due course.

4.5.2 Outcomes measurement

Patient and clinician-reported outcomes measures

While there are a large number of validated patient-reported outcomes measures (PROMs) and CROMs in mental health that can be used to track change over time, they are not generally useful in a single episode such as an urgent or emergency mental health assessment. However, it is recommended that the Clinical Global Impression Improvement Scale (CGI-I) is used as a CROM to measure the person's condition at the end of every assessment (see Table 5).

PREMs are useful for gauging the quality of the person's experience. See Table 6 for a suggested PREM to use. This has been developed from the Service User Experience in Adult Mental Health NICE guideline and the Service User Experience in Adult Mental Health Services NICE quality standard and should be used retrospectively and confidentially.

Providers and commissioners should work together to ensure the routine collection and review of outcomes data in line with existing national guidance. Nationally the intention is that, in time, these outcomes measures will be collected through national datasets.

The Liaison Psychiatry Faculty at the Royal College of Psychiatrists has developed a Framework for Routine Collection of Outcome Measurement in Liaison Psychiatry (FROM-LP). This resource will be updated in the future, and commissioners and providers should consider using any new outcomes measures included within this framework.

Table 5: Clinical Global Impression Improvement Scale (CGI-I)[37]

Compared to the person's condition at the start of assessment, his/her condition is:

Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7

Table 6: Patient-reported experience measure

The following statements are adapted from the Service User Experience in Adult Mental Health NICE guideline and the quality standard. They were identified by service users as important to them when they are receiving care and support from mental health services. Please state, on a scale of 1 to 5, whether these statements reflect your experience of using liaison mental health services (with 5 meaning that they completely reflect your experience, and 1 meaning that they do not reflect your experience at all):

	Statement	Please circle one number				
1	If I experience a mental health crisis again, I feel optimistic that care will be effective.	1	2	3	4	5
2	During the treatment for my crisis, I was treated with empathy, dignity and respect.	1	2	3	4	5
3	During the treatment for my crisis, I felt actively involved in shared decision-making and supported in self-management.	1	2	3	4	5
4	I feel confident that my views are used to monitor and improve the performance of mental health care for crises.	1	2	3	4	5
5	I can access mental health crisis services when I need them.	1	2	3	4	5
6	During the treatment for my crisis, I understood the assessment process, diagnosis and treatment options, and received emotional support for any sensitive issues.	1	2	3	4	5
7	During the treatment for my crisis, I jointly developed a care plan with mental health and social care professionals, and was given a copy with an agreed date to review it.	1	2	3	4	5
8	When I accessed crisis support, I had a comprehensive assessment, undertaken by a professional competent in crisis working.	1	2	3	4	5
9	The mental health crisis team considered the support and care needs of my family or carers when I was in crisis. Where needs were identified, they ensured that they were met when it was safe and practicable to do so.	1	2	3	4	5

4.5.3 Quality assessment and improvement programme

All services will be expected to participate in a quality assessment and improvement programme. This will be organised and administered by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) through the existing quality network for liaison psychiatry services (PLAN).

The CCQI is working with a subset of the Expert Reference Group that oversaw the development of this guide, to produce:

- an assessment framework, setting out expectations for care in accordance with the implementation guide, and an accompanying four-point performance assessment scale
- a web-based self-assessment tool, which allows services to gauge their performance. Self-assessment returns will be validated and scored, and results from the self-assessment will be published. Services will be provided with benchmarking data to see how they compare to others nationally. Commissioners and providers will be able to use self-assessment information to target areas for service development and quality improvement.

Throughout the process, the CCQI will facilitate shared learning between clinical teams. The CCQI will also provide quality improvement advice and support to services.

Those services that choose to take part in the full PLAN accreditation process will receive additional support, such as peer review visits by trained clinicians and services users and access to additional training and learning activities.

5 Key commissioning considerations and service development

> *If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There's no support out there during these times. It's crucial that this is changed for the benefit of service users, their families and carers.*
>
> *Source: Five Year Forward View for Mental Health*

Most areas have a liaison mental health service in place, but getting them to meet the recommendations set out in this guide will require significant service development by commissioners and providers. Creating a new service or increasing the capacity of an existing service is central to improving outcomes; however, this alone will not achieve the necessary transformation in the quality of liaison mental health services across England. The following is a practical guide for commissioners and providers.

5.1 Step 1: Understand local demand

Commissioners should undertake an assessment of local need that involves people with relevant lived experience and their families/carers. Their engagement in assessing need, reviewing current services, deciding priorities and designing services will enhance the commissioning process.

Any assessment of local need and reviews of attendance at EDs and admission to general hospitals should:

- predict the number of referrals of people who may be in need of urgent and emergency mental health care in the general hospital setting
- predict patterns of presentation
- include a gap analysis
- include a clear understanding of how children and young people's specific needs will be met if the service provides an all-age response
- understand the reasons for ED attendances and general hospital admissions for people with mental health problems, including referral routes from primary care and NHS 111, and transport by ambulance services, for example
- review the completeness and quality of diagnostic coding of mental health in general hospitals and put improvement plans in place accordingly.

When liaison mental health services are developed fully, identification of mental health problems by general hospital staff, and therefore referrals, will also increase accordingly.[10]

Commissioners should ensure they have access to appropriate data to inform commissioning decisions. Where liaison mental health services are underdeveloped, it is likely that existing referral levels will not be an accurate indicator of the level of demand. Therefore, commissioners should not assume that current referral data are a reliable estimate of demand in these areas. The *Appendices and Helpful Resources* pack that accompanies this guide provides examples of liaison mental health services that are working at sufficient capacity and with general hospitals to identify cases; if both of these factors exist, the number of referrals received are more likely to be a reliable indicator of demand.

5.1.1 Commissioning for a hospital population

Where NHS trusts have more than one ED across their hospitals, a liaison mental health service should be commissioned specifically to meet the needs of each hospital, rather than considering the trust population as a whole.

However, a significant number of hospitals serve local populations across more than one CCG. In these cases, CCGs should identify a lead commissioner and contribute to funding on a proportionate basis, rather than having a number of separate contracts. This will ensure that services avoid duplication and provide an equitable service to different CCG populations. These arrangements could be identified as part of local Sustainability and Transformation Plans. There is an opportunity through Urgent and Emergency Care Networks to establish arrangements over a wider geography, ensuring that comprehensive pathways for access to liaison mental health services and wider crisis care are considered.

5.2 Step 2: Develop an outline service model

Commissioners should consider the examples of service models in this guide and the *Appendices and Helpful Resources* pack, while taking into account staffing, geography and location. Service delivery should reflect local demand, therefore different models may be required in rural and urban areas. The liaison mental health service should provide a range of options to ensure provision of urgent and emergency mental health care for those in rural communities or areas of low population density. Consideration should be given to traditional face-to-face service provision as well as options made available through new technology, for example telemedicine, particularly for ward referrals in hospitals that do not have an ED.

5.2.1 Consider the appropriate service model

Given that services need to provide 24/7 care, only the core 24, enhanced 24 and comprehensive models should be considered by commissioners where EDs in general hospitals operate on a 24/7 basis.

All liaison mental health services within hospitals providing regional and supra-regional services should aim to implement the comprehensive service model.

5.2.2 Identify and understand current referral pathways

Commissioners need to understand:

- external and internal referral sources (for example, self-referrals, GPs, NHS 111, general hospital wards, drug and alcohol services and the police)
- partners in service delivery (for example, voluntary and community organisations, and social care)
- discharge pathways (for example, into community mental health teams, home treatment teams, voluntary sector services, primary care, general wards, or intermediate care and residential care for older adults).

5.2.3 Consider establishing drug and alcohol use services

There is evidence that the provision of drug and alcohol use services working alongside liaison mental health teams, in particular alcohol use services (sometimes known as alcohol liaison services or alcohol care teams),[38] improves outcomes for those who have experienced a mental health crisis. Benefits include:

- a reduction in general hospital admissions and length of stay for those with alcohol-related problems
- a reduction in mortality related to the use of alcohol through early identification of alcohol-related conditions
- a reduction in alcohol-related ED attendances
- avoiding unnecessary lengthy hospital stays during full detoxification by completing treatment in the community.

There is also evidence to support a significant return on investment through the provision of a specialist-led alcohol team that provides case identification, comprehensive physical and mental health assessment, specialist care planning, medically-assisted alcohol withdrawal, psychotherapeutic interventions and liaison with community alcohol services for ongoing treatment.[39] (See also Section 5.5.2.)

5.3 Step 3: Obtain baseline current service provision and identify gaps

As set out in the CCG Improvement and Assessment Framework 2016/17, commissioners should be working with providers to undertake a baseline assessment of service provision and produce a service development and improvement plan (SDIP). The baseline assessment should include the current service model, the number of whole-time equivalent staff, skill mix and competences in the service.

Commissioners should establish how liaison mental health services respond to mental health crises currently and if they meet the recommended response times and provide an evidence-based package of care informed by NICE guidance as set out in this guide. If they do not meet these requirements, commissioners should work with other relevant services to either commission a new liaison mental health service (if one does not exist) or alter their current service provision in line with requirements.

5.4 Step 4: Agree staffing, recruitment and training plans

Providers will be required to show they have sufficient staff trained in evidence-based interventions, collaborative practice and the use of outcomes measures to meet the predicted need, or have a plan to develop the staff through a transformation programme. See Section 3.4 for further details.

5.5 Step 5: Design local referral to treatment pathways and accompanying protocols and guidance

5.5.1 Providing appropriate and safe environments for assessments

Commissioners need to ensure that EDs have sufficient and appropriate rooms to provide a confidential and safe place to support the person in need of care. See the PLAN for details on providing such an environment.

If the service will be providing support for children and young people, commissioners should refer to *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People* (forthcoming) for further details on an appropriate environment for this age group.

> *"Having to wait in loud fluorescent busy echoing waiting rooms for a long time. I can't always do it."*
>
> *Source: Service user, 2016*

5.5.2 Providing support for people with drug or alcohol use problems

General hospital admissions data show that coexisting alcohol use and mental health problems are common among people presenting in crisis. Commissioners need to ensure that people who are intoxicated and experiencing mental health problems do not get turned away by liaison mental health services,[40] but are assessed and given appropriate support. All hospitals have access to a drug and alcohol liaison service, which is either part of a liaison mental health service or via another model, such as an alcohol care team. CCG and local authority public health

commissioners should work together to ensure that all hospitals have access to such a service.

Liaison mental health services should provide referrals and signposting to drug and alcohol services and these details should be included in the person's urgent and emergency mental health care plan.

Drug and alcohol and liaison mental health services should work together closely, ensuring clear agreements are in place for screening, assessment and ongoing treatment, and that people under their care receive seamless, joined-up support.

5.5.3 Managing frequent attenders

Given that frequent attendances have both a human cost as well as a cost to the NHS, it is important for services to provide appropriate support and care in a way that minimises the stigmatisation of people who frequently attend EDs. Early identification of mental health problems and effective follow-up helps to reduce re-attendances at EDs. The Royal College of Emergency Medicine has produced guidance on the management of frequent attenders in EDs.[41]

Liaison mental health services play a critical role for EDs in identifying not only primary mental health presentations, but also underlying mental health problems for frequent attenders with physical health needs. They can also recognise the most common attenders, understand the needs of certain groups (for example, people who use drugs and alcohol, people who self-harm, and older people), review care and crisis plans and refer to other services. Liaison mental health services can work with local partners to review local care pathways and identify potential gaps in provision (for example, third sector and voluntary services or peer support) that lead to attendances at EDs.

Innovative programmes such as the 'Frequent Attenders Project' developed by Central North West London NHS Foundation Trust in collaboration with general hospital trusts across North West London have shown promising results.[42] Significant clinical improvements have been made and there has been a reduction in attendances through integrated case management and attendance planning.[42]

A national 'CQUIN' scheme for acute and mental health providers was announced in the two-year planning guidance for 2017-19 to incentivise care in a similar way to the North West London project, and a final version of the scheme for 2017-19 was published by NHS England in November 2016.

Commissioners should consider putting in place a policy to ensure that those with mental health needs who need to attend EDs frequently are offered appropriate support, including multi-agency care planning. Clinicians should have access to integrated electronic health and social care records so that they can provide the most effective care.

5.5.4 Providing care between assessments and reviews

There should be agreements in place to ensure continuing support between assessment and treatments for those receiving care while they are in the ED or on a ward. General hospital staff such as healthcare assistants, with appropriate training, can support liaison mental health service staff with this.

5.6 Step 6: Establish data collection and outcomes measurement protocols

5.6.1 Overview

There is currently widespread difficulty for professionals involved in responding to mental health crises to access full and relevant healthcare records. This is a significant barrier to improving the safety, efficiency and effectiveness of care because professionals should have quick and easy access to key, relevant patient information for those in crisis. Where records are available, the person's circumstances may have changed without the opportunity to update the records, or liaison staff may have to double enter patient information on IT systems. Liaison staff working in EDs and general hospital staff should have access to current clinical (including mental health care) records, ideally in an integrated and editable electronic format, including:

- community records on mental health, for example primary care records and those associated with drug and alcohol use
- records from the liaison drug and alcohol/ addiction team
- records from acute trusts
- existing care and/or crisis plans.

Commissioners and providers should take steps to establish ease of access for liaison mental health staff to interoperable, integrated electronic care records where they are not already in place, covering physical, mental and public health, and social care. The basic or enhanced NHS Summary Care Record is currently the only nationally available electronic care record containing key patient information and can also be used as an enabling platform. The Multi-agency Information Sharing and Suicide Prevention Consensus Statement and the revised Caldicott Principles[43 44] set out the circumstances under which information should be shared in a crisis situation.

Caldicott Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

'Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.'[36]

The Quick Guide to Sharing Patient Information for Urgent and Emergency Care produced by NHS England and the Information Governance Alliance is designed to help frontline providers and commissioners confidently share information to support the delivery of safer, faster and better urgent and emergency physical and mental health care. Commissioners, acute providers, mental health providers and other partners (such as local authorities, NHS 111 and ambulance services) should have in place data collection and sharing policies and agreements to optimise patient care, the means to collect and analyse such data and the ability to review and make service changes based on the analyses. Patient views should inform the quality of the service. The Centre of Excellence for Information Sharing also provides a range of resources to support this.

5.6.2 Developing reports for monitoring performance

Commissioners and providers will need to develop and produce reports on outcomes measures and service activity and quality, and agree how the data from these reports are best used to support service monitoring and development and future commissioning.

The parameters that need to be considered to judge what 'good' looks like are:

- Response to the crisis: all responses should be as rapid as possible and within the timelines outlined in Section 4
- Delivery of an evidence-based package of care informed by NICE guidance as defined in this guide
- Effective management and support of the person in care until resolution of the crisis; satisfaction with case management and support should be appropriate and measurable.

5.7 Step 7: Create a benefits realisation plan

Commissioners should outline in their plans how the development of liaison mental health services will improve care and lead to efficiencies. The benefits realisation plan should use a baseline of 2016/17 to set out and publish how the following outcomes will be achieved and monitored:

Health and patient experience outcomes:

- People requiring urgent and emergency mental health care from a liaison mental health service have an improved experience of care
- The liaison mental health service will provide NICE-recommended care, as set out in (Section 4.1 and Appendix A in the *Appendices and Helpful Resources* pack)
- People who frequently use the ED and have underlying mental health problems will have individual care packages that result in improved health outcomes and experience
- People receive treatment promptly accorded to the EBTP standards set out in Section 4.
- Adults and older adults receive care appropriate to their needs, from teams that have specialist training.

Healthcare utilisation, efficiency and financial benefits:

- Average length of stay and re-attendance rates will be reduced for people receiving care from the liaison mental health service
- Associated financial savings will be identified and realised
- Staff from different agencies will be able to access all relevant records at the time that a person requires urgent or emergency care from a liaison mental health team
- Links and protocols are in place to better support people who require support for drug and alcohol use.

Definitions of terms and abbreviations

Table 7: Definitions

Term	Definition
Appropriate and safe environment	In this document the term 'appropriate and safe environment' refers to a locally agreed place to which a person experiencing a mental health crisis, who has not been detained under section 135(1) or 136 of the Mental Health Act, can be taken to be supported and assessed by the appropriate professionals before the next step in their care is in place (whether this be discharge, referral or admission to a ward). The Royal College of Psychiatrists provides information on what facilities should be provided in an appropriate and safe environment (see the PLAN).
Carer	Any person who cares for a family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid and include those who care for the frail older adults, people with long-term medical conditions, disabilities, mental health problems and people receiving palliative care.
Crisis plan	A document put together jointly by the person and the healthcare professional(s) which outlines the management plan in the event of a mental health crisis. The plan should include advice and instructions for both the person and the healthcare professionals supporting the person, when the person is experiencing a crisis. It should include key contact details, including phone numbers, and details of coping and self-management strategies.
EBTP clock	The 'evidence-based treatment pathway' or EBTP clock is the term for the clock referenced throughout this guide, pertaining to the recommended response times for mental health crises and access to an evidence-based package of care informed by NICE guidance as set out in the pathway in this guide.
Emergency	An unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.
Expert Reference Group	A group of experts with a variety of different experiences, expertise and/or qualifications, established by the NCCMH to support the development of the implementation guides and the evidence-based treatment pathways. The Expert Reference Group included topic experts from areas such as commissioning and public health, service providers, health and social care professionals (including liaison psychiatrists), 'blue light' service representatives, academics and people with lived experience of using mental health services.
Full biopsychosocial assessment	A comprehensive and person-centred assessment that obtains information about a person's physical and psychological health, including any drug and/or alcohol problems, current risk (physical and/or mental health including self-harm), relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment. Biopsychosocial assessments should be consistent with the Service User Experience in Adult Mental Health NICE clinical guideline and quality standard.

Term	Definition
Intoxication/ intoxicated	A condition that 'follows the administration of a psychoactive substance and results in disturbances in level of consciousness, cognition, perception, judgement, affect or behaviour, or other psychophysiological functions and responses'.[45] 'Severely intoxicated' describes a person who may be unconscious or semi-conscious, and/or has severely impaired cognition, perception or judgement and/or other psychophysiological functions and responses that warrant emergency care.[46]
Liaison mental health	The sub-specialty that provides mental health care to people attending general hospitals, whether they attend outpatient clinics, EDs or are admitted to inpatient wards. Also commonly known as 'liaison psychiatry' or 'psychological medicine', the term 'liaison mental health' is used in this guide to reflect the multidisciplinary nature of liaison teams.
Liaison mental health service	A service providing support and treatment for those presenting in general hospitals with (for example): • a mental health crisis • coexisting physical health problems that are affecting their mental health • self-harm that may first require medical attention • mental health problems triggered or exacerbated by drug or alcohol use (where physical health stabilisation is a priority).
Mental health crisis	A situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.
Urgent	An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.
Urgent and emergency mental health care	The range of responses that health and care services provide 24/7 to people who are experiencing a mental health crisis. This can be an immediate emergency response to a situation (which may threaten life, long-term health or the safety of an individual or others), or urgent advice, attention or treatment for situations that are not immediately life threatening.
Urgent and emergency mental health care plan	A document put together jointly by the person requiring urgent and emergency mental health care and mental health professional(s), which includes details of treatment options, goals, advice, and coping and self-management strategies. A crisis plan can also be included as an element of this care plan.
Urgent and emergency mental health service	Any responding mental health service attending to a person experiencing a mental health crisis, including a crisis team, 24/7 mental health service and street triage team.

Table 9: Abbreviations

Abbreviation	Full term
CCG	clinical commissioning group
CCQI	Royal College of Psychiatrists' Centre for Quality Improvement
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	crisis resolution and home treatment team
CROM	clinician-reported outcomes measure
EBTP	evidence-based treatment pathway
ED	emergency department
GP	general practitioner
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PLAN	Psychiatric Liaison Accreditation Network
PREM	patient-reported experience measure
RAID	Birmingham Rapid Assessment, Interface and Discharge
WTE	whole time equivalent

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Care (Education) and Treatment Reviews

The role of health and social care providers

‘Transforming Care isn’t just about reducing beds, it's about changing a whole person’s life with good quality services in hospital, and good quality services in the community that will prevent unnecessary admissions. Care (Education) and Treatment Reviews help to make sure that happens.’

Gavin Harding MBE, Learning Disability Adviser, NHS England

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Care (Education) and Treatment Reviews

The role of health and social care providers

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request from england.improvinghealthquality@nhs.net.

Equality and Health Inequalities statement
Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

1. Introduction

This booklet has been written to help health and social care providers ensure that Care (Education) and Treatment Reviews improve the lives of people they support.

C(E)TRs were developed as part of NHS England's commitment to improving the care of people with a learning disability, autism or both in England as part of Transforming Care. CTRs are for adults who have been, or may be about to be, admitted to a specialist mental health/learning disability hospital in the NHS or independent sector. The equivalent system of review in England for children and young people is called Care Education and Treatment Reviews or CETRs. C(E)TR is used to refer to both.

Fundamentally, a C(E)TR aims to identify how each person can have the best quality of life possible, and how care and treatment can fully support this aim. In the belief that 'hospitals are not homes', a C(E)TR will consider whether the person needs to be in hospital or how this can be minimised, and how the right services can be put in place for people to live safely in their communities. In looking at the person's care and treatment it enables a view to be taken about what progress has been made in relation to this.

C(E)TRs bring together those responsible for commissioning and providing services (nurses, social workers, education commissioners and other health, education and social care professionals alongside strategic commissioners where appropriate) with independent clinical opinion and the lived experience of people with learning disabilities, autism or both and families from diverse communities.

The aim of the C(E)TR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met and that barriers to progress are challenged and overcome. To this end, as well as the commissioner and a clinical expert, the panel includes an expert by experience. This may be a person with a learning disability, autism or a family carer with experience of services. It is this independent and diverse blend of expertise that makes a C(E)TR unique.

A care provider may at times feel under the spotlight during a C(E)TR. While considering the quality of a person's care and treatment is obviously paramount, the C(E)TR is actually about **all** the factors that affect whether and why a person should, or should not be, in hospital. This might be due to factors outside the care providers' control. As the care provider, you also have a right to bring some constructive challenge where such barriers exist, with the shared aim of improving someone's life. A C(E)TR should be about **everyone** working together as equals, with the person and their family at the centre of this process.

The information and tools which follow are based on CTR/CETR policy and the CTR/CETR Code and Toolkit, which can be downloaded from the NHS England website, along with and a range of easy read resources and other materials www.england.nhs.uk/ctr.

Information is also provided on how to submit information on CTRs that are undertaken to the Mental Health Services Data Set (MHSDS). It is really important that CTR information is captured in MHSDS as this enables NHS England to monitor whether the care and treatment of patients is being reviewed in line with national guidance.

2. The role of providers

The C(E)TR policy outlines the overall responsibilities of providers as to:

- Ensure that the C(E)TR process is implemented as set out in the pathway
- Work in partnership with commissioners to facilitate C(E)TRs
- Support people with a learning disability, autism or both and their families in the C(E)TR process including with understanding the review process, and with consent
- Work in partnership with people, their family carers and partners co-productively before, during and after the C(E)TR
- Ensure agreed recommendations for providers are implemented from the C(E)TR
- Utilise the learning from C(E)TRs and the independent opinion, to improve the quality of services provided
- Take actions from C(E)TRs into CPA and ward rounds/other clinical meetings
- Carry out audits of C(E)TR process and outcomes, and people's experiences of C(E)TRs
- Act on relevant concerns flagged by a C(E)TR and report actions back to the chair of the panel, the person and family
- Provide challenge to blockages identified within the C(E)TR that are the result of funding or community barriers outside of the provider's control

3. When does a C(E)TR happen?

The service provider should help to ensure that C(E)TRs happen on time and that people are supported to request one if they wish.

A **Community C(E)TR** should be organised when a hospital admission is being considered. A Community C(E)TR asks what extra support can be put in place for the person and family to avoid unnecessary admission to hospital. In 4 out of 5 cases, it has been found that a Community C(E)TR has prevented admission to hospital at that time. Except where a clinician has determined an urgent need for admission to an acute mental health facility as part of a pre-determined crisis management plan with clear timescales for discharge, if there is a crisis and no time for a C(E)TR, a fast response is needed to consider if admission can be avoided. A meeting should be set up with the person, their family and those around them to explore what alternative support could be put in place.

- **For adults in non-secure settings, CTRs should happen every 6 months.**
- **For adults in secure settings, they happen every 12 months.**
- **If an adult does not have a CTR before being admitted to hospital, one should take place within 4 weeks of admission (or 2 weeks for children and young people under 18 years old.)**
- **CETRs should be every 3 months for children and young people in hospital.**
- **Anyone involved in the person's care, including the person, their families and support team, can ask for a CETR to happen sooner than planned.**

Requests for C(E)TRs should be made to the person's care coordinator. They should first try to deal with the concerns that have led to the request. If it is felt that a C(E)TR is needed, the care coordinator will contact the commissioner.

4. Supporting C(E)TRs to happen well

The service provider needs to provide all the documents required for the C(E)TR panel on the day.

The C(E)TR combines discussion with exploration of all aspects of a person's care and treatment, within a framework of themes and issues to be addressed and, if necessary, challenged. Findings are gathered in conversations and meetings, by seeing where the person lives and by looking at the person's care notes, which the provider should have ready on the day.

In common with the approach taken by the Care Quality Commission, the CTR/CETR policy uses Key Lines of Enquiry (KLOEs) to guide and structure the review process. Each KLOE template varies slightly depending on who the C(E)TR is for (adult or child/young person) and where it takes place (community, low secure or medium secure hospital), but they all follow the same structure.

Each KLOE consists of a key question followed by examples of probe questions that reviewers use to explore and gather information on the main issue. Each KLOE also suggests sources of evidence that the team might look for or ask to be provided to substantiate their findings.

The Key Lines of Enquiry provide information and evidence to enable a summary and feedback for the person that says:

- Am I safe?
- What is my current care like?
- Is there a plan in place for my future?
- Do I need to be in hospital for my care and treatment?

The 10 KLOEs that an adult CTR seeks to address are:

1. **Does the person need to be in hospital?**
2. **Is the person receiving the right care and treatment?**
3. **Is the person involved in their care and treatment?**
4. **Are the person's health needs known and met?**
5. **Is the use of any medicine appropriate and safe?**
6. **Is there a clear, safe and proportionate approach to the way risk is assessed or managed?**
7. **Are any autism needs known and met?**
8. **Is there active planning for the future and for discharge?**
9. **Are family and carers being listened to and involved?**
10. **Are the person's rights and freedoms being protected and upheld?**

KLOEs for a CETR also follow this format, with one further KLOE which is

11. **Are any specific issues for children or young people being addressed?**

5. Providing the necessary documents

For a hospital C(E)TR the responsibility for producing the documents is with the provider. For a community C(E)TR, the commissioner is responsible for providing the documents.

The C(E)TR chair should ensure that all written and verbal information provided will be kept private and confidential within the C(E)TR. The C(E)TR panel will not take any of these documents away with them nor make copies to take away. These are the documents that should be prepared ahead of the day for the C(E)TR panel and put in to a pack:

- Risk assessments
- Mental Health Act papers
- The most recent Mental Health Act Tribunal report
- Social circumstances report
- The community service specification
- The last four weeks of progress notes
- Safeguarding reports from the last year
- Incident forms where restraint was used, either since admission or last C(E)TR
- Health Action Plan
- Person centred care plan
- Positive Behaviour Support Plan and other care plans
- Education, Health and Care Plan
- Communication Passport
- Hospital Passport
- Medication Chart
- Mental Capacity Assessments
- Ministry of Justice documents, where appropriate

6. The ‘PERSONAL’ principles of C(E)TRs

The provider should help the C(E)TR panel uphold these principles:

C(E)TRs are based on a set of principles that are summed up in the word PERSONAL:

1. **P**erson centred and family centred
2. **E**vidence based
3. **R**ights led
4. **S**eeing the whole person
5. **O**pen, independent and challenging
6. **N**othing about us without us
7. **A**ction focused
8. **L**iving life in the Community

1. Person centred and family centred

The person, their family and advocate if invited, should be at the centre of the C(E)TR. The C(E)TR checks that the people who provide the person’s care are working in a person and family centred way. That people get all the information and support they need to have an active part in the C(E)TR before, during and after. In the way that works best for the people involved.

2. Evidence based

The C(E)TR Panel should all be able to see and hear information to help them understand what is working or not working about the person’s care. And that care is carried out to a high standard. This is so they can decide with the person and others if anything needs to change or get better.

3. Rights led

The person has the right to be treated as an equal in their C(E)TR and to have all the support they need to take part. The C(E)TR should uphold the person’s rights. Rights are things like choice, contact with family, independent advocacy and being able to say what one thinks. Other rights are being treated well, and having a good quality of life. And respect for one’s personal life and beliefs.

4. Seeing the whole person

A C(E)TR is not just about a person’s mental health or how they behave. It is about seeing the whole person. Their quality of life, likes, dislikes, choices, hopes and fears.

5. Open, independent and challenging

Each person on the C(E)TR panel can say if something does not seem right about the person’s care. They can ask questions and say if something needs to change to make it better. Together the panel will decide what needs to happen to make it right. Recommendations will go into the CTR report that is agreed by the panel after the C(E)TR.

6. **Nothing about us without us**

The person, and their family carers if taking part, should be fully involved in the C(E)TR. From giving consent, to getting ready, taking part, getting a copy of the C(E)TR report and knowing what is happening afterwards. The C(E)TR report should also be written in words the person will understand.

7. **Action focused**

The C(E)TR report after the meeting should have clear actions. Actions are things that need to be done. The actions should be easy to understand. The report will say who needs to do each action and when it should happen by. The actions should improve the care the person receives now and in the future. The commissioner will check these things are happening and that the person knows the reason if any action cannot be carried out on time.

8. **Living life in the community**

C(E)TRs are about what is needed to help people live well in their communities. When someone is in hospital, a C(E)TR will ask if they need to be there, or if their care can be provided safely in the community. It will also look at how people are supported to access the community while they are in hospital. The C(E)TR will check there are good plans in place to keep the person and others safe in the community. The C(E)TR will also check that the plans still give the person the chance to lead as full and independent a life as possible.

Ensuring the C(E)TR upholds these principles

Everyone, including providers, should be able to say to the C(E)TR Chair if they feel that any of these principles are not being upheld, giving clear reasons and suggesting how any issues might be resolved.

7. Supporting the person and their family

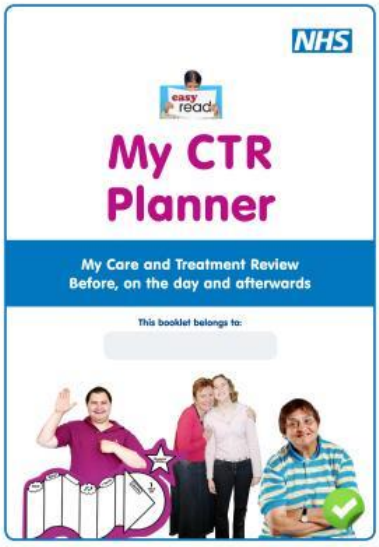
The service provider should support the person to give informed consent to the C(E)TR, check that family carers have been invited if the person wishes this and it is appropriate, support the person to prepare for their C(E)TR, take part in it, understand the C(E)TR report and know what the progress of recommendations are. Families should also be fully involved and informed as appropriate.

Materials to support the person to take part

The following booklets can be downloaded from the NHS England website www.england.nhs.uk/ctr. They are available with and without Photosymbols to suit people's needs.

My Care and Treatment Review - information about:

- What a Care (E) and Treatment Review does
- The C(E)TR panel
- Community C(E)TRs
- Hospital C(E)TRs
- How often they happen and right to request
- Getting ready, on the day and afterwards
- The C(E)TR report
- Good standards for leaving hospital



My CTR Planner - tools for the person to use:

- Information about consent
- A consent form with sections for choosing whether to invite a family carer, advocate or other important person, and whether the person wants the C(E)TR on the same day as another care meeting or not
- A template form for planning what the person would like to say on the day
- Tips about taking part on the day
- C(E)TR feedback form
- Space to summarise the actions from the C(E)TR report in a way the person finds easy to understand.

8. Making C(E)TRs part of what you do

A C(E)TR isn't just about what happens on the day. Service providers should support good planning, communication, support, action and follow up.

A C(E)TR allows providers to show due accountability for the care and the treatment they provide to the person, as well as providing the review team with the evidence base for the service being delivered. It should be based around what the person's needs and wishes and what they will benefit most from.

C(E)TRs were designed to take a full day to allow time for panel members to meet everyone, accommodate the person's needs, read notes and come to some decisions. In practice, sometimes they take less than a day. This works for some people e.g. because it helps them get ready for a CPA on the same day. Other people may find it too much to have two meetings in one day. Some people like to be in their C(E)TR from start to finish. But others might not even know if they want to take part in it until the day.

This is why a C(E)TR should be based around the needs of the person. Everyone should feel able to challenge this if it is not.

It helps to ensure that more than one room is available on the day so the person and family can meet panel members as informally as possible. Providers should also support the person to show panel members where they live and things they enjoy doing. There is a template form on page 13 to help with C(E)TR planning and support, and embedding recommendations into the person's care.

A good recommendation sets a realistic goal with as short a time frame as possible, and says who will carry it out by when. The care provider's role is to carry out recommendations relating to the person's current or future care within that service, or any responsibility in a transition from that service. It includes supporting people and families to enquire about the progress of any recommendations, whether or not it relates to your particular service. Providers also have a duty to report as agreed on the progress of their actions to the commissioner, the person and their family.

C(E)TR recommendations should be incorporated into the CPA process.
A process for feeding back to the commissioner, the person and their family as appropriate, following a C(E)TR or CPA meeting, should be agreed at the end of the C(E)TR.

9. Pro-active about good advocacy

The provider should ensure that the person understands and is able to make use of good advocacy support throughout the C(E)TR process.

Advocacy is about supporting people's rights and wishes at every stage of a C(E)TR, from planning to being represented as an equal on the day, to ensuring that the person knows what is happening afterwards and is able to speak up if there are any concerns. It is not just about having a voice, it's also about feeling part of a C(E)TR, listened to, worthwhile and encouraged to engage with the services and support being provided.

Providers should support the person to understand different kinds of advocacy and its benefits, and be pro-active if they feel that the person's advocacy arrangements need some review, additional investment or support.

An advocate from a specialist organisation brings skills, knowledge and independence to the process. This can either be to speak on the person's behalf or to support the person to self-advocate for themselves. Advocacy organisations can often provide training to self-advocates to support this. Informal advocacy, from a family member, friend or member of staff, can work well if the person is appropriately supported to explore their views on a topic, and this is communicated in an impartial way. Informal advocacy is only a substitute for formal advocacy when the person is happy with it, it is independent and its benefits are clear. The quality of any advocacy is evident from how the person's wishes are expressed and the quality of understanding and involvement the person has in the C(E)TR and their care, including decision-making.

The quality of advocacy support people receive is a recurring concern in C(E)TRs and it can become an issue for a number of reasons, such as:

- The person may refuse an advocate if he/she does not know what advocacy is
- They may not like the advocate offered to them
- The advocate may not have enough time to get to know the person
- Having a statutory advocate may not be right for that person

Some top tips for helping people to access good advocacy for their C(E)TR are:

1. Support the person to understand what advocacy is and why it is important
2. If an advocate was refused, find out why and if it can be resolved
3. Make sure advocacy time is protected from staff pressures or other appointments
4. Make sure advocacy is planned into each stage of the C(E)TR process
5. Make reasonable adjustments like providing a quiet or otherwise adapted space to meet, or being able to meet outside of the hospital if possible
6. Support the team and the family to work together in providing advocacy support for the person, if this is of benefit.

10. C(E)TR Provider Planning

This section suggests ways of integrating CTR planning into your work.

ACTION
ONGOING
The person should understand what their C(E)TR is about, how it can help them, and what progress is being made as a result of it. There are two booklets for the person (available with or without Photosymbols) to support this. One booklet provides CTR information, the other is a planner which provides forms for consent, preparation, on the day and afterwards. They can be downloaded from www.england.nhs.uk/my-ctr. Staff, advocacy and/or family support if appropriate, should be offered to help the person plan for and monitor their C(E)TR progress. Staff should practice a rights based approach to ensuring that the person is at the centre of their C(E)TR from start to finish e.g. www.humanrightsinhealthcare.nhs.uk DH Easy Read Mental Health Act – www.nhs.uk/easy-mentalhealthact
If the person is in hospital, the provider and staff should use **Discharge Steps and Standards** (see Section 15 for best practice) to ensure discharge is progressing well. The person should be involved and supported to produce an accessible discharge plan e.g. a downloadable example planner is available at www.changepeople.org/blog/february-2016/independence-pack
AT LEAST TWO WEEKS BEFORE THE C(E)TR
Consent to a C(E)TR and to family/advocacy involvement if appropriate is gained – to give people, families and advocates time to make arrangements. Raise any issues with the C(E)TR chair promptly. The signed C(E)TR Consent Form is copied and sent to the C(E)TR chair and care coordinator. If the person lacks capacity and does not have a legal appointee, a Best Interests Process and documentation is followed.
If the person isn't sure about taking part in their C(E)TR, reassure them that they can decide any time up to and including the actual day. If the date isn't good for the person, push back on this. If the person is still unsure about taking part, consider how else the person can ensure their voice is heard e.g. in writing, or audio/video recordings about life now, what is good or could be better, and hopes for the future. The person's attendance is the ideal, but if it is not possible, the other materials can be used on the day instead.

Ensure practical arrangements for the day are made and confirmed with the C(E)TR chair and others e.g. a suitable room or two rooms to enable the C(E)TR panel to meet with more than one person at a time, food and drink arrangements, along with any regulations the panel needs to know about getting into the building and travel information.

If it will help the person feel at ease on the day, ask the CTR Chair for appropriate one-page profiles of the panel members, if not already supplied.

THE WEEK BEFORE THE C (E)TR

Get the documents ready which the C(E)TR panel may ask to see – it is best to do this before the day of the C(E)TR. The document checklist is in Section 4 of this document.

If the person has had a C(E)TR before, you should **review what happened last time with the person** and what progress has been made since. Support the person to prepare what they would like to say and any questions they have for the panel.

Support the person to prepare for their C(E)TR. There is a document for this in the person's C(E)TR Planning booklet, which should be written in the person's own words (or pictures) where possible.

If the person has communication difficulties, other methods should be used to ensure their views are captured. If the person wishes, involve family carers and/or advocacy in helping to complete the profile. **The person should bring this document to their C(E)TR meeting if they are happy to do so.**

Reflect on what **you** think is working or not working for the person and possible solutions, in case your views are sought on the day. This is about what you think, not a team opinion. You can ask to speak to a panel member if not directly invited. Your views will be treated confidentially.

ON THE DAY OF THE C(E)TR:

Support the person to take part in the way they feel most comfortable e.g. meeting members of the panel privately, choosing to have a family carer, staff member or advocate present, or choosing to meet panel members on their own.

The person should be able to meet the panel in the best way for them, and have the opportunity to decide about this on the day. For example, the person might feel more comfortable meeting panel members in a different room from where the C(E)TR is taking place and/or might like to show the panel around where they are living. You should support this to happen if so. The person should be supported to attend the closing meeting if they wish.

Ensure the person's wishes are respected and that the person is happy with the way the C(E)TR is carried out.

Support the person to present and discuss their C(E)TR planning document in the way they wish and check what support they would like in this, if any.
The C(E)TR should respect how the person chooses to take part e.g.: • The person and family if appropriate should have time to plan for and take part in the way that suits them; • The C(E)TR should be a positive experience for the person and family; • Whoever the person has chosen to attend or support them are given every opportunity to attend (this can be by phone or in writing if unable to attend on the day).
Staff should feel able to share their views in confidence and respect is shown for their views.
Immediate actions identified by the CTR are noted, along with the responsible person. Any immediate actions required of the provider are actioned urgently and the CTR Chair, care coordinator, person and family (if appropriate) are kept informed.
WITHIN A WEEK OF THE C(E)TR:
Reflect on the C(E)TR with the person and other staff as needed. Record any queries or concerns and flag them up with the C(E)TR chair. The person's CTR planner contains a sample feedback form that anyone can use.
Ensure the person is supported to fill in the **feedback form** in their C(E)TR Planner booklet by someone they choose, if they wish. Copies are sent to the C(E)TR Chair and Care Coordinator.
The C(E)TR report should be received within **2 weeks** by post. If not, ask the C(E)TR chair for a copy which can be circulated to everyone who took part, including family carer/advocate if relevant.
Support the person to understand the report and to write the C(E)TR actions in their own words in their C(E)TR Planner booklet if this will be helpful.
Relevant CTR recommendations and actions should be acted on and carried forward into CPA and/or other care meetings for regular review.

WITHIN 3 MONTHS OF THE C(E)TR:

C(E)TR actions needing to be completed should be reviewed in a care meeting e.g. CPA. This should include:

1. The progress of required actions against the given timeframe and if there are any barriers, how they will be addressed;
2. The progress of reporting on actions by named staff to CTR chair or other designated contact(s);
3. How the person, their advocate and family carer (if involved) are being involved and kept up to date of this progress;
4. What further steps are required;

ONGOING DISCHARGE PLANNING – also see section 15

Hospital teams should make links with local services where the person is moving to e.g. Voluntary organisations, self-advocacy groups, local services, doctors, dentist, education etc. to enable them to link with the person and make contact while they are in hospital. Consider creating a Circle of Support with the person linking to information about how they work and can be developed (lots on the internet). A Circle of Support is about building strength arounds the person for the future (and with familiar, reassuring parts of the past) which is ambitious and has the person at the centre. Previous support might bring a valuable dimension to the group along with old friends the person may want to engage with again.

ONGOING ANALYSIS AND REPORTING OF CTRs

Providers should have a process in place for taking an overview of C(E)TR reports for people in their care, and what can be learned from this. See Section 12 of this booklet.

Monthly CTR reporting is included within Mental Health Services Data Set (MHSDS) data submissions. See section 14.

11. Ensuring the quality of C(E)TRs

The service provider has a role in ensuring that the C(E)TR is carried out in a way that supports the person at every stage, and that C(E)TR recommendations are carried out on time.

Each section of this document contains advice that contributes to the quality of a person's C(E)TR. The C(E)TR panel has a fundamental role in ensuring the quality of the process which providers should also support. The Chair of the C(E)TR is responsible for ensuring the quality of the process as follows:

- The C(E)TR is based on the principles and standards in the C(E)TR policy;
- It is independent, fair, rigorous and constructive;
- It ensures that everyone gets to have their say;
- It ensures that the views and wishes of the person whose care and treatment is being reviewed, and their family members if involved, are clearly established and are at the centre of the reviews discussions.
- It ensures that both experts are fully involved and treated as equal members of the team. They bring important skills to the C(E)TR and to the drafting of the report, which should be a collaborative process. Ensures that information is made available as per the document checklist.
- It establishes an outline plan for the review day and, if required, to modify this according to any particular issues that may emerge during the review.
- It helps the team develop a pen-picture at the beginning of the day of the person whose care and treatment is being reviewed.
- It is alert to any issues of concern regarding the welfare and safety of the person and to respond immediately and appropriately to issues that require prompt or urgent action and / or escalation.
- It enables the team to have discussions with the clinicians responsible for the person's care and treatment and those who may be supporting them.
- It enables the C(E)TR panel to challenge aspects of the person's current and future care and treatment.
- It clarifies and summarises the findings and recommendations of the review panel both on the day and in a subsequent report.
- It agrees a timescale for recommendations, naming the individual responsible and following agreed actions through after the review and ensuring they are embedded in the CPA process.
- It allows providers to show due accountability for the care and the treatment they provide to the person, and provides the review team with the evidence base for the service being delivered.

12. Applying the learning from C(E)TRs

Providers should be able to identify common themes or trends from C(E)TRs carried out in their services, and implement the learning from this.

By its very nature, a C(E)TR is about the care and treatment of an individual person. However, since they began in 2015 each provider will have supported numerous C(E)TRs to be carried out in their service. As part of their continuing development, providers can learn a great deal from taking an overview of the contents of C(E)TR reports and ensuring that this learning is used to improve the services they provide. This is a useful adjunct alongside service-wide learning from CQC inspections which can be aggregated and used to inform wider strategic planning in a given locality/region.

There is an expectation from C(E)TR panels and commissioners that this is happening and services may be asked to evidence their overall C(E)TR learning and outcomes, for example as part of their contract arrangements.

Providers should consider any themes or learning they can derive from C(E)TRs, in order to enhance the services they provide. The KLOEs provide a helpful structure for evaluating the effectiveness of care and treatment; as evaluated from the point of view of the person using the service. NHS England has produced a simple Excel tool, which allows C(E)TR recommendations to be aggregated under these headings, available from www.england.nhs.uk/ctr.

See also Section 14 Reporting CTRs to the Mental Health Services Data Set (MHSDS).

13. Becoming a C(E)TR panel member

As part of their continuing professional development, service providers should support staff who wish to become C(E)TR clinical experts.

The clinical expert in a C(E)TR helps other panel members understand clinical notes and offers professional opinion. For this reason, the clinical expert should hold a professional health qualification, such as Doctor (Psychiatrist), Psychologist, Nurse, Occupational Therapist or Speech and Language Therapist. All panel members have to be independent and impartial.

The Clinical Expert offers a different perspective to the existing clinical team and will engage the person, their family and their local team in discussion to identify if there are barriers to discharge or to identify what support would enable the person to live their life in the community. The Clinical Expert, where required, advises the other members of the team on matters such as the Mental Health and Capacity Acts, diagnosis, mental and physical health issues, treatment options and their evidence base. Conflicts of interest should be declared e.g. it would not be appropriate to act as a clinical adviser for a C(E)TR in a service where you have ever worked. For more information, see the C(E)TR Code & Toolkit at www.england.nhs.uk/ctr

14. Reporting CTRs to the Mental Health Services Data Set (MHSDS)

Details on all patient CTRs should be captured in MHSDS to enable NHS England to monitor whether the care and treatment of patients is being reviewed in line with national guidance. Providers are required to submit patient CTR data to MHSDS.

An Information Standards Notice (ISN) has been issued for the MHSDS (DCB0011), which mandates monthly submission from all services that give care to in-scope[1] adult and child and adolescent mental health, learning disability or autism patients. Full guidance on data requirements and how to submit can be found at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/how-do-i-submit-data-to-the-mental-health-services-data-set

CTR data should be included in MHSDS submissions using the MHS202 Care Activity table (linked to MHS201 Care contact). Where a CTR has taken place this should be recorded using the Coded Procedure and Procedure Status (SNOMED CT) data item. The following national codes should be used to record the type of CTR (i.e. inpatient, community or post admission)

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060751000000101	SNOMED code for **Community** CTR (procedure). Defined as a CTR taking place in the community where a person is facing potential admission to a specialist learning disability or mental health inpatient setting. Where the patient is subsequently admitted to hospital, a **Community** Care and Treatment Review is defined as one which is undertaken **up to 2 weeks before the inpatient admission.**
MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060761000000103	SNOMED code for **Post admission** Care and Treatment Review (procedure). Defined as a CTR taking place **within 4 weeks of the date of admission (or 2 weeks after the date of admission for children/ young people under 18).**

[1] For further information on the scope of MHSDS please see the latest MHSDS Requirements Specification at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0011-mental-health-services-data-set.

MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060741000000104	SNOMED[2] code for **Inpatient** Care and Treatment Review (procedure). Defined as a CTR taking place at any point **more than 4 weeks after the date of admission (or 2 weeks after the date of admission for children/young people under 18 years).**

Organisations whose local systems are not fully SNOMED CT compliant should still submit this data to MHSDS by undertaking manual mapping of data to SNOMED CT terms. For more guidance on the use of SNOMED CT in MHSDS, including additional links to national SNOMED guidance, please see the MHSDS User Guidance at the above link.

A CTR is different from a Care Programme Approach (CPA) review which is recorded in Table MHS702. In practice, CTRs inform the CPA review but CTRs should be recorded separately in Table MHS202 (Care Activity).

Reporting of CTR data is included in the NHS Digital monthly Learning Disability Services Statistics and will develop over time as reporting improves: https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics

Current reporting by NHS Digital includes which providers have submitted CTR data to MHSDS and the number and type of CTRs reported in the month for each.

[2] SNOMED indicates Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)

15. Hospital Discharge Good Practice Standards

The CTR policy outlines good practice in relation to discharge planning as follows. More detailed steps are contained in the CTR policy appendix: www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance

Good Practice Standard	How will it be measured?
1. I have a named **discharge facilitator in hospital**, who is a member of my multidisciplinary team (MDT). This person will help me with my discharge planning - with me and the people I choose.	This person is named on my admission document
2. I have **a named CPA community care coordinator** from the community team. This person makes sure all my health and social care needs are met after I leave hospital and works closely with me and others to plan my discharge, and have an important role in carrying out actions agreed as part of my CPA and C(E)TR meetings.	Named on my admission and discharge documents
3. I have a **named social worker** who will support my discharge into the community. (This person may also be my CPA Care Coordinator)	Named on my discharge plan
4. **I am supported to be involved in my discharge planning** and in making plans for my future with the people who are involved in and important to my care and support. I will have a copy of a **discharge plan that is easy to understand**, that shows the stages in my discharge plan, who is responsible for what, and by when. An easy read Leaving Hospital Planner and an Independence Pack[3].	'Me and my family' will give feedback about how people responsible for my care involve us in discharge planning. There will be a questionnaire for us to fill in from the provider. My discharge plan will show how involved I am too.
5. **Keeping in touch with friends and family**: While I am in hospital I will have support to maintain my relationships with the family and friends I choose to. This will help me when I leave hospital.	There will be a questionnaire for us to fill in from the provider, written in a way we can understand.
6. I will have a **named advocate** who is independent of the people who provide my care. This person knows me well and helps me speak up or speaks up for me.	This person is named on my discharge plan and on my admission document.

[3] www.changepeople.org/blog/february-2016/independence-pack

7. While I am in hospital and before I am discharged, I will have **full and regular reviews of my medication** to make sure I am not taking medicines that I don't need and to find other ways of helping me.	Medication reviews will be shown on my discharge documents, letters to or from my GP, responsible clinician and community team.
8. **Meetings held to plan for my future** will include my hopes and wishes and will include the people I want to be there. Meetings will be easy to understand so I can take part. Information will be provided in a way I can understand. Future plans will also support any needs I have that are caused by my experiences before or in hospital (e.g. trauma). Plans will include what extra support needs I have because of this while supporting me to be as independent as possible.	I will give feedback about how this goes. There will be a questionnaire for me to fill in from the provider, written in a way I can understand.
9. The Responsible Clinician (RC) will support my discharge, offering advice and guidance to the discharge facilitator and both inpatient and community multidisciplinary teams (MDT) during my admission. The RC will be active in dealing with the Ministry of Justice if this applies to me. The RC will work closely with me and my family to support my future community package. The RC will make sure actions from Care and Treatment Reviews are carried out. The RC will also work with the community team doctor who will provide my future health care.	'Me and my family' will be able to ask the RC how all these things are going.
10. **Planning for my future life outside of hospital while I am in hospital**. Plans put in place to support me in hospital will also support me to make a good move into the community. This could include being supported to take more risks as I grow in confidence, skills and independence.	Care plans will show how I am gaining in confidence, skills and independence for leaving hospital.

For more information

Please visit www.england.nhs.uk/ctr

Information about other work of the NHS England Learning Disability Programme can be found at www.england.nhs.uk/learningdisabilities

This includes:

Transforming Care – ensuring that people with a learning disability, autism or both receive the support they need in the community to reduce the number of people needing care and treatment in specialist learning disability hospitals **www.england.nhs.uk/learningdisabilities/care**

STOMP – stopping the over medication of people with a learning disability, autism or both with psychotropic medicines **www.england.nhs.uk/stomp**

Ask Listen Do – making it easier for people with a learning disability, autism or both and families to give feedback, raise a concern or make a complaint in health, social care or education **www.england.nhs.uk/asklistendo**

Annual Health Checks and other GP initiatives – for people with a learning disability **www.england.nhs.uk/annual-health-checks**

NHS RightCare Pathways – joint work with NHS RightCare Pathways to improve health outcomes and make it easier for people with a learning disability to receive the care they need for diabetes, dysphagia, epilepsy, heart disease and other conditions **www.england.nhs.uk/rightcare2**

Mortality Review – also known as the LeDeR Programme, a local process for reviewing the deaths of people with a learning disability **www.england.nhs.uk/mortality-review**

Mental Health Services Data Set - Full guidance on data requirements and how to submit can be found at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/how-do-i-submit-data-to-the-mental-health-services-data-set

The framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities

Framework for inspecting local areas in England under section 20 of the Children Act 2004

Age group: 0–25

Published: April 2016

Reference no: 160025

Contents

Introduction

1. New duties on local areas regarding provision for children and young people with special educational needs and/or disabilities are contained in the Children and Families Act 2014 (the Act) and amplified in regulations and in the 'Special educational needs and disability code of practice: 0 to 25 years'[1] (the Code of Practice). The Code of Practice is statutory guidance published by the Department for Education (DfE) and the Department of Health (DoH). The duties came into force in September 2014.

2. The Minister of State for Children and Families has tasked Ofsted and the Care Quality Commission (CQC) with inspecting local areas on their effectiveness in fulfilling the new duties.

3. This framework sets out the key inspection principles and should be read alongside the Code of Practice and the 'Handbook for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities'.[2]

4. The inspection handbook is a guide for inspectors on how to carry out local area inspections. The framework and handbook are made publicly available to help ensure that local authorities and health services, early years settings, schools, further education providers and other organisations are informed about the process and procedures of these inspections and to support local areas in their self-evaluation and ongoing improvement. It is also available to young people, parents and carers to help ensure that they are aware of how these inspections are carried out.

The purpose of inspection

5. Ofsted and CQC are required to carry out their work in ways that encourage the services they inspect and regulate to improve, be user-focused and be efficient and effective in their use of resources.[3]

6. These inspections will provide an independent external evaluation of how well a local area carries out its statutory duties in relation to children and young people with special educational needs and/or disabilities in order to support their development. The inspection will review how local areas support these children

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[1] 'Special educational needs and disability code of practice: 0 to 25 years', (DFE-00205-2013) Department for Education and Department of Health, 2015; www.gov.uk/government/publications/send-code-of-practice-0-to-25.

[2] 'Handbook for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities'; www.gov.uk/government/publications/local-area-send-inspection-guidance-for-inspectors.

[3] As set out in section 119(1) of the Education and Inspections Act 2006; www.legislation.gov.uk/ukpga/2006/40/section/119; and section 3(2) of the Health and Social Care Act 2008; www.legislation.gov.uk/ukpga/2008/14/section/3.

and young people to achieve the best possible educational and other outcomes, such as being able to live independently, secure meaningful employment and be well prepared for their adult lives.[4] Therefore, although these inspections are designed to hold local areas to account, they also intend to assist local areas in improving and developing their processes and support systems in order that local areas become more effective and deliver better outcomes for children and young people.

7. The inspection leads to a published report that:

   - provides children and young people, parents,[5] elected council members, local providers and those who lead and manage the delivery of services at local level with an assessment of how well the local area is meeting the needs of children and young people with special educational needs and/or disabilities, and how well service providers work together to deliver positive outcomes
   - provides information for the Secretary of State for Education about how well the local area is performing its role in line with its statutory responsibilities and the Code of Practice
   - promotes improvement in the local area, its education, health and social care provision
   - where relevant, requires the local area to consider the actions that it should take in light of the report and prepare a written statement that sets out those actions and the timetable for them.

The local area and the role of the local authority, health partners and other agencies

8. It is important to note that these inspections will evaluate how effectively the local area meets its responsibilities, and not just the local authority. The local area includes the local authority, clinical commissioning groups (CCGs), public health, NHS England for specialist services, early year's settings, schools and further education providers.

9. Each local area will be asked to nominate a representative – a 'local area nominated officer' – who will act as a single point of contact on behalf of all local agencies throughout the inspection and until the publication of the inspection report. Their role will be to liaise with the lead Her Majesty's Inspector (HMI) throughout the inspection so that inspection activities can be coordinated effectively.

[4] Section 19(d) of the Children and Families Act 2014; www.legislation.gov.uk/ukpga/2014/6/section/19/enacted.
[5] The term 'parents' refers to mothers, fathers and/or carers.

10. The local area is the geographical area of the local authority. However, the responsibility of the local area for children and young people who have special educational needs and/or disabilities extends to those who are residents of the local area but attend educational establishments or receive services outside the local authority's boundaries.

11. During the inspection, inspectors will visit providers, such as nurseries, schools, colleges and specialist services.[6] These key activities to gather evidence are critical to enhancing inspectors' understanding of how all local providers and agencies work collaboratively together to improve the life chances of children and young people with special educational needs and/or disabilities. However, it is important to note that when inspectors visit providers, these providers are not under inspection but remain subject to separate institutional inspection arrangements in line with Ofsted's and CQC's statutory and regulatory duties and powers. Therefore, inspectors are not there to evaluate the effectiveness or quality of the individual service or provider.

12. If during the course of these inspections inspectors become aware of concerns of a safeguarding or child protection nature, they will make additional enquiries to satisfy themselves that such matters are being dealt with appropriately by the relevant authorities and in line with statutory requirements.[7] In circumstances where inspectors remain concerned that children and young people are not safeguarded, or are at risk of harm, Ofsted and/or CQC will consider whether it is appropriate to take further action. This could include, where appropriate, inspectors referring individual children's and young people's cases to the local authority or inspection of the individual service or provider in line with Ofsted's or CQC's statutory and regulatory duties and powers.

13. The starting point for inspection is the expectation that the local area should have a good understanding of how effective it is. Leaders[8] for the local area should be able to accurately assess how well the local area meets its responsibilities. Leaders should have an understanding of strengths and aspects that require

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[6] Services will include specialist support and therapies, such as clinical treatments and delivery of medications, speech and language therapy, assistive technology, personal care (or access to it), Child and Adolescent Mental Health Services (CAMHS) support, occupational therapy, habilitation training, physiotherapy, a range of nursing support, specialist equipment, wheelchairs and continence supplies and also emergency provision. They could include highly specialist services needed by only a small number of children. Social care services include childcare, leisure activities, support for young people when moving between social care children services and social care adult services, and support for young people in living independently and participating fully in society.

[7] 'Keeping children safe in education', Department for Education, 2015; www.gov.uk/government/publications/keeping-children-safe-in-education--2, and 'Working together to safeguard children'; www.gov.uk/government/publications/working-together-to-safeguard-children--2.

[8] The term 'leaders' refers to those responsible for the strategic planning, commissioning, management, delivery and evaluation of services to children and young people with special educational needs and/or disabilities.

further development. Inspectors will test out the accuracy of this understanding during the inspection as they make their evaluation.

Legislative basis for inspection

14. Local area inspections of responsibilities for children and young people with special educational needs and/or disabilities are carried out under section 20 of the Children Act 2004.[9] This section enables Ofsted and CQC to undertake joint inspections of each local area in accordance with a timetable approved by the Secretary of State for Education.

15. Further, 'The Children Act 2004 (Joint Area Reviews) Regulations 2015'[10] require that:

> 'The Chief Inspector of Education, Children Services and Skills must (having regard in particular to the nature of the review):
>
> (a) determine whether it is appropriate for a written statement of proposed action to be made in light of the report; and
>
> (b) if so, determine the person or body ("the principal authority") who must make this statement.'

16. Where Her Majesty's Chief Inspector (HMCI) has determined that a written statement of action is required, the local area must produce this statement within 70 days following receipt of the final inspection report/letter, publish it on local websites and send a copy to Ofsted, CQC and the Secretary of State.[11]

17. Subject to HMCI's determination, a written statement is likely to be required where inspectors identify significant concerns in relation to one of the following:

- illegal practice
- failure to meet the duties under the Act.[12]

18. On receipt of the written statement of action, HMI will assess whether the statement is fit for purpose and the relevant Ofsted Regional Director will write to the local area to communicate this assessment. Where HMI assess that the written statement is not fit for purpose, they will make recommendations about how the statement needs to improve. The local area should then make appropriate changes and republish the written statement of action.

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[9] Children Act 2004, section 20; www.legislation.gov.uk/ukpga/2004/31/section/20.
[10] Regulations 3(3)(a) and (b); www.legislation.gov.uk/uksi/2015/1792/regulation/3/made.
[11] Regulation 4(5); www.legislation.gov.uk/uksi/2015/1792/regulation/4/made.
[12] Inspectors will use their professional judgement to assess whether the overall evidence gathered causes them sufficient concern to recommend that a written statement of action be produced.

Post-inspection

19. Inspections are intended to be constructive for local areas as well as hold them to account. Where a written statement of action is required, the DfE, working with the DoH and NHS England where relevant, will seek to engage closely with the local area to provide appropriate challenge and support to bring about the necessary improvements identified by the inspection. After a period of time, usually around 12 months after the publication of the inspection report, the DfE will advise the Minister on progress made in delivering the improvements. In exceptional circumstances, this may include a recommendation to Ministers that the local area for a further inspection by Ofsted and CQC. Under section 20(1) of the Children Act 2004, Ofsted and CQC must inspect a local area when requested to do so by the Secretary of State for Education, in accordance with the terms specified in that request. Annex A to the inspection handbook outlines the post-inspection support and challenge arrangements.

How local areas are selected for inspection

20. All local areas will be inspected at least once during a five-year period. As set out above, the Secretary of State retains the power to request further inspection activity in a specific local area following the initial inspection. Selection of local areas to be inspected in a given year will endeavour to ensure a spread across the country and will, wherever possible, take account of the timing of other Ofsted and CQC inspection activity to avoid undue burden being placed on local areas.

21. Ofsted and CQC will ensure that scheduling of inspections retains flexibility. Where evidence suggests that there are concerns about a local area, the schedule can be adapted and that local area may be inspected earlier than might have been the case otherwise. This may occur where Ofsted or CQC have significant concerns about how well an area is fulfilling its responsibilities, including, but not exhaustively, in relation to:

    - the academic achievement of relevant children and young people over time, taking account of both attainment and progress
    - rates of attendance and exclusion for relevant children and young people
    - the destinations of relevant children and young people including data for young people not in education, employment or training (NEET)
    - the outcomes of any inspections of local authorities and of educational establishments, and health services carried out by Ofsted or CQC
    - complaints received about providers or services that are regulated or inspected by CQC and/or Ofsted
    - local area performance in the completion of assessments and the making of education, health and care plans within the statutory timescales

- rates of appeal to the First-Tier Tribunal (Health Education and Social Care Chamber)
- any other significant and relevant concerns that are brought to Ofsted's and/or CQC's attention.

The focus of inspection

22. Inspectors will consider how effectively the local area identifies, meets the needs of and improves the outcomes of the wide range of different groups[13] of children and young people who have special educational needs and/or disabilities as defined in the Act and described in the Code of Practice.

23. The inspection will focus on the contribution of education, social care and health services to children and young people with special educational needs and/or disabilities, as set out in the Act, the Regulations and the Code of Practice.

Reporting on the inspection outcomes

24. The outcomes of the inspection will be reported in a letter and the judgements will be in narrative form. The letter will outline areas of strength and key priorities for improvement. It will be published on the Ofsted and CQC websites, usually within 33 days of the end of an inspection.

25. The inspection of the local area will cover and report on the following key aspects in arriving at a judgement about the effectiveness of the local area:

    - the effectiveness of the local area in identifying children and young people who have special educational needs and/or disabilities
    - the effectiveness of the local area in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities
    - the effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities.

26. In reaching their judgements, inspectors, in line with the requirements of the Code of Practice*,* will pay particular attention to:

    - the accuracy and rigour of the local area's self-evaluation,[14] the extent to which the local area knows its strengths and weaknesses, and what it

[13] These groups of children and young people are detailed in Part 2 of the 'Handbook for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities'.

[14] It is important to note that Ofsted and CQC do not require self-evaluation to be provided in a specific format. Any assessment that is provided should be part of the local agencies' business processes and not generated solely for inspection purposes.

needs to do further to improve the life chances of children and young people with special educational needs and/or disabilities

- to what extent the outcomes for children and young people are improving as a result of the collective actions and support of local agencies and bodies
- the efficiency of identification of special educational needs and disabilities
- the timeliness and usefulness of assessment
- how well local agencies and bodies plan and coordinate their work to assess need and provide necessary effective support
- how well the local area engages with children and young people, and their parents and carers, to inform decisions about the strategic commissioning of services (joint strategic needs assessment)
- how well the local area involves the individual child or young person, and their parents and carers, in the process of assessing their needs
- how well the local area communicates with children and young people, and their parents or carers, to ensure that these primary users are clear about the identification and assessment processes and the criteria used to make decisions
- the extent to which the local area gives due regard to its duties under the Equality Act 2010 to children and young people with special educational needs and/or disabilities.

27. Please see the inspection handbook for more detail on how the inspection is conducted and the range of evidence that will be considered by inspectors and that will underpin the inspection findings.

Composition of the inspection team

28. The inspection team will be led by an HMI from Ofsted and will include a Children's Services Inspector from the CQC, and an Ofsted Inspector (OI) usually recruited from a local authority but without connection to the local area being inspected.

29. The OI will have: specialist knowledge of disability and special educational needs; a thorough understanding of local area structures and strategic delivery of services; and a health, social care or education background. CQC may, on occasion, allocate more than one inspector to the inspection of the local area. The complexity of the local health economy will be an important consideration. The decision on whether to deploy more than one CQC inspector will be based on a number of risk factors, including, but not restricted to, the number of NHS providers, the geographical area and the number of CCGs.

Conduct during inspection

30. Inspectors must uphold the highest professional standards in their work and treat everyone they encounter during inspections fairly, and with respect and sensitivity.

31. Inspectors will:

- evaluate objectively, be impartial and inspect without fear or favour
- uphold and demonstrate Ofsted and CQC values at all times
- evaluate provision in line with frameworks, national standards or regulatory requirements
- base all evaluations on clear and robust evidence
- declare all actual and perceived conflicts of interest and have no real or perceived connection with the provider that could undermine objectivity
- report honestly and clearly, ensuring that judgements are fair and reliable
- carry out their work with integrity, treating all those they meet with courtesy, respect and sensitivity
- take all reasonable steps to prevent undue anxiety and minimise stress
- act in the best interests of service users, prioritising the safeguarding and well-being of children and learners at all times
- maintain purposeful and productive dialogue with those being inspected and communicate judgements sensitively, but clearly and frankly
- respect the confidentiality of information, particularly about individuals and their work
- respond appropriately to reasonable requests
- take prompt and appropriate action on any safeguarding or health and safety issues
- use their title of HMI, Ofsted Inspector or CQC inspector only in relation to their work as inspectors.
- make reasonable adjustments in order to communicate with children and young people and adults with disabilities in line with the Equalities Act 2010.

Expectations of local areas and providers

32. It is important that inspectors, the nominated officer for the local area and staff from agencies and providers establish and maintain a positive working relationship. Ofsted and CQC expect providers to:

- be courteous and professional, treating inspectors with respect and sensitivity

- apply their own codes of conduct in their dealings with inspectors
- enable inspectors to conduct their visit in an open and honest way
- enable inspectors to evaluate the provision objectively against the frameworks, standards or regulatory requirements
- provide evidence that will enable the inspector to report honestly, fairly and reliably about their provision
- work with inspectors to minimise disruption, stress and bureaucracy
- ensure the good health and safety of inspectors while on their premises
- maintain a purposeful dialogue with the inspection team
- draw any concerns about the inspection to the attention of inspectors promptly and in a suitable manner
- recognise that, sometimes, inspectors will need to observe practice and talk to staff and users without the presence of a manager or registered person.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

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BARNSLEY
Metropolitan Borough Council

SEND Improvement Plan 2018-2020

This plan provides an overview of activities to be undertaken to achieve quality improvement in the areas identified as the most important priorities for improvement in SEND Local Area arrangements. These priorities have been selected on the basis of performance data; feedback from service users, and because improvement in these areas are considered fundamental to improving experiences and outcomes for children and young people with SEND, and for their families

RAG STATUS
Activities delivered and evidence of impact
Activity on Track
Activity begun but not yet complete or task extended to include increased activity
Activity not begun and out of timescale

Success criteria can be articulated at 3 levels

1. Securing engagement and support (e.g. Partners participating in training, schools using recommended support plan)
2. Securing demonstrable changes in practice (e.g. exclusions of SEND support pupils reduce)
3. Impact on children and young people's progress and outcomes

The implementation of the plan is **monitored** through tracking actions. The effectiveness of the plan is **evaluated** against the success criteria, particularly in relation to changes in quality of practice or provision, and the impact on children/young people's outcomes
Oversight and accountability of the Improvement Plan resides with the SEND Oversight Board who ensures progress is made through check and challenge.

BARNSLEY SEND IMPROVEMENT PROGRAMME

	Early Identification and Support for SEND	Education, Health and Care Plans (EHCPs)	Participation & Co-production	Specialist Provision and Services	Pathways to Adulthood
AIMS	We will work with early years settings, schools and universal health providers to get better at identifying and meeting children's additional needs as early as possible	Where an Education Health and Care Plan is needed, we will improve the planning process so that children, young people, their parents/carers have a better experience and are confident the plan meets their needs	We will create more opportunities for children, young people, parents and carers to contribute to and co-produce strategies and planning for SEND Local Area arrangements	We will develop special education provision locally so more children can be educated within Barnsley We will improve access to specialist health and therapy services	We will develop better pathways to adulthood so that young people's voice, needs and ambitions are the primary focus, and they have access to timely and co-ordinated advice, support and service to enable them to plan for the future
ACTIONS	Review and develop effectiveness of mandated universal checks in identifying needs Develop the capacity of early years, childcare and health providers to identify and meet SEN in children under 5 years old Develop the capacity of primary and secondary schools in identifying and meeting SEN	Revise EHCP process so that children and young people are at the centre; decision-making is timely and informed, and communication is regular and more personal Improve integrative working across health, education and social care with better measurable outcomes for pre-emptive planning especially for early years and post 19	Develop new local arrangements to enable participation and co-production with young people, parents and carers Develop a consultation strategy and networks for young people with SEND Undertake a co-production exercise to capture 'what it is like to live in Barnsley with a learning disability' engaging with young people and their families	Revise SEND sufficiency strategy and implementation plan based on analysis and projection of need Develop SEND commissioner arrangements Review and improve pathways for children's therapy services; ASD, paediatric services and CAMHS Reduce access and waiting times for children's therapy services	Work with young people, parents and carers to identify priorities and plan for improvement Raise aspirations and increase opportunities for young people Enable young people to articulate their ambitions and to develop the skills that will support progress into employment Improve transition planning
IMPACT	All children identified at the earliest opportunity, appropriate support offered and plans in place Better understanding of local need and improved workforce skills Reduced exclusions in primary and secondary mainstream schools	Professional input is relevant and purposeful to meet identified need Each child has detailed and pre-emptive planning and progress mapped by multiagency teams around them Timely, fair and consistent service outcomes	Young people feel they are actively engaged in decision making and their planning arrangements Parents/carers are empowered to better understand and meet the needs of their children Families continue to engage in steering the development of transition pathways	Commissioning capacity increased to support sufficiency planning and delivery All young people with EHCP's are allocated places Needs data linked to Joint Strategic Needs Assessment (JSNA) and used to support provision planning	Young people and families feel they have influenced and shaped service delivery. Increased numbers of learners with EHCP age 16-24 participating in supported internships Increased employment opportunities
PROGRESS	SEND Early Yeas PVI inclusion audit complete Area EY SENCO delivering training to settings Primary SENCO champions recruited, school support plan developed	EHC Plan Quality Assurance Toolkit developed and trialled New EHC Plan template crafted and launched Vulnerability matrix (Annex A) developed, soft release Sept 19	Young Persons Participation officer recruited Consultation sessions with young people complete Parent/carer workshops and co-production event planned	First draft of SEND forecasting tool developed with data and insights informing JSNA Additional Ed Psych and specialist Early Years capacity established Additional school places created	Preparation for adulthood event held with young people

ENABLERS

- Ensure the Local Offer meets all requirements and provides relevant information which supports young people, parents/carers and professionals independently accessing support, services and provision
- Implement robust performance management to ensure that young people with SEND are receiving the support needed and the most vulnerable children are being identified
- Establish information management systems which support efficient and effective case management, including appropriate information sharing across agencies
- Ensure professionals across all relevant services have access to and engage in continuous professional development which supports them in identifying and meeting the needs of children and young people with SEND, in line with the code of

VALUE FOR MONEY AND FINANCIAL BALANCE

PRIORITY 1: Early Identification and Support	**We will work with early years settings, schools and universal health providers to get better at identifying and meeting children's additional needs as early as possible**			
OBJECTIVE 1.1	**Review and develop effectiveness of mandated universal checks/screening in identifying needs**			
Overall Progress:	**Green**	**Owner:**	**Alicia Marcroft**	
Actions		**By who?**	**Timescale**	**Progress**
Establish an audit process in relation to completion and quality of both health and education 2 year checks including integrated assessments 03/12/19 - SystmOne template has been developed for 2-2.5yr review. Inclusion in this is ASQ scores which is now enabling identification of children not meeting the developmental milestones. Next step is to launch this within the service which will enable development of the audit process. Joint session with Lisa has taken place to work jointly on it's implementation. Request to move the date on to Jan 2020? 05/12/19 (LH) - Audit process already in place in respect of both quality and the content and identification of children who may need additional support		Tracy Letchford Lisa Bosson	Jan 20*	Green
Develop and implement E-form for 2 year old checks to improve efficiency and information sharing by early years providers 05/11/19 - this work will still happen if the e-form isn't implemented, however it is less efficient. An indication from IT regarding capacity to support and deliver is needed 22/11/19 - work is still ongoing with digital services (LL) 03/12/19 - we are worried about this action being completed on time. This action is reliant on IT support to complete. suggest we take an alternative approach which would be to explore the possibility of using an extranet site on SharePoint as the portal 05/12/19 (LH) - Digital team have stated no further work can't take place due to the election - planning to be reviewed in January and to discuss the SharePoint option as an alternative to the e-form which has now been deemed as having limited functions and unable to meet the need		Lisa Bosson	Jan-20	Green
To investigate the gap between national data and Barnsley in relation to the number of young children with EHCP's pre school 17/11/19 - this is being investigated. Laura to improve this action to be a bit more descriptive. Also there is a new follow on action from this - Laura to add this in 08/01/20 - Work is underway to between ESFS and EHCP team to explore this in more detail and actions have been added elsewhere in the plan relating to inclusion grant as it is believed that this relates to early years providers accessing the early years inclusion grant to address the need rather than applying for EHCP		Melanie Szoke	Jan-20	Green
Revision of parent carer consent following advice from Information Governance to be actioned in relation to the termly audit data sharing including data impact assessment being undertaken 08/01/20 (LH) - New consent agreed with IG and DPIA completed and added to register new paperwork being shared with settings		Lisa Bosson	Jan-20	Green
Improve systems for tracking numbers and outcomes of integrated checks (e.g. onward referrals to service) across 0-19 PHNS, Early Years and SEND 03/12/19 - Lisa Bosson is working with Rob Priest to make arrangements for tracking numbers. Work is on track for completion by Mar 20. Work is also taking place to develop the template within SystmOne which will capture data around onward referrals enabling tracking of outcomes from integrated reviews. 08/01/20 (LH) Meeting is scheduled with Rob Priest and Lisa Bosson to progress this		Tracy Letchford Lisa Bosson	Mar-20	Green
Evaluate the quality and impact of ASQ assessments 03/12/19 - ASQ scores are being inputted into SystmOne recording system enabling reporting to be produced which is informing the ASQ assessment outcomes. This will now enable evaluation of quality and impact to be carried out		Tracy Letchford	Mar-20	Green
Undertake an audit on eligible 2-2.5 year olds to establish if integrated review has taken place and to expected quality standards 03/12/19 - action reliant on the template being produced which is on track		Tracy Letchford Sam Tingle	Mar-20	Green
Improve systems within BMBC for known SEND and EHCP to be shared with 0-19 health, linking this into the Vulnerability Matrix		Tracy Letchford Sara Barnett	Mar-20	Green

Success Criteria (Impact)
All children who require an Integrated 2 year assessment receive one and have an action plan in place
All children with additional need are identified at the earliest opportunity and appropriate support offered and action plans in place
Shared understanding of a child's needs and the provision needed
Children making progress against plan outcomes or age/stage appropriate expectations
E-Form in place and in use by settings. Information is gathered in an efficient and effective manner (potentially SharePoint extranet site) to meet needs and reduce lag between collection and analysis
ASQ data identifies children early with appropriate action being taken in a timely manner
Improved joint working with early years and health leading to early identification and action planning for 2-2.5yr olds
Update on Progress and Impact
SystmOne is now able to generate quarterly data to identify children who have had an integrated review. This report is being analysed by PHNS and a programme of audits is currently being planned. All children who receive an integrated review and action plan. A process has now been developed which clearly provides an escalation route should the plan be reviewed at 8 weeks and have no demonstrable progress - the protocol would now move these children onto the SEND provision planner.
Currently reviewing system in place in North Lincs in relation to information sharing for children who flag as delayed on TY Assessment with SEND/EHCP team. Termly audit report will be available based on Summer term data by End October 2019
SystmOne has undergone development to improve recording of ASQ scores which can be used to highlight children who are below expected development, this can aid audit process to early identify children and that appropriate support has been offered and plans in place
Audit on children previously flagged as delayed within a TY check will be followed up and contained with the termly audit report. EYFS data analysis will be undertaken with children with emerging across the board, to establish whether this data is as expected due to summer born children or an early flag for delay.
Meeting has been held with Digital Hub team and Lisa Bosson, and an e-form is under development with the expectation that this will be piloted in October with a view to implementation from January 2020.
SystmOne template is in development to be able to capture data of outcomes of integrated reviews such as onward referrals
Meeting with Lisa Bosson 14.10.19 to look at a cross sectional sample of health reviews and progress checks where children identified as being below expected development. This identified a need to improve timeliness of progress checks being shared to ensure shared understanding of need at the earliest opportunity
Working party of Child Development Practitioners has been established to meet termly as a means of identifying examples of best practice, develop opportunities for peer learning and support, problem solving
Evidence

Review of tailored plans (assess, plan, do, review) (JP?) - discuss with Jo this may be captured on another plan now	Termly 2 1/2 yr report and any relevant feedback from parents, professionals and other agencies (LB Jan 20)	Report of analysis of EHCP's rate in early years (MS Jan 20)
Audit report of 2yr integrated reviews (TL Mar 20)	EYFS Data (AS Dec 19)	Map of new process (LH Jan 20)
Rainbow Report (ST) - also for Perf Mgnt	ASQ Data (TL Mar 20)	Outcomes Report of 37 children (ST) - also for Perf Mgnt

PRIORITY 1: Early Identification and Support	**We will work with early years settings, schools and universal health providers to get better at identifying and meeting children's additional needs as early as possible**			
OBJECTIVE 1.2	**Develop the capacity of early years, childcare and health providers to identify and meet special educational needs in children under 5 years old**			
Overall Progress:	**Green**	**Owner:**	**Laura Hammerton**	
Actions		**By who?**	**Timescale**	**Progress**
Current Early Years Inclusion Grant to be further developed to bring in line with the schools provision map/planner that has recently been implemented enabling a smooth transition from grant to EHCP where required		Melanie Szoke	31/03/2020	Green
Support settings with good or outstanding outcomes where SEND has been a factor to provide peer support to other settings		Melanie Szoke	Apr-20	Green
Undertake a review of the early years transition guidance process and documentation to ensure it is still fit for purpose		Sam Tingle	Sep-20	Green
Provide an Early Years Inclusion Grant funded via Early Education Funding to settings to support them in meeting the needs of children with SEND 05/11/19 - 69 Children funded in the Summer Term with a further 30 in the Autumn Term therefore 99 children supported via the grant so far this year. 08/01/20 (LH) - Propose this is changed to annual report to be produced reporting on numbers of applications to inclusion grant and allocations agreed		Melanie Szoke	Monthly	Green
Success Criteria (Impact)				
Fund is maintained to meet needs of children with additional needs who require additional support to access their early education entitlement.				
Increased take up of 2 year old early education for children in receipt of DLA				
Annual training needs assessment is complete with SENCOs in all settings and childminders (excluding schools)				
25 early years SENCO's in Barnsley have a SENCO qualification 08/01/20 (LH) Should there be an action relating to this?				
SEND inclusion audit completed with every PVI and family centre SENCO, and an action plan for each setting co-constructed with the EY Area SENCO for the setting to identify strengths and areas for development 08/01/20 (LH) Should there be an action relating to this?				
Early years needs analysis and early years focussed plans developed with EY SENCOs to implement in EY settings to ensure children with SEND will have their needs identified and met at the earliest opportunity				
Better understanding of local need in relation to SLCN and the skills of the workforce 08/01/20 (LH) Should there be an action relating to this? Is this relating to the EOF and PDF work that is being undertaken?				
Early years sector led support arrangements in place, leading to improved practice and outcomes				
Update on Progress and Impact				
98 children supported in 2018/19 compared with 64 in 2017/18				
66% Summer Term 2018; 67% Autumn Term 2018; 67% Spring term 2019				
Completed in Autumn 2018 and as a result passport to inclusion training is being relaunched to provide a framework for all SEND related training for individual practitioners				
50% of the course completed with the remaining to be done by the end of the year				
All PVI and family centre setting has carried out an audit. All settings now have the action plan				
Bid complete, project plan complete, workforce development and identification underway which is multi agency. (CG) 29/08/19 majority of staff in Family Centres/Early Start and Families Service have undertaken an SLCN self assessment to baseline their current skills, knowledge and understanding/confidence levels. ELKLAN (0-3yrs) training programme has commenced within Family centres over the summer and by December 2019 all Family centres will have a Communication Lead practitioner. December 2019-Sept 2020 will see the roll out of ELKAN training to the entire staff teams within Family centres, following which the 6 sites will be awarded the status of Communication Friendly settings. EY Professional Dev Fund - By the end of Sept 2019, 8 language champions will be identified in schools and settings alongside at least 20 target schools and settings who will also receive the ELKLAN 3-5yrs training and maths training.				
New application process for the Early Years Inclusion Grant in place and is now being used by settings. Workshop being undertaken with settings to help them with the new process (MS)				
EYFS Transition Guidance document shared with all Head Teachers and all EYFS practitioners in all settings and schools. Summer term EYFS meetings had a focus on transition and the guidance documents.				
Evidence				
Early Years Settings Ofsted reports with SEN comments (April 19, Sept 19) (MS 19)	KPI - Percentage of children eligible in early education (AS Jan 20)	Training needs analysis annual report for Early Years Sector (MS May 20) - move to workforce dev plan		
SENCO qualification certificates, list of staff completed - replace with a qual tracker EY LH (schools BB)	SYEOP Oct Project update (CG)	Early Years needs analysis improvement plan template (LH Dec 19)		
Perf Report on how many children with SEN's are supported through inclusion grant (LH Jan 20)	Early Years Transition (Guidance, Introduction Summary Record) (ST)	Early Years Transition Guidance Review, findings and recommendations paper (ST Sept 20)		
Early Years Inclusion Grant Parent or Carer Consent Form (MS Jan 20)	Early Years Inclusion Grant Application Form (MS)			

PRIORITY 1: Early Identification and Support	**We will work with settings, schools, post 16 providers and universal health providers to get better at identifying and meeting children and young peoples additional needs as early as possible**			
OBJECTIVE 1.3	**Develop the capacity of primary and secondary mainstream schools in identifying and meeting the needs of children and young people with special educational needs**			
Overall Progress:	**Amber**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Recruit Inclusion Development SENCo to provide advice, guidance and training to schools 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Judith Nash	May-19	Complete
Establish working party with schools to test quality of guidance, toolkits, training etc. 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Judith Nash	Jun-19	Complete
Continue to provide generic training programme for SEND legislation and area specific information relating to SEN support within schools 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Judith Nash	Sep-19	Complete
Develop set of criteria to identify schools causing concern in relation to SEND practice/provision and incorporate into main school categorisation system 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Judith Nash	Oct 19*	Complete
Recruit to Educational Psychologists to build capacity within the service to enable schools to identify and meet needs of children with SEND 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Richard Lynch	Apr-20	Complete
SEND support ratings for schools data to be compiled and used to highlight schools requiring tailored support and those with outstanding practice managing inclusion. Risk Analysis to be added to bespoke training package 13/01/20 - report going to oversight board on Monday 20/01, includes outcome of rating		Angela Stephens Bev Bradley Richard Lynch	Dec-19	Complete
Improve data collection and subsequent reports to examine and reduce exclusions for children with SEND 07/10/19 - an audit has been completed with JN needs to discuss with Sarah Sinclair to ensure co-ordinated approach 17/12/19 - Richard requested meeting with Bev, Jo and Naomi in the new year to take this forward. Plan to have this ready by Jan 20		Richard Lynch	Dec-19	Green
Provide inclusion toolkit to schools to support graduated response 14/11/19 - toolkit discussed at 22/10/19 JPG, feedback / comments being collected from the partnership to further enhance the inclusion toolkit. Toolkit to be fully signed off by Dec 19 (JN) 08/01/20 - SENCO working party group meeting to review progress so far on the framework. Stakeholders including parents of SEN Support children to be part of the review and progress updates. Early years work coming through during February. Draft 6 -		Bev Bradley	Mar 20*	Green
Champion SENCO Reviews of SEN Provision and Practice in mainstream schools to develop confidence and capacity in early identification, and challenge practice where needed, as a result of this review implement bespoke training packages where needed for schools 14/11/19 - work is ongoing, school SENCO forum and working party established and record of visit being collected and used (JN) 17/12/19 - action needs to be more specific, speak to Sharon and Bev		Judith Nash	Sep 19 - June 20	Green
Educational Psychologists to develop Inclusion Support Planning tools and processes to enable schools to meet the needs of children at risk of exclusion 17/12/19 - Jo P to make this action more specific		Joanne Patterson Naomi Robinson	Jun-20	Green
Following the analysis of schools submission data and the SEND schools risk analysis data, inclusion SENCO's to create and deliver a bespoke training package to enhance quality and appropriateness of EHC applications 26/11/19 - the data is expected this week in order to be able to start this work 17/12/19 - action needs to be more specific, Bev and Hannah to do this		Bev Bradley	Jul-20	Green
Inclusion SENCO's to create and deliver a bespoke training package to enhance quality and appropriateness of EHC applications		Bev Bradley	TBC	Green

Success Criteria (Impact)		
All schools engage in revised processes and access training where required		
SENCO Networks re-established and schools engage		
Schools supported by Inclusion Development SENCO to manage the needs of most children within Quality First teaching using the inclusion toolkit		
Children at risk of exclusion have a plan to identify and meet need		
Fair Access Panel (FAP) have robust data and information to inform decision making process		
Staff in schools have a pupil centred process and outcome focussed inclusion support plan for identifying and meeting needs of C/YP at risk of exclusion.		
Schools following a robust graduated approach before applying for needs assessment		
Schools are supported to look at alternatives to exclusion and the new SENCOS will work with schools to identify children at risk		
Update on Progress and Impact		
93% of schools have completed group training; over 80% have individual school training. Will need embedding in practice. Primary school engagement stronger		
SENCOs identified to support implementation of Peer Reviews, analysis of trend etc.		
Inclusion Development SENCO recruited and will fill minimum 5 days full time equivalent from Sep 2019 funded by Barnsley Alliance		
Inclusion Support Planning training programme underway and now being offered to pastoral teams in Barnsley secondary schools		
FAP protocols being reviewed by Dec 19		
Alliance approved strategy subject to change re aspiration - to cabinet 13th Nov		
EHC analysis of applications complete, and is now being used to implement more specific training Borough wide		
Evidence		
School SEND Risk Assessment Tool (JN)	Inclusion Toolkit (Bev Bradley Feb 20) (also for 1.4)	Inclusion Development SENCO Action Plan
School Focus Plan document and supporting tools (JN)	Schools Support Ratings Summary (RL Jan 20)	2018/19 Exclusions Summary Report
Schools training and attendance tracker 18/19 (HG/BB Oct 19)	Schools training and attendance tracker 19/20 (Bev Bradley Nov 19) also for 1.4	Report on School Submissions for EHC Application (BB Nov 19)
Alliance Strategy (RL Nov 19) - talk to Kirsty	Report on Exclusions re SEND pupils (AS Jan 20)	

PRIORITY 1: Early Identification and Support	**Develop a strong borough wide inclusion agenda focusing on quality first teaching to meet the needs of all learners with best practice adapted and modified provision at the earliest opportunity.**			
OBJECTIVE	**Develop confidence and capacity of inclusive practice for all pupils within Barnsley settings.**			
Overall Progress:	**Amber**	**Owner:**	**Judith Nash**	
Actions		**By who?**	**Timescale**	**Progress**
Create SENCo networks known as SENnets with limited number of SENCOs in attendance (8 - 10) where key information and approaches will be introduced. Use the SEND risk assessment to identify key areas of development and promote this within small scale SENnet training 26/11/19 - SENnets training packages have been distributed to schools to book onto the sessions. Once risk assessments have been completed key areas can be identified 17/12/19 - this is complete and duplicated in another plan		Bev Bradley	Jan-20	Green
Good practice statements and audit for pupils transitioning through across phases who have additional needs but not necessary identified at SEN support. Ensure safeguarding and sharing of information		Lyn Dixon	Jan-20	Green
Use new OFSTED framework to identify key standards within inclusive teaching. Hold training event Steps to OFSTED success with supplementary handout including support during inspections 26/11/19 - work has not started on this action, request to move date on to Feb?		Bev Bradley	Jan-20	Green
Promote understanding and value of QFT and Inclusion Agenda with all in service stakeholders(social care and health care) through cross team training event 26/11/19 - first QFT and provision mapping training has taken place today, service professionals and ECP co-ordinators were in attendance 04/12/19 - QFT and provision mapping training delivered to SENCOs and other professionals during SENCO Network meting. 12/12/19 - Provision mapping training giving at SENNETS meeting. Bespoke training given on a personal level to meet training needs. 28/01/20 - BB to meet with SENDIASS to deliver provision map training.		Bev Bradley	Feb-20	Green
Design and distribute an Inclusion Toolkit to specify guidance on early identification/intervention. This framework will have a specific area focusing on element 1/2 and all four areas of need. This will be a coproduced document from all service professionals 26/11/19 - work is in progress, the toolkit has been distributed to professionals for feedback and input as part of co-production		Bev Bradley	Feb-20	Green
Write a 'what works' document for inclusion within SEN Inclusion Toolkit which is given to all mainstream schools, identifying well founded interventions to be used with QFT (Tried and Tested) 26/11/19 - this is being included into the inclusion toolkit, work is progressing. a series of bring and share sessions are being held to support this work 08/01/20 - BB to work with other professionals to include well - evidenced interventions in the support sections of the Inclusion framework - These meetings have not been finalised but invites have gone out. (BB)		Bev Bradley	Feb-20	Green
Inclusion Development team to work with all SENCOS and settings to promote and use best endeavours from within element 1 and 2. To enhance understanding about low and rising support areas from within universal approaches at early graduated response. This will be through 1-1 sessions, whole school training and SENCO networks.(SENnet)		Bev Bradley	Mar-20	Green
Develop Inclusion Agenda through whole school INSET and QFT training events promoting quality first teaching and inclusive practices. Develop understanding of a provision model of support rather than needs and diagnosis led 20/11/19 - Talk to Bev about changing this action so it is about needs led - query from Sarah Sinclair 08/01/20 - NEW ACTION - Develop Inclusion Agenda through whole school INSET, Twilight and training events promoting quality first teaching and inclusive practices. Develop understanding of a provision led model based on needs of support rather than diagnosis led 08/01/20 - BB has already led on 5 twilights last term and also trained on SENCO cluster meetings. Very positive		Bev Bradley	Jul-20	Green
Create new model of SEN support funding known as the Inclusion Development Fund, which promotes shared support within settings and enhances best endeavours for all children. Designed new application form, criteria and overview and decision making. Monitor this through a robust review process		Bev Bradley	Jul-20	Green
Key messages following the graduated response to be shared throughout all Inclusion SENDCo visits and SENnets 17/12/19 - move this into the progress section 08/01/20 - ongoing and key messages are being given consistently.		Bev Bradley	Jul-20	Green
Deliver London Leadership Reviews of SEND practice across identified schools 17/12/19 - remove this action as on previous tab - owner is Sharon		Richard Lynch	Jul-20	Green
SENCO satisfaction survey to capture success of Inclusion Development team and areas still needed for training and support. To be given out at every SENCO forum 08/01/20 - BB has created a 1 page profile style document and sent to every SENCO to discover strengths and areas for development, background information, training strengths and needs moving forwards. Around a quarter have been sent back and have been welcomed by SENCOs. 08/01/20 - All training events have attendance registers and feedback forms to determine how the training was received.		Bev Bradley	Dec-20	Green

Success Criteria (Impact)		
Settings have a clear view of what constitutes Quality First Teaching and how this embeds inclusivity.		
Children have needs identified and met at an earlier point, thus reducing the level escalating to SEN Support and EHC level.		
Settings have proactive resources and provision that targets whole school inclusivity, not just higher levels of needs (e.g. SEN support).		
Transitions between key stages and phases are more robustly supported, with stronger consistency for children and young people in their education journey.		
Every school adapts a holistic inclusive approach which meets of all learners within the setting regardless of need and background		
There is a common borough wide shared understanding of the Inclusion Agenda and every teacher in every school accepts accountability of SEND provision within their class		
Evidence based LL model of peer reviews promotes learning and delivers sector led improvement in SEND practice		
SENCO have further knowledge of the SEND system and documents relating to SEN support and the EHCP process, the graduated response in schools is robust and consistent		
Schools have a broad knowledge of the new inspection framework and how this impacts on SEND in Barnsley schools		
Service professionals and the EHC team have a broad knowledge of quality first teaching and provision maps		
Update on Progress and Impact		
Inclusion Development SENDCos have quality first teaching audit available to share and discuss with colleagues during visits.		
A training package is currently being devised to support schools with meeting pupil's needs with whole-school quality first provision.		
Some settings are already seeing that some of their children, who have historically been categorised as SEND support do not need to be, thus their SEND register is decreasing but the children's needs are still being met.		
Schools procedures are becoming tighter and quality of provision is being enhanced by ongoing training. There is a developing whole school awareness		
SENCOs have a better understanding of provision mapping and higher skills and confidence levels to manage all children within their settings. SENCOs are upskilled to deliver best practice within their own settings		
Some settings are trying to implement early support for all children and not just targeting their more complex children.		
The inclusion toolkit is developing and will be ready for publishing in February 2020. There have been cross team and multi professional input to enhance quality and use		
Evidence		
SEND Provision map (BB)	ROV (Record of Visits) to schools (BB Dec 19)	Inclusion Toolkit (BB Feb 20) (also for 1.3)
Schools training and attendance tracker 19/20 (BB Nov 19) also for 1.3	Outcome of London Leadership Review summary report (RL Sept 20)	Inclusion development fund, criteria and application form BB)
EHC Training Co-ordinators Manual - Best practice statement for key transitions page (SB Jan 20)	Inclusion development fund, tracker and evaluation (BB July 20)	SENCO satisfaction survey (BB Dec 20)
SENnet meeting minutes (BB Dec 19)	Quality First Audit Tool (BB Nov 19)	

PRIORITY 2: Education, Health and Care Plans (EHCPs)	**To meet all statutory duties for the annual review process**			
OBJECTIVE 2.1	**All annual review processes will be managed accurately and in a timely manner resulting in EHC plans which are purposeful and relevant to the child or young person**			
Overall Progress:	**Green**	**Owner:**	**Judith Nash**	
Actions		**By who?**	**Timescale**	**Progress**
Include annual review training within the EHC induction and manual so that the EHC team are aware of their statutory duties and can respond appropriately		Judith Nash	Dec-19	Green
Create a temporary purposeful annual review team to tackle the backlog and ensure timely delivery of all annual reviews until August 2020		Judith Nash	Dec-19	Green
Ensure all out of borough annual reviews are attended by a senior EHC member, to look at appropriates and value of current placement. Use OOB planning report to identify children with potential to move back to in borough placement 18/12/19 - children identified and parents contacted by Senior Coordinators. Awaiting follow up meeting with Helen Perrin that was cancelled before Christmas. (SB)		Sara Barnett	Dec-19	Green
Ensure attendance at all annual reviews by a local authority representative, ensure EHC team member at all year 6 and year 11 reviews		Sara Barnett	Dec-19	Green
Transparent, equitable and robust decision making process in place which ensure timely delivery of annual reviews and subsequent plans.		Judith Nash	Dec-19	Green
Ensure that children are prioritised appropriately where annual reviews are out of date, ensure plans are up to date and reflect need. 13/01/20 - work is ongoing and children are being prioritised through annual review process where reviews are out of date. Re-worded action to 'ensure that children are prioritised appropriately where annual reviews are out of date, ensure plans are up to date and reflect need'		Sara Barnett	Jan 20*	Green
Create specific page for annual review on the Local Offer. Ensure information is accurate and helpful to parents and young people		Hannah Glennon	Jan-20	Green
Maintain an accurate data set of all children with an EHC plan in the borough and which allows key dates and financial planning for annual reviews		Judith Nash	Feb-20	Green
Hold school specific and cross team training events which ensure all service users and stakeholders understand their core statutory duties within the EHC annual review process, enabling the EHC team to respond with a relevant and timely EHC plan. 16/01/20 - Annual Review SENNets clinics. SENCOS invited to bring ARs to be overseen by the Inclusion Development team and ask any questions about ARs. SENCOs booked on to time slots - Drop in sessions also happening later in the year - date to be finalised BB		Bev Bradley Hannah Glennon	Apr-20	Green
Use SENNETs to develop training for SENCOS focusing on all service users accessing the appropriate paperwork and completing to a high standard with appropriate evidence attached. Focus of current use of language and roles within annual review process 16/01/20 - Annual Review SENNets clinics. SENCOS invited to bring ARs to be overseen by the Inclusion Development team and ask any questions about ARs. SENCOs booked on to time slots - Drop in sessions also happening later in the year - date to be finalised. twilight training has been delivered to various settings to support staff (whole school) in using correct paperwork and also completing to a high standard with a focus on provision led planning. BB		Bev Bradley	Jul-20	Green
Schools to submit provision maps to show evidence of funding and impact for 12 months during review cycle. Use these in decision making for future funding 08/01/20 - Provision map training given at SENCO network meeting (04/12/19) to highlight the crucial element of the provision map to secure personalised funding for CYP. SENNETs also to create bespoke training packages for SENCOs needing support with provision maps. (12/12/19) Visits to schools happening and ongoing to provide support to heads / deputies and SENCOs on provision mapping. BB		Bev Bradley	Jul-20	Green
Success Criteria (Impact)				
All annual reviews will be process within a timely manner and will result in a relevant and purposeful EHC plan				
All stakeholders and service users will understand their duties and respond appropriately to support the development of a relevant and purposeful EHC plan				
Outcomes, needs and provision will be challenged appropriately during the EHC process				
There is easy accessible information on all funded children with an EHC which allows clear forward planning				
Improved data systems and process ensure that children who are at risk can have better outcomes and remove the need for OOB placements by more appropriate equivalent placements available within borough.				
Partners, parents/carers and other stakeholders are signposted to accurate and up to date information				
Update on Progress and Impact				
A overview report has been written placing all CYP in a priority group. There is a clear way of working established				
A new AR temp team has been set up to support with the completion of all annual reviews				
EHC training manual includes Annual review processes				
School training schedule includes AR processes				
A data set is being established which included placements, key dates and funding attached				
Evidence				
Out of Borough planning report (JN Dec 19)	SEND Report on Out of Borough (JN Dec 19)	School training schedule (BB Dec 19)		
Annual Review Renewal Agenda Report (JN)	EHC training manual chapter on annual review process (JN Dec 19)	Vulnerability Matrix (AS) (also for 4.1)		

PRIORITY 2: Education, Health and Care Plans (EHCPs)	**To embed and strengthen a relevant and timely EHC service which is transparent, equitable and robust in its delivery**			
OBJECTIVE 2.2	**All statutory assessment processes will be managed in a timely and effective manner resulting in a high quality relevant EHC plan**			
Overall Progress:	**Green**	**Owner:**	**Judith Nash**	
Actions		**By who?**	**Timescale**	**Progress**
Ensure every CYP and their family has a known EHC Coordinator that they are able to establish a sound relationship with and are able to contact easily when support is needed		Sara Barnett	Jan-20	Green
Ensure EHC coordinators have an appropriate caseload that matches their working arrangements and are able to work through this effectively using the current management tool		Sara Barnett	Jan-20	Green
Use the vulnerability matrix as part of daily team working to identify and secure provision for the most vulnerable children ensuring processes for these children are prioritised where possible.		Sara Barnett	Jan-20	Green
Improve all written communications from EHC team which allow user better understand of process, keeping content simple, relevant and appropriate to audience (school, parent, young person) Work with young peoples group to redesign letters		Sara Barnett	Jan-20	Green
Use EHC applications Quality Assurance Toolkit to score and give feedback to schools. Record and monitor scores and use to contribute to the SEND School Risk Assessment. Ensure data is reported regularly to SEND Service Manager 03/12/19 - session with Andy Marsden has taken place, school risk assessments complete. QA Toolkit also complete. Feedback now being given		Bev Bradley Judith Nash	Jan-20	Green
Increase capacity of EHC team so that it is able to meet service demand at all times - new EHC Coordinators recruitment to start in January 2020 07/01/20 Appointments made and awaiting checks in order to give start dates. Appointments do not increase capacity as we currently have interim staff in place which they will replace.		Sara Barnett	Apr-20	Green
Identify and confirm EHC team training schedule which looks to increase knowledge for all EHC coordinators so that they are able to feel confident and skilled to tackle daily working. To be used as part of induction and refreshing for experienced coordinators 03/12/19 - The handbook is almost completed, skills assessment now needed		Judith Nash	Apr-20	Green
EHC Coordinators manual used for all new starters. Skill tests as part of induction and general development 07/01/20 Coordinators Manual not yet received so unable to use at present		Sara Barnett	Apr-20	Green
Work with young peoples group to redesign application paperwork to be suitable for young people and is able to capture their views, thoughts and wishes without being parent focused		Sarah Cairns	Apr-20	Green
Ensure the EHC section of the Local Offer appropriately signposts parents and young people, is easy to access and relevant to the EHC team		Hannah Glennon	Apr-20	Green
Use SENCO working party to improve school EHC application paperwork and communications with school in letters / emails 08/01/20 - BB to organise SENNETs to support SENCOs with their EHCNAR applications BB		Bev Bradley	Apr-20	Green
Enhance Quality Assurance Frameworks and a set of core expectations for contributions form health and social care. Embed this as normal standards and practice across all teams		Hannah Glennon	Apr-20	Green
Monitor quality and quality of EHC applications to identify trends and areas for development for schools		Bev Bradley	Apr-20	Green
Ensure recording in decision making captures current outcomes and is easy to feedback to any stakeholder or service user.		Sara Barnett	Apr-20	Green
Establish daily and effective core use of the Quality Assurance Toolkits for all SEND teams and Service. Introduce regular reporting and monitoring to SEND service manager. Develop training for EHC Cos as part of skill development		Sara Barnett	Apr-20	Green

Success Criteria (Impact)		
The EHC team is able to meet service demand at all times and respond with a timely, robust and equitable delivery to all stakeholders		
The EHC team is fit for purpose and all members are skilled and confident to tackle their caseload		
There is easy accessibly to the EHC team for all stakeholders and service users. The service is forward facing and is transparent in its actions		
All contributors to the EHC needs assessment process understand their role and responsibilities and respond with relevant and useful information to the children, young person and their family.		
A skilled and effective 0 - 25 EHC team		
All EHCs are written on the new template and are written to the highest standard. They are issued within statutory timeframes. Annual reviews are completed within statutory requirements		
A Quality assurance toolkit raises the standards of the service and coordinated contributions towards and EHC plan		
The EHC team delivers a fair and consistent service in which users have clarity about responsibility, accountability, time scales and decisions. Decision making groups are able to achieve fair and consistent outcomes. Professional input is relevant and purposeful to the process		
Parents are able to give relevant feedback to the service which allows for proactive planning and improved systems		
Update on Progress and Impact		
New EHC specific email addresses introduced and used for all users and stakeholders		
New EHC plan issued and old version being reviewed out of process		
Quality assurance toolkit completed and issued to staff. Training is now starting		
Terms of ref for decision making now in place - fairer, more robust equitable panels and cases progressed within timescales.		
Parent feedback questionnaire developed and now in use, and is starting to impact ways of working		
Evidence		
Quality Assurance Framework and Toolkit - EHC applications (JN)	EHC Team Induction Co-ordinators Handbook (JN Dec 19)	New EHC team structure (JN)
Quality Assurance toolkit - Social Care Contributions (HG Jan 20)	Quality Assurance toolkit - Health Care Contributions (HG Apr 20)	New Format EHC plan (JN)
EHC pages of Local Offer (HG Jan 20)	Revised EHC communications and letters (SB Feb 20)	Terms of Ref for decision making groups (JN)
Revised EHC application paperwork (BB Feb 20)	EHC Parent Feedback Questionnaire (JN)	

PRIORITY 2: Education, Health and Care Plans (EHCPs)	**To safeguard and plan for the most vulnerable children in the borough with SEND**			
OBJECTIVE 2.3	**The most vulnerable children with SEND will be identified and planned for in advance of transitions in a process where their needs met through a cross team approach**			
Overall Progress:	**Green**	**Owner:**	**Judith Nash**	
Actions		**By who?**	**Timescale**	**Progress**
Create a matrix which identifies key factors of successful provision for children with SEND in the schools and scores/rag rates settings against each criteria. This highlights the vulnerable or at risk settings with possibly high vulnerable children in attendance 27/11/19 - AM to look at entering data. BB to work with AM to complete manual entries where needed		Judith Nash Bev Bradley	Dec-19	Green
Set up cross team planning meetings to contribute to the safeguarding of the identified pupils and schools. All teams understand the importance and contribute accordingly 27/11/19 - all teams to buy in. Training needed 03/12/19 - no known progress, need to discuss further at senior level		Richard Lynch	Dec-19	Green
Establish how the planning meetings can feed seamlessly into cross team decision making groups so that future plans are agreed and secure 03/12/19 - no known progress to date, session required between Judith and Richard urgently		Judith Nash Richard Lynch	Dec-19	Green
Use the Schools SEND risk assessment to identify training opportunities or best practice across borough and for individual or groups of schools. 08/01/20 - BB is still waiting for the Schools SEND risk assessment data for this action, however, other training opportunities are being identified using SENCO information sheets and other training events.		Bev Bradley	Dec-19	Green
Ensure LA/EHC team attendance at annual reviews of identified children		Sara Barnett	Jan-20	Green
Ensure ways of capturing the views, wishes and feelings of the child, young person and their family so this is central to the planning process and keeps them at the centre of the journey		Judith Nash	Feb-20	Green
Use Individual planners to plan sufficiency in borough for placements in advance of transition. Start to map trends and needs to support forecasting		Sara Barnett	Apr-20	Green
Success Criteria (Impact)				
A vulnerability matrix identifies the most vulnerable children within BMBC who then have their outcomes and progressed mapped by a multiagency team around them. Each children has detailed and pre-emptive planning which is discussed regularly at a senior team level				
Update on Progress and Impact				
Evidence				
Vulnerability Matrix (JN)	Championing All Our Children Framework (JN)	SEND Support Rating (JN Dec 19)		
Template Individual Journey Planning (JN Dec 19) - review what this is with RL				

PRIORITY 2:	**Joint Working - consider 2 seperate joint working plans, one for EHC and one for SEN support?** **Improving graduated response** **process from initial identification within setting** **how agencies work together and signpost** **universal, targetted,** **use sources of info we already have and tailor to SEN** **improve knowledge across the system** **right process, right time** **joining together assessments**			
OBJECTIVE 2.4	**TBD**			
Overall Progress:	**TBC**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Ensure joint planning and delivery mechanisms are being fully utilised to meet the needs of individual children including through team around the family approaches 13/01/20 - revise action 'ensure joint planning and delivery mechanisms are being fully utilised to meet the needs of individual children including through team around the family approaches'		Judith Nash	Nov-19	Amber
Establish a series of information sharing sessions to promote cross team working and knowledge including, data sharing, key documents bring and share and cross team decision making process event		Judith Nash	Nov-19	Amber
Share the learning and feedback and implement the actions set out in the action plan developed from the Mock Inspection Focus Groups		Judith Nash Lisa Loach	Dec 19*	Green
Ensure the EHC team know who to contact during EHC processes		Sara Barnett	Dec-19	Green
Improved integrative working across health and education to create 0 - 25 service with better measurable outcomes and future pre-emptive planning especially for EY and post 19 07/10/19 - the start of a series of sessions have been completed, more to follow		Judith Nash	Dec-19	Green
Improved integration working across social care and education to create 0 - 25 service with better measurable outcomes and future pre-emptive planning especially for EY and post 19		Judith Nash	Dec 19*	Green
Organise education, health and social care professionals into a team around the school and individuals within school, possibly known as the SEND Family Group to promote secure inclusion agenda and best ways of working for children with SEND.		Bev Bradley Judith Nash	Jan-20	Green
Ensure children with SEND are being met from within schools support team and that all professionals take understanding of role within that offer.		Bev Bradley Judith Nash	Jan-20	Green
Psychological advices are completed within the statutory timescale		Joanne Patterson Naomi Robinson	Jul-20	Green
To provide an Educational Psychology service to PVI's, early year providers so that needs will be identified and met earlier to support the EHC needs assessment process		Joanne Patterson Naomi Robinson	Jul-20	Green
Success Criteria (Impact)				
Increasing capacity within the Educational Psychology service and reducing reliance on locum staff to enable psychological advices to be written by BMBC Eps				
More EHC needs assessment requests from PVI's have Educational Psychologist involvement				
Update on Progress and Impact				
Draft Vulnerability Matrix in place with increasing criteria identified for further iterations. List becoming more widely known with additional teams contributing service information. CAOC framework underway with appropriate team members to be identified				
Forms for contributions from health and social care have been designed and currently being trialled				
Evidence				
Outcomes Training - presentation slides (JP)	EP Advisors Performance Report (JP)	Mock Inspection Focus Groups Action Plan (LL)		
Advice ProForma, Health and Social Care (JN)	Individual Journey Maps Tool (JN Nov 19) - suggest remove?			

PRIORITY 2:	**Exclusions**			
OBJECTIVE 2.5				
Overall Progress:	**TBC**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Improve data collection and subsequent reports to examine and reduce exclusions for children with SEND 07/10/19 - an audit has been completed with JN needs to discuss with Sarah Sinclair to ensure co-ordinated approach		Judith Nash	Dec-19	Green
Jane Allen Secondary heads Primary exec Richard Lynch				
Success Criteria (Impact)				
Schools are supported to look at alternatives to exclusion and the new SENCOS will work with schools to identify children at risk				
Update on Progress and Impact				
Evidence				
SEND Report on Exclusions (RL?)				

PRIORITY 3: Participation & Co-production	**We will create more opportunities for children, young people, parents and carers to contribute to and co-produce strategies and planning for SEND Local Area arrangements**			
OBJECTIVE 3.1	**Develop new local arrangements to enable participation and co-production with young people**			
Overall Progress:	**Green**	**Owner:**	**Julie Hammerton**	
Actions		**By who?**	**Timescale**	**Progress**
Recruit participation officers to support engagement with children and young people with SEND 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Emma Baines	Dec-18	Complete
Core group of young people to be directly involved in writing the SEND CYP Plan using feedback from their peers 03/12/19 - work is ongoing and young people are being involved.		Emma Baines	Dec-19	Green
Parent/carer workshops to be held for children post diagnosis for Autism to facilitate support and a network for parents of children with Autism		Naomi Robinson	Dec-19	Green
Ensure young people's priority areas around SEND are included in the SEND Strategy and Improvement Plan, review this years Make you Mark priorities and ensure inclusion, where relevant, in the SEND Strategy and Young People's Plan 20/11/19 - SEND priorities have been agreed and used in the development of the SEND C&YP Plan and will be included in the SEND Strategy which is currently being developed		Sarah Sinclair	Dec-19	Green
Young people to be involved in recruitment to senior SEND posts		Emma Baines	Dec-19	Green
Greenacre SEND focus group established in school with Youth Voice Coordinator as a satellite of the forum		Emma Baines	Dec-19	Green
Develop opportunities for young people with SEND to participate and influence service policy and improvements 03/12/19 - evidence to date includes the takeover day input, make your mark feedback		Emma Baines	Mar-20	Green
Undertake periodic consultations with young people with SEND to identify if their needs are being met and how improvements can be made e.g. lived experience, short breaks, workforce development, SEND Strategy		Emma Baines	Mar-20	Green
Hosting of termly open access SEND young peoples summits 06/11/19 - first Summit completed Oct 2019		Emma Baines	Apr-20	Green
To encourage and support young people to be involved in local, regional and national consultation forums and events e.g. Regional SEND conventions		Emma Baines	Jul-20	Green
Representation and involvement of young people in community events, including the No Limits Disability Festival in 2020 and the Mayors Parade		Emma Baines	Jul-20	Green
To encourage and promote inclusion of parents/carers through establishing a parent group for visual and hearing impairment to support service improvements		Toni Harvey	Jul-20	Green
Involve young people with SEND in developing and refreshing the Local Offer website, testing its accessibility and promoting its use and what's on offer to them and their peers		Emma Baines	Dec-20	Green
Success Criteria (Impact)				
Young people have co-produced and take ownership of the new SEND strategy / SEND CYP Plan				
Parents / carers and young people are more actively involved in positive participation opportunities				
Young People feel that they are actively engaged in decision making processes and planning arrangements				
Increase in young people involved in voice and influence activities and their understanding and awareness of how they can get involved				
Parents /carers are engaged in service planning and improvements for children with visual and hearing impairments				
Parent/carers are empowered to better understand and meet the needs of their children in relation to autism				
Links are created with Greenacre, Barnsley College, Abbey School and Springwell				
Future short breaks provision meets the needs of young people with SEND				
Young people feel better supported and their needs are being met				
Workforce development strategy is developed considering young peoples views and training is identified to reflect gaps identified				
Young people directly involved in the recruitment to key senior positions within the service				

Update on Progress and Impact		
Work is currently taking place on developing a Voice and Influence strategy for young people with SEND		
KIDS consultation complete, model of participation has been agreed by parents, KIDS to lead this work to bring parents together around the new model, Sept 19		
Various Satellite consultation sessions have been undertaken and will continue as and when necessary		
Deaf Friends parent/carer group established, currently small but growing, Visual Impairment group in the process of being established with support from KIDS		
1st set of workshops have been delivered and further workshops are planned for the Autumn term		
Links created with Greenacre and Barnsley College to allow young people to be involved in consultations and groups formally established within these settings		
Young people feel able to voice their opinions and are engaging in consultations		
A core group of young people has been established with links to further satellite groups for consultation and focused work		
Young People's views submitted to be included in the short breaks review, consultations have taken place at various short breaks provisions during Summer		
Sessions planned to involve young people in the Local Offer refresh		
Young people with SEND have been further consulted on the training needs of the SEND workforce		
Parent/carer Autism workshops have been delivered and evaluated. Further dates have been released for booking in the Spring term		
First SEND YP Summit taken place during Oct Half term		
Young people were involved in the recruitment panels for senior SEND posts		
Young people presented their priorities to the Joint Annual Meeting of the Safeguarding Board and TEG Nov 2019 (SS)		
Evidence		
Consultation Feedback report on lived experience of young people with SEND (EB)	KPI - Young People with SEND involved in participation opportunities and consultations (EB Apr 20)	YP Workforce Development Consultation feedback (EB)
Make Your Mark Results Report (EB)	Children & Young Peoples Plan (SS) (also for 5.1)	Voice and Influence Strategy for young people with SEND (EB Dec 19)
YP and Peers contributions (and issues and topics) to SEND CYP Plan (EB)	Barnsley SEND Youth Voice and Participation Infrastructure document (EB)	Parent/carer autism workshop evaluations (NR ?)
SEND Strategy (SS Jan 20)	Short Breaks Statement 2020-21 (SS Apr 20)	Minutes of Joint TEG / BSCP Event 29 Nov 19 (EB Jan 20)
SEND YP Summit - Oct 2019 (EB)	SEND CYP Plan (SS Jan 20)	SEND Youth Forum Presentation to TEG/ECG (SS)
YP Short Breaks Comments (EB)		

PRIORITY 3: Participation & Co-production	We will create more opportunities for children, young people, parents and carers to contribute to and co-produce strategies and planning for SEND Local Area arrangements			
OBJECTIVE 3.2	Develop new local arrangements for participation and co-production with parents and carers			
Overall Progress:	Amber	Owner:	Mellissa Mackell Sarah Sinclair	
Actions		**By who?**	**Timescale**	**Progress**
Strategic group established to implement the findings from the Red Quadrant co-production exercise		Liz Taylor	Oct-19	Amber
Engage and include parents/carers in the development of a robust and outcome focussed pathway for young people with SEND age 14-25 07/10/19 - date scheduled to discuss approach and next steps 20/11/19 - upon receipt of update, discuss this with Sarah Sinclair in terms of next steps		Liz Taylor Sara Cairns	Dec-19	Green
KIDS to continue to raise awareness and promote the opportunities for parents to be involved and co-produce in order to reach as many families as possible from across Barnsley 20/11/19 - opportunities for promotion are being taken, communication agreement is in place with FIS to disseminate dates of Alliance sessions, KIDS social media page and database, promoted within children's centres and other communication groups		Mellissa Mackell	Dec-19	Green
Incorporate findings of parent survey into the SEND Strategy and Improvement Plan 20/11/19 - work is ongoing and on track		Sarah Sinclair	Dec-19	Green
KIDS to facilitate a session with parents regarding the new council EHC IT case management system so they can decide if they would like to access their child's information directly in the future 20/11/19 - KIDS awaiting further instruction from the team leading this in order for arrangements to be made to facilitate a series of session. Might need to consider moving the timescale on?		Mellissa Mackell	Jan-20	Green
Engage with parents/carers to establish appropriate representation and consultation in planning groups and the reviews of provision e.g. short breaks 20/11/19 - action moved here, but more discussion required to identify specifically what the action should be about 03/12/19 - A programme of activity to be agreed with parents via the parent alliance focusing on strategy development, process planning and service reviews/commissioning. To be agreed once Alliance is established. Officers will need to identify key areas for engagement. This will need to be consolidated in one plan for agreement and prioritisation. SS to support Mellissa as appropriate (SS)		Mellissa Mackell	Jan 20*	Green
Develop and agree local arrangements for co-production through the development of a Co-Production Policy/Charter 20/11/19 - this action was marked as complete but it isn't really, action reopened and reworded and a realistic timescale attached to it		Mellissa Mackell	Mar-20	Green
Consultation with parents on refreshed Sufficiency Strategy 20/11/19 - KIDS are awaiting further instruction to be able to take this forward		Mellissa Mackell	Mar-20	Green
Ensure foster carers are included in co-production arrangements/development		Jon Banwell Mellissa Mackell	Mar-20	Green

Success Criteria (Impact)
Strategies evidence co-production by the Barnsley SEND Alliance
Parents and carers feel supported to engage at all levels to influence planning and decision making
Co-production exercise event held to capture 'what is it like to live in Barnsley with a learning disability?' with recommendations identified
Decision making includes parents / carers at all levels
Feedback loop implemented and can be evidenced in the Local Offer
Families continue to engage in steering the development of transition pathways
Co-production with parent/carers in relation to SEND Strategy and Inclusion Strategy via the Parent / Carer Alliance Focussed workshops
Sufficiency Strategy which reflects the voice of the SEND community
Foster carers of SEND children are included as a specific group in co-production arrangements
IT system established with parent / carers increasing parent / carers involvement in individual service level planning
Update on Progress and Impact
KIDS service operational and resource for the development of co-production in place
Parent / Carer survey complete and being used to develop services and SEND Strategy, inclusion of parent / carer voice in strategic development
Parent / Carer Alliance established and operationally functioning and providing the appropriate framework for co-production in relation to service development, continuous improvement
Parent Alliance workshops held to build on survey findings and further inform the SEND Strategy and Improvement Plan
New case management system discussed with parents at talkabout and action taken to ensure more in depth consultation is planned to ensure parents feel their voice has been heard and utilised in how BMBC move forward with the implementation of this system

Evidence		
ToR Parent / Carer Alliance (MM Jan 20)	KIDS Parent Carer Contract 2018-2020 (SS)	Co-production Timeline of Development (MM Dec 19)
Co-production exercise report of findings and recommendations (MM Nov 19)	SEND Parent Survey Highlight Report (MM)	Preparation for Adulthood Feedback paper (MM Nov 19)
Use the link to the statement in Local Offer (contact Claire Archer)	Engagement Plan for key areas of development (SS Feb 20)	KIDS Contract Monitoring Q3 Performance Report (MM Jan 20)
Parent / Carer Alliance Schedule of dates (MM ?)	Accessibility Strategy (AT Feb 20)	SEND Parent Survey Progress Report to DMT (SS)
SEND Parent Survey Full Report (MM)	Parent Participation Development in Barnsley (MM)	Co-Production Policy/Charter (MM Mar 20)
KIDS Parent Carer Service Specification (SS)		

PRIORITY 4: Specialist provision and services	**We will develop specialist education provision locally so more children can be educated within Barnsley.**			
OBJECTIVE 4.1	**Develop specialist educational provision locally**			
Overall Progress:	**Amber**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Develop SEND analysis for inclusion in JSNA 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Cheryl Devine Ruth Speare	Oct-19	Complete
To create and recruit to the post of SEND Commissioner 03/12/19 - Post appointed to 29/11/19 proposed start date Feb 2020 (SS)		Richard Lynch Sarah Sinclair	Dec-19	Green
Develop options to create additional school places in accordance with SEND sufficiency planning		Richard Lynch	Jan-20	Green
Review the projections tool for school placement requirements, sufficiency group to develop an action plan		Josh Amahwe Sarah Sinclair	Feb-20	Green
Consult on capital plans to develop specialist provision and utilise DfE special provision fund 07/11/19 - if this is a risk it needs to be escalated - Nina/Richard to confirm to Rachel 09/12/19 - risk no longer high, can be moved to green		Richard Lynch	Mar-20	Green
To refresh SEND Sufficiency Strategy & Implementation Plan		Richard Lynch	Apr-20	Green
Undertake a review of the pilot Autism Friendly Audit Tool to enable schools to self assess their capacity to meet the needs of children with Autism		Naomi Robinson	Jul-20	Green
Success Criteria (Impact)				
All children and young people with EHCPs are allocated places, with final plans issued, by February and March deadlines (yr6/7, post 16 transfers)				
Needs data linked to JSNA used to support provision planning.				
SEND Sufficiency Group established and Sufficiency Strategy refreshed in line with financial modelling and improved needs data				
Commissioning capacity increased to support sufficiency planning and delivery				
Post 16 pupils with EHCP reviewed to ensure EHCP still necessary and appropriate				
Pupil vulnerability matrix established with improved planning for pupils at risk of escalating need				
Through the pilot, schools have a tool and process for identifying strengths and areas for development to plan for achieving charter mark status in relation to meeting the needs of pupils with autism				
Improved early offer for specialist support through education psychology, social communication and interaction and portage services				
Improved sufficiency of school places through diversified offer that is responsive to more pupils needs				
Update on Progress and Impact				
First draft forecasting/projections tool considered by sufficiency group Jun 19. Subsequent iterations developed and presented to group.				
Evidence gathered from other LA's, JSNA in development, due Oct 19. DPH has identified capacity to lead on this work				
Sufficiency Group now in place				
Delegated report to establish positions received lead member approval 14 Jun 19				
Post 16 service to work with EHC team to identify young people with inactive plans, report back to sufficiency group Jul 19				
Matrix developed with multiple sources of data requires further refinement by BI team following completion of BU1 scorecard				
Standards developed and piloted				
Additional EP's recruited				
Additional Portage worker recruited				
Improved case management and monthly tracking including key transitions now in place				
Evidence				
Joint Strategic Needs Assessment - https://www.barnsley.gov.uk/barnsley-jsna (MR) also see Perf Mgnt)	ToR SEND Sufficiency Group (LL)	Barnsley Autism Friendly completed audit standards tool and planning tool (NR)		
EHCP's ceased report (JN Nov 19)	Vulnerability Matrix (AS) (also for 2.1)	Revised EP Core Offer to schools (NR/JP Jan 20)		
Post 16 Case Management Tracker (SC Dec 19)	Projections Tool (JA Oct 19)	Sufficiency Strategy (RL Apr 20) (also for AFB)		

PRIORITY 4: Specialist provision and services	**Improve Access to Specialist Health Services**			
OBJECTIVE 4.2	**Review and improve pathways for children's therapy services; ASD, paediatric services, and CAMHS**			
Overall Progress:	**Amber**	**Owner:**	**Patrick Otway**	
Actions		**By who?**	**Timescale**	**Progress**
Improve support to parents of children and young people with (or expected to have) autism 25/11/19 - this has been done. Extra funding has supported the family support pathway. IAPT training has taken place. Discuss further with Laura Hamilton. PO is updating the LTP for children's mental health - this can be used as evidence. Audit also carried out through the autism strategy group against CG170 around support functions post diagnosis		Patrick Otway Sarah Sinclair	Dec-19	Green
Recruit to the role of Designated Clinical Officer 20/11/19 - public health have assumed responsibility for development and recruitment of this role due to 2 unsuccessful rounds of recruitment. This has also led to a review of the job role to separate specified DCO functions from complex clinical care oversight. Patrick, Alicia and Sarah to ensure all responsibilities in relation to each of these functions are appropriately developed. 09/12/19 - Alicia aiming to get sign off this week, going to JE this week, post will be advertised in Jan. agreed to move the date on to Feb 20		Patrick Otway Alicia Marcroft	Feb 20**	Green
To reduce the access and waiting times for Children's therapy services to a minimum of 18 weeks RTT to ensure best possible life outcomes for children and young people 25/11/19 - additional funding has been provided from the CCG based on the service review completed jointly by LA and CCG and a capacity and demand modelling exercise between SWYPFT and the CCG which outlines actions to be taken and impact on waits, is currently being finalised (SS)		Patrick Otway Sarah Sinclair	Mar-20	Green
To reduce the access and waiting times to the ASD pathway to a minimum of 18 weeks RTT 25/11/19 - Realignment of the pathway to paediatrics and additional investment from CCG to reduce waits and increase pathway capacity/reduce waiting times has been completed. Impact is starting to be demonstrated and will be monitored by the ASD strategy group against the 18 week target (SS)		Patrick Otway Sarah Sinclair	Mar-20	Green
Develop an All-age Autism strategy and Implementation Plan 25/11/19 - work is happening at both a local and regional level around this action, a regional workshop was held in Nov 19 to identify key areas of focus. The Autism Strategy Groups membership has been extended to include adult services to enable the development of a joint strategy and approach. The group is awaiting national strategic guidance in relation to the strategy development which is expected early in the new year. The joint strategy was discussed at the ASD strategy group in Nov 19 (SS)		Patrick Otway Sarah Sinclair	Mar-20	Green
Consult with parents/carers around ASD pathway/strategy 25/11/19 - work is yet to commence on this - this will be planned via the ASD Strategy Group (SS)		Mellissa Mackell	Mar-20	Green
Develop a single neurodevelopmental pathway with a prerequisite of having an Early Help Assessment 25/11/19 - a prerequisite has been added to the ASD pathway and appropriate governance undertaken to support this change ECG Nov 2019. The neurodevelopment pathway will take substantial development and will need to be undertaken with the CAMHS provider established via the planned retender - this will involve partnership work with Paediatrics. An ASD and ADHD pathways exists, a neurodevelopmental pathway will combine the two. Resource in relation to EH support to both pathways will be incremental and review around capacity and demand will need to be undertaken. Proposed joint pathway Dec 21 (SS)		Patrick Otway Sarah Sinclair	Dec-20	Green
Success Criteria (Impact)				
A reduction in the average waiting times to access therapy services.				
Waiting times, especially on the over 11 ASD pathway have significantly reduced from the March 2019 level of 2.5 years				
Parenting programmes established focusing on parents of children and young people with autism				
An All-age Autism Strategy and Implementation plan is published on BMBC and BCCC websites which aligns to ICS regional development work				
DCO role offering strengthened health input into the SEND agenda providing support to parents, young people and professionals				
Full time complex case manager in post, enabling the timely occurrence of all CTR / CETR's and ensuring the most appropriate level of care is provided to deliver the best possible outcomes for children and young people				
SEND lead at Barnsley Hospital identified and is ensuring the best possible care of patients with SEND who attend hospital				
Single neurodevelopmental pathway with all young people having undergone an Early Help Assessment is ensuring that all young people, regardless of diagnosis, are accessing the appropriate level of support. Comorbid assessment reducing the need for two separate pathways to be accessed				
Paediatric Service review completed, with findings and recommendations communicated to ensure effective and efficient utilisation of resources to deliver the best possible outcomes for our children and young people				
Barnsley CAMHS review completed, with findings and recommendations communicated to ensure efficient and effective utilisation of resources to deliver the best possible outcomes for our children and young people				
Communications are circulated in a timely manner to all relevant professionals enabling children and families to be informed of key decisions in relation to their care promptly				

Update on Progress and Impact
Additional funding for 2019/20 has been agreed of circa £228,000 - impact of the additional investment on waiting list and access times will be evaluated at 6 monthly intervals
Additional recurrent funding of circa £125,000 has been agreed for 2019/20 and management of the over 11 ASD pathway now sits with the paediatricians
Parenting programme has been established by MindSpace but is not fully utilised - this support group will continue to be promoted. Additional recurrent funding has been approved to enable Family services to develop an ASD Parenting practitioner programme
CCG have supported recruitment of a DCO Band 8a role for 22.5 hours per week, recruitment in progress
A Complex Case manager appointed, commenced in May 2019
A SEND lead has now been identified within Barnsley Hospital and as the lead is a senior nurse within the Community Paediatric Team this will strengthen the links to children's continuing care
Development of a single neurodevelopmental pathway is being progressed via the ASD / ADHD Steering Group - all partners are in agreement to work towards this development.
A Paediatric Service review will be undertaken by an independent senior nursing clinician during June / July 2019. A formal feedback session outlining the recommendations of the review will take place on 31 July 2019.
NHS England's Intensive Support Team undertook a review of the Barnsley CAMHS and MindSpace service in April 2019 - key outcome retender of CAMHS Service. Specification completed, consultation exercise completed. Tender submitted to market, closed in Nov 19, evaluation scheduled Dec 19, award to be made Jan 20 with the new service in place from April 20. Local Authority officers included in writing of the spec and procurement activity
Decision to recruit to band 3 admin support has been approved, support will be given to complex case manager and DCO to improve the administrative processes within Children's Continuing Care. Administration processes are in place and the panel functions as designed, DST checklists are submitted by professionals and guidance is available. Work is taking place with the CCG to align children's and adults CHC/CCC processes and resources
ASD Regional workshop has taken place involving key stakeholders, overview of workshop was presented to the ASD Strategy Group in Nov 19, key areas for development were identified via the workshop

Evidence		
KPI - Performance Report to ECG (AS)	Parenting support programme established by MindSpace is utilised effectively (PO or SS)	Autism Strategy and Implementation Plan (PO or SS)
ASAD Parenting practitioner in post and outcomes evaluated by use of Family STAR and/or other validated tools (LH June 20)	ASD Regional Workshop ICS Priorities for Action (SS Nov 19)	KPI - Reduction in waiting times / improved conversion rates / ADHD diagnosed young people commencing treatment without delay (PO or SS)
TCP trajectories / reduced in-patient admissions for young people (PO or SS)	Review report and recommendations from NHS England (PO or SS)	Report of Review of Paediatric Services Delivered by Barnsley Hospital (PO or SS)
Barnsley CYP Mental Health Review (Apr 19)	Service Review Report of finding and recommendations	CAMHS Revised Service Specification (PO)
CAMHS Contract (PO Mar 20)		

PRIORITY 5: Pathways to Adulthood	**We will develop better pathways to adulthood so that young people's voice, needs and ambitions are the primary focus, and they have access to timely and co-ordinated advice, support and service to enable them to plan for the future**			
OBJECTIVE 5.1	**Work with young people, parents and carers to identify priorities and plan for improvement**			
Overall Progress:	**Green**	**Owner:**	**Angela Lomax**	
Actions		**By who?**	**Timescale**	**Progress**
To share the outputs from the consultation regarding 'preparation for adulthood' sessions		Mellissa Mackell	Jan-20	Green
To bring together the key partners to discuss this priority area and agree lead officers		Richard Lynch	Jan-20	Green
Promote the new post 16 learning provider through the Local Offer 09/01/20 - tender specifications are in the process of being written prior or being advertised. As such, timescale will need to be moved on.		Angela Lomax	Feb-20	Green
Improve pathways for planning and access to employment opportunities for young people with SEND		Liz Taylor	Mar-20	Green
Improve input from parents and carers within the planning process, through co-production events 25/11/19 - evaluation of preparation to adulthood event information, consultation through the Alliance and work with children and young people via the SEND plan task and finish group to determine key area required when planning for children and young people between adults and children's services 03/12/19 - Further events to be planned as required (SS)		Sarah Sinclair Kwai Mo	Mar-20	Green
In addition to co-production events, work around individual cases to be undertaken to better connect service planning and identify a joint response across education, health and care supported by developmental sessions with staff which result in referrals to CRAG where appropriate		Sarah Sinclair Kwai Mo	Mar-20	Green
Review the ADASS survey findings Yorkshire and Humber along with the Notts Multi-Agency Transitions Protocol - good practice example to identify key learning and local action for improvement 09/01/20 - Awaiting decision of Oversight Board on 20-01-20 to identify partners and actions		Angela Lomax + other partners	Mar-20	Green
Relevant service leads to use the outcomes of the preparation for adulthood consultations to inform and further develop priorities across the key preparation outcomes (employment, health, independence and friends, relationships and community) 09/01/20 - Awaiting decision of Oversight Board on 20-01-20 to identify partners and actions		Angela Lomax + other partners	Jun-20	Green
Review transition planning at year 9 annual review		Judith Nash Sarah Cairns	Jul-20	Green
Success Criteria (Impact)				
Young people, parents/carers engage with events				
Improvement themes identified and plan drafted				
Transition planning starts early and clearly reflects the views, wishes and aspirations of young people				
Views and expectations from carers and parents are shared and explored as part of the planning through transition				
Online Local Offer accessibility improve giving greater navigation for children, parents/carers				
More young people in paid employment				
Improved joint planning and commissioning of services and care provision that supports transition to maximum independence				
Update on Progress and Impact				
46 attendees. Feedback collated and published through KIDS				
Plan drafted for further discussion/ development				
Year 11 completed, year 9 due to start Sept 19 with improved transition planning				
First phase of the improvement work has taken place which has identified navigation improvements and use of terminology				
Meeting taken place with LT and Sarah Cairns				
Locality Managers working with youth team on developing offer and promoting volunteering and work opportunities				
New marketing materials created for ABLE service launch by end Nov 2019				
Evidence				
KPI - LD/Employment (LT?)	Year 9 annual review audit (Amber Burton - Jun 20)	Complaints and compliments (LL Apr 20)		
Mystery shopper/QA report of findings and recommendations (MM Apr 20)	Children and Young Peoples Plan 2019-2022 (SS) (also for 3.1)	Post 16 Destination Data 19 data and 20 data (AL Jul 20)		
QA and Auditing findings and recommendations report	Preparation for Adulthood Feedback (MM Nov 19)	Post 16 New Provider Learning Contract (AL Jan 20)		
Year 11 Consultation Form (AL)	Preparation for Adulthood What's Working Event Feedback (MM)			

PRIORITY 5: Pathways to Adulthood	**We will develop better pathways to adulthood so that young people's voice, needs and ambitions are the primary focus, and they have access to timely and co-ordinated advice, support and service to enable them to plan for the future**			
OBJECTIVE 5.2	**Raise aspiration, increase opportunities for young people articulate their ambitions, and to develop skills that will support progress into employment**			
Overall Progress:	**Green**	**Owner:**	**Angela Lomax**	
Actions		**By who?**	**Timescale**	**Progress**
Provide guidance for relevant professionals on ensuring the voice of the young person is prominent in planning meetings and transition plans 07/10/19 - post recruited to who will now be able to drive this forward		Judith Nash Sarah Cairns	Dec-19	Green
Create access to more vocational options for young people in school, in partnership with colleges and training providers		Liz Taylor	Apr-20	Green
Provide targeted support for children and young people aged 11-25 with mild to moderate learning difficulties and /or disabilities, with a focus on personal and social development through a broader inclusive youth offer 03/12/19 - session has taken place to make arrangements to deliver this action		Liz Taylor Julie Hammerton	Apr-20	Green
Increase employment opportunities by promoting the supported internship route to a wide range of employers through the more and better jobs strategy 22/11/19 - Working with key stakeholders through the Pathways to Employment Forum to further develop and source employment opportunities. Work is ongoing with employers through the More and Better Jobs strategy and the Employer Promise to raise awareness of SIs and employment for those with SEND. 09/01/20 - Work is ongoing to promote SIs to employers to ensure there is placement capacity to meet demand.		Angela Lomax	Sep-20	Green
Work with providers to develop a consistent approach to preparing young people with the work ready skills they need for employment for young people with SEND age 14-24 16/10/19 - this is done through the Pathways to Employment Forum. Members have agreed the key components of a Supported Internship and key messages to promote them. Celebration events are planned to showcase SIs to employers. 05/12/19 - key messages are being promoted to young people via TIAG service. Ongoing work continues with schools and colleges		Angela Lomax	Sep-20	Green
Support employers with a job coach to increase the number of successful work placements		Liz Taylor	Sep-20	Green
Establish an annual audit cycle to track uptake of supported internships and numbers progressing into employment from these		Angela Lomax	Oct-20	Green
New action around linking this work to the Early Help All Age Strategy - Claire/Laura to work this action up				
Success Criteria (Impact)				
Young people and their parents/carers feel engaged and involved in the development of service pathways.				
Increased numbers of learners with EHCP age 16-24 participating in supported internships				
Increased proportion of EHCP learners moving into sustained employment following completion of supported internships				
Employment opportunities increases by 1 per month				
Increase in options and uptake of social activities				
Parents/carers are involved in the short breaks review				
Young people accessing supported entitlements and opportunities				
Update on Progress and Impact				
The KPI on increased proportion of EHCP learners moving into sustained employment following completion of supported internships is not yet captured				
Short break review has started				
Robust and outcome focussed pathway to being 'work ready' established				
Evidence				
SEND 2 data report (AS Jan 20)	Supported Internships Videos (AL)	SEND Scorecard KPI (AS Jan 20)		
Supported Internships Forum Terms of Reference (AL)	Case Study - Shared Positive Outcomes (JH Apr 20)	Supported Internship Plan (AL)		
Supported Internships Flyer (AL)				

PRIORITY: Local Offer	**Ensure the Local Offer meets all requirements and provides relevant information which supports young people, parents/carers and professionals independently accessing support, services and provision**			
OBJECTIVE	**Update Local Offer to address identified gaps and establish processes for regular quality assurance**			
Overall Progress:	**AMBER**	**Owner:**	**Laura Hammerton**	
Actions		**By who?**	**Timescale**	**Progress**
EHCP team to provide information on EHCP processes to Families Information Service to add to Local offer Education tile 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD) 08/01/20 (LH) - This has not been provided to FIS to upload to the local offer		Sara Barnett	Oct-19	Complete
Review local offer in relation to EHCP quality and accuracy of information and identify further improvements 15/12/19 - Review completed and actions identified. Meeting scheduled with Claire Archer 14.1.20 to discuss actions moving forward		Sara Barnett	Dec-19	Green
Review the navigation of the Local Offer site to identify if improvements can be made 03/12/19 - work is being completed to improve the navigation of the site. Work is also underway with IDOX exploring longer term solutions 08/01/20 (LH) work is currently underway to complete the workaround solution and IDOX are still working to find a permanent solution, we are pushing for this to be resolved quickly proposing this is moved to a date of Mar 20		Laura Hammerton	Dec-19	Green
Refresh the hard promotional materials in relation to the Local Offer 08/01/20 (LH) First draft received and feedback given to comms work ongoing		Laura Hammerton	Jan-20	Green
Provide information on Personal Budgets to families Information service to add to Local offer in relation to: • Barnsley's process for applying for Personal Budgets • Personal Budgets and Short Breaks 25/11/19 - request to move this date on due to other competing priorities? - Feb 2020		Sarah Day Sarah Sinclair	Feb 20**	Green
Develop an Accessibility Strategy and incorporate this into the Local Offer (**Note:** Barnsley.gov.uk page describes and links to a 'One Path, One Door Strategy' with hyperlinks to the 2010 and 2011 reviews and states that our next review will be in 2015. The page also links to a SEN Handbook which was last amended in 2010) 09/12/19 - due at DMT in Jan, move date onto Feb 20		Anna Turner Zahid Qureshie	Feb 20*	Green
Set up mystery shop processes to test accessibility of information on Local Offer using both the DfE auditing guidance tool and local additional tool 08/01/20 (LH) - Meeting has been held with KIDs and SENDIASS - toolkit to be drafted and circulated with follow planned to finalise arrangements		Laura Hammerton	Mar-20	Green
Include Local Offer demonstration at the learning event in partnership with KIDS		Laura Hammerton Melissa Mackell	Mar-20	Green
Improve accessibility of the online Local Offer to clearly promote the post 16 training offer and the pathways 16/10/19 - work is already progressing. Aim is to review layout and accessibility before Christmas and then look at how this is communicated to stakeholders Jan-Mar 2020		Angela Lomax	Mar-20	Green
Increase communication methods utilised on the Local Offer to include a video of young people encouraging feedback		Laura Hammerton	Mar-20	Green
Agree a programme of auditing following mystery shop exercise		Laura Hammerton	Apr-20	Green
Success Criteria (Impact)				
Parents/carers to continue the development of the Local Offer.				
Mystery shopper exercise complete				
Consultation results are reflected in the revised Local Offer				
Increased level of personal budgets				
Improved satisfaction of parents/carers and young people accessing Local Offer website				
Increased feedback from parents/carers and young people accessing Local Offer website				
Audit timetable and programme established, further enhancing the Local Offer and addressing quality and access issues				
Update on Progress and Impact				
Personal budget and Short Breaks information written. Application process for a personal budget being drafted further consultation in relation to EHCPs required with SEND Team. Personal budgets in place for short breaks and health however consistency of offer/process is required. Oct 19- completion date.				
Evidence				
KIDS Local Offer Audit tool (MM - this needs Barnsleyfying Feb 20)	Local Offer - SEN pages (insert link) (was HG - need to reassign)	ECG Performance Report (also for P4 4.2) - move evidence here		
Local Offer Peer Review (LH)	Mystery shopper findings briefing paper (LH Mar 20)	Local Offer - SEN Improvement Action Plan (JN)		

PRIORITY: Performance Management	Implement robust performance management which identifies key areas for further action and use this information to improve performance			
OBJECTIVE	Review and evaluate data collated to ensure that children and young people with SEND (0-25) are receiving the support needed and the most vulnerable children are being identified.			
Overall Progress:	Amber	Owner:	Richard Lynch	
Actions		By who?	Timescale	Progress
Investigate and explore opportunities for automation of data analysis (what, how, who) 15/11/19 - unable to identify the evidence relating to this completed action from the evidence listed below (JD)		Malachi Rangecroft Richard Lynch	Sep-19	Complete
Explore national benchmark data to identify proportion of internships into sustained employment 16/10/19 - met with Neil Wilkinson and confirmed significant differences between data he holds and data that has previously been reported in SEN2. Also identified that the core data report used for EHCP pupil list from Capita One is not accurate - pupil bases are not up to date. Data provided by Neil will be incorporated into the SEND Key Data on the Scorecard 27/11/19 - No further updates - 2020 Scorecard should be available by end December. (AS) 06/01/20 - The data that Neil has provided doesn't include a good benchmark, Angela to discuss further with Neil		Angela Lomax Angela Stephens	Dec-19	Amber
To investigate the possibility of automating a monthly SEND overview of all children with details of an EHCP from Capita 14/11/19 - further discussion required re owner as service unable to contribute to actioning this (JN) 27/11/19 - Is this new? There is currently no capacity within BII Tech Team to take this on. (AS) 06/01/20 - please provide further information regarding this action as it's not clear what is being asked to do, Richard or Nina to advise (AS)		Angela Stephens	Dec-19	Amber
Develop SEND scorecard and Vulnerability Matrix (AS 17/10 - next release December 19 27/11/19 - 2020 version currently being created. Jude met with Andy Marsden recently to sign off the SVM but further testing of the data within it still needs to be carried out before it can be officially released. (AS) 13/01/20 - merge with action above		Angela Stephens	Dec-19	Green
Use the outcome of the parent / carer survey to inform the SEND Strategy 03/12/19 - change to Jan 2020 (SS)		Sarah Sinclair	Jan-20*	Green
To investigate if we are able to incorporate the Annual Reviews date into the Vulnerability Matrix		Angela Stephens	Jan-20	Green
Establish a data set to facilitate engagement and consultation with young people with SEND e.g. 'home educated young people with SEND' 06/11/19 - TYS in touch with FIS to look at the potential of accessing their self registered and consented data base for disabled children and families to promote events, publish consultations etc. where relevant 27/11/19 - Due to ongoing data quality concerns I am unsure which data source could be used to ensure we don't breach GDPR and that correspondence goes to the correct address. Capita One data needs further investigation. If address data is coming from the school then once we have B2B Open fully implemented we should be in a position to have more confidence in the address data currently held. (AS) Emma please advise 13/01/20 - move date onto Feb 20, delayed.		Emma Baines Angela Stephens	Feb 20**	Green
Improve the business intelligence in relation to the identification of schools where outcomes for SEND are low year on year for Secondary settings		Angela Stephens	Feb-20	Green
To incorporate annual review data set into the weekly SEND Scorecard tab		Sara Barnett	Feb-20	Green

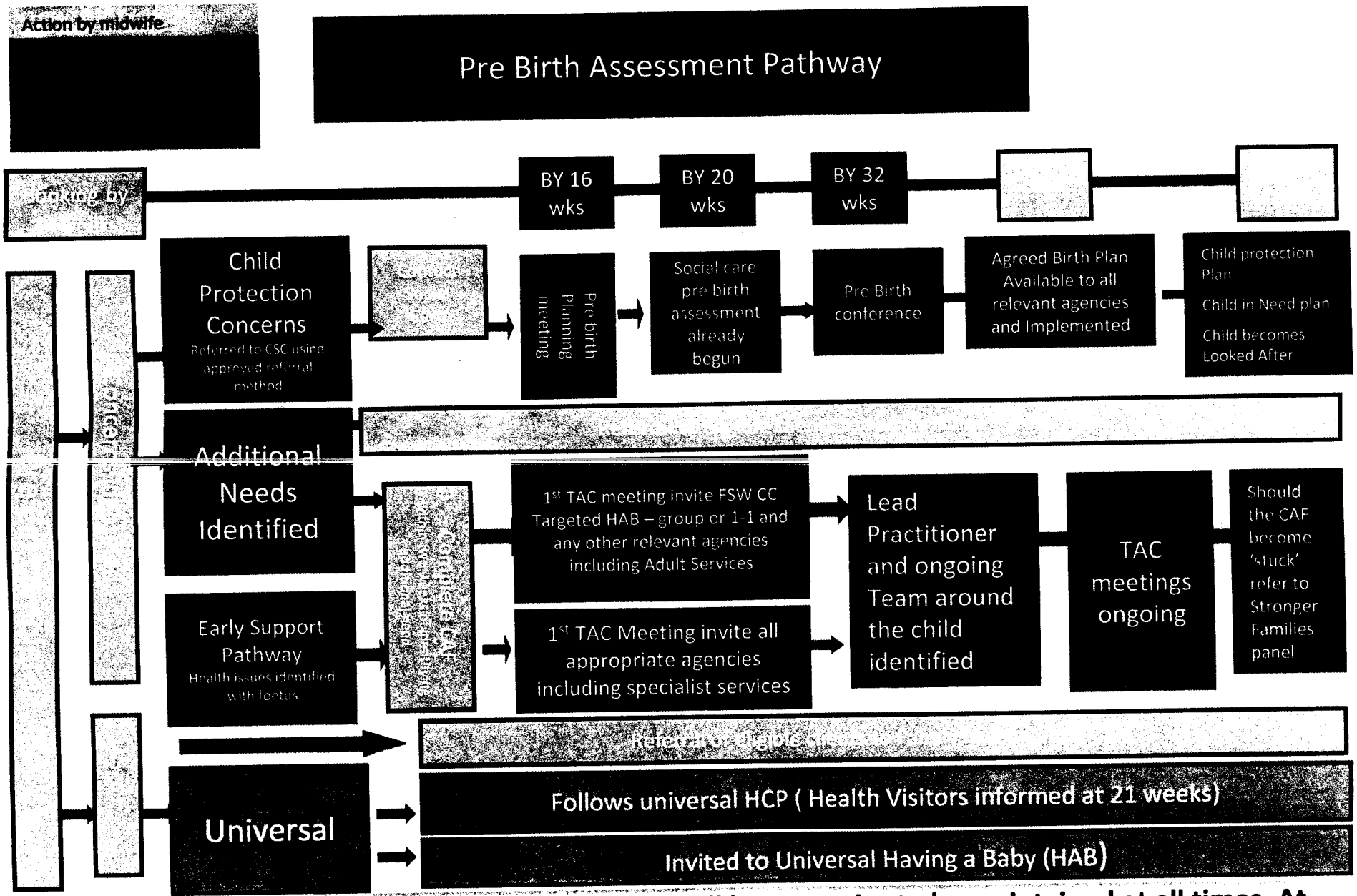
To review the data on the weekly SEND Scorecard tab and agree on an appropriate format	Angela Stephens Sara Barnett	Feb-20	Green
To review and evaluate the Rotherham monthly report to identify key SEND information that can be translated for use in Barnsley to assist in improving data and information	Angela Stephens Sara Barnett	Feb-20	Green
To develop the 20/21 version of the SEND Scorecard	Angela Stephens	Feb-20	Green
To automate the SEND Vulnerability Matrix 06/01/20 - AS providing the latest version to Richard for checking and signing off	Angela Stephens	Feb-20	Green
As a result of the evaluation of data held within Capita One, address the gaps and data cleanse the information held within Capita One **15/10/19 The scope of this needs narrowing - would not be happy for this broad statement to be included. Also needs to be a combined Service / BII action - not just BII (MR).** 14/11/19 - agree also service responsibility, please can conversation take place with Angela BII re contribution of inputting data? (JN) 27/11/19 - We have agreed support from one of our Data Management Officers which will begin with ending 200+ plans that service have identified. However BII have concerns regarding the multiple data sources in use at the moment e.g. Capita One, BRUCE and spreadsheets. If we carry out this task in Capita One who will update the other data sources to ensure inaccurate and out of date information is not being used? I have put in an IT request for myself and our DMO to be given the rights to edit the SEND data in Capita One - status says On Hold. This is because IT are waiting for SEND team to authorise the request (email went to Sarah McCarthy). There is also a lack of clarity in how data from the new EHCP Hub will feed back into Capita One. Although some data can be exported from this hub in the form of an API, no conversation has taken place with Capita One to ensure they will allow the data to be imported back in. It is possible they will not allow it or if they do that it will incur some costs that have not been taken into account. Also concerns that we will be effectively continuing with multiple data sources. (AS)	Emily Wilson Angela Stephens	Mar-20	Green
Implement a robust system and mechanism for implementing learning and feedback from complaints which is focussed on improving services delivered to children and families with SEND 20/11/19 - Action plan is in the process of being developed 10/01/20 - Action plan now developed	Lisa Loach Sara Barnett	Mar-20	Green
Implement and embed the use of Vulnerability Matrix alongside SEND school risk assessments to inform and improve delivery and support to schools	Bev Bradley - (new SM when in post) Angela Stephens	Apr-20	Green
Implement a rationalised data set in order to report more accurately and remove potential for duplication and delay, including: through implementation of the EHC Hub and decommissioning of BRUCE	Emily Wilson Angela Stephens	Jan-21	Green
Work with the implementation of the preferred data management system (currently CapitaOne) to optimise services for children with SEND	Emily Wilson Angela Stephens	Jan-21	Green
Regular updating and monitoring of the SEND Scorecard 16/10/19 - All updates from BI have been actioned in a timely manner - issue with service weekly updates needs resolving 27/11/19 - 2019 Scorecard is up to date (with exception of the weekly data Service should provide. Work has begun on the 2020 Scorecard which will contain additional data and a re-vamp of the weekly tab to ensure we can easily compare ourselves to the same point in time the previous year, allowing us to track performance more closely (AS)	Angela Stephens	Ongoing	Green

Success Criteria (Impact)		
SEND scorecard further developed, published and used regularly		
Annex A data (now known as SEND Vulnerability Matrix) set further developed and used regularly by the service to inform service delivery		
EYFS outcomes report used and embedded into business as usual service delivery and more under 5's identified with SEN needs accessing support		
2yr old termly analysis used and embedded into business as usual service delivery and more 2yr olds identified with SEN needs accessing support		
Key stage trend report used and embedded into business as usual service delivery, schools better supported to deliver appropriate SEN needs		
Evaluation of Capita One data quality complete and findings and recommendations report distributed		
Parent/carer survey complete and findings known		
Update on Progress and Impact		
SEND scorecard produced and is being used by the service, further development work ongoing		
SVM (formerly Annex A) dataset produced and is being analysed within the scorecard. Service aware of it's availability and any concerns highlighted. Automation of list developed by BI team, soft release planned Sept 19 Workshop held on 11 September, follow up due on 30 September. Amends required, and sign off via Nina and Richard required following this.		
2019 data provided to key staff		
EYFS outcomes report used by the Early Years Consultant team in order to further identify those children who may have SEND.		
Discussions taking place with Information Governance		
2019 data currently being collected, next data set will be circulated end of Sep		
survey to go live in four weeks		
Automation of the SEND Vulnerability Matrix (SVM), previously known as the SEND Annex A, has been implemented. Further developments to SVM are being planned in over the next few months. Automation of other reports (SEND Scorecard etc.) is business as usual for the BII Team in developing any future reporting		
Evidence		
Barnsley LA Rainbow Sheet 2019 (State-funded providers)	SEND and SEN Support Lists (SVM, formerly known as Annex A)	Joint Strategic Needs Assessment - https://www.barnsley.gov.uk/barnsley-jsna (MR)
Parent/carer survey report (MM Oct 19) - this was in batch that came across with other docs	SEND Outcomes Trend Analysis - Primary Schools (AS)	Out of Borough Placements Review Plan (Helen Perrin Jan 20)
SEND Scorecard - Dec 19 (AS)	2yr old termly analysis (Jan 20 LB)	Complaints and Incidents Action Plan (LL Mar 20)
List of recommendations from SEND Strategy for Plan (SS Jan 20)	SEND Outcomes Trend Analysis - Secondary Schools (AS Feb 20)	Outcomes report of 37 children (ST Oct 19) - also for P1 O1.1
ECG Minutes - parent/carer survey report (SS Oct 19)	Rainbow Report (ST Oct 19) - also for P1 O1.1	

PRIORITY: Records and Case Management	**Establish Information Management Systems which support efficient and effective case management, including appropriate information sharing across agencies**			
OBJECTIVE	**Review current records management systems; identify and implement actions to improve efficiency and quality of record keeping and case management**			
Overall Progress:	**Green**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Develop new action around information sharing across all agencies, link in the apps as part of SharePoint online, also include IT, Riley Marsden, SharePoint team Shane Jagger (Judith / Angela Lomas / Tracey Letchford to work up the action)		Judith Nash	Jan-20	Green
Create and recruit to dedicated project manager positon 20/11/19 - post created, recruitment underway - closing date 29/11		Richard Lynch Lisa Loach	Jan-20	Green
Develop a detailed programme plan for the Hub implementation		Richard Lynch Lisa Loach	Feb-20	Green
Implement phased introduction of hub with partners and parents		Richard Lynch	Jul-20	Green
Review impact and effectiveness of the hub		Richard Lynch	Jan-21	Green
Success Criteria (Impact)				
New case management system implemented and all stakeholders working collaboratively				
Improved customer experience				
Service efficiency increases, quality of data improves				
Dedicated project manager support in place				
Update on Progress and Impact				
Hub system procured				
Implementation plan in development, background preparatory work underway				
Project manager post out to advert				
Demo of the EHCP Hub with key stakeholders has taken place				
Recruitment of additional business support (time limited) underway				
Evidence				
User satisfaction survey	Management information report	Hub Review Report (LL Jan 21)		
Hub Implementation Project Plan (LL Feb 20)				

PRIORITY: Workforce Development	**Ensure professionals across all relevant services have access to and engage in continuous professional development which supports them in identifying and meeting the needs of children and young people with SEND (0-25), in line with the Code of Practice**			
OBJECTIVE	**Partnership workforce feel confident in identifying and meeting the needs of children and young people with SEND**			
Overall Progress:	**TBC**	**Owner:**	**Judith Nash**	
Actions		**By who?**	**Timescale**	**Progress**
Establishing qualification levels of current SENCO's and teaching assistants, whether the training is sufficient to meet need and establish targets which will lead to an appropriately qualified workforce (to include in workforce strategy and plan) 23/12/19 - not sure where this action has come from as it is not included within the Workforce Development Strategy and Plan therefore cannot be completed by November 2019. Please contact AJG to discuss (AJG) 13/01/20 - Bev Bradley to pick this up ongoing		Bev Bradley	Nov-19	Amber
We have a clear vision in place that is understood by all, including ensuring vision articulated in CYP Plan/SEND Strategy is aligned to priorities and is embedded to ensure everyone is working to the same goals and outcomes		Sarah Sinclair Amanda Glew	Mar-20	Green
We use feedback to identify what is working well and where we need to make further improvements, through the development of Quality Assurance activities and tools		Judith Nash	Mar-20	Green
We ensure we have the right people with the right skills and behaviours in roles that support children, young people and their families through effective workforce planning across all partners 05/11/19 - workforce planning to be included within the actions for the Training and Development Task & Finish Group 23/12/19 - to commence once the training and development matrix is complete (AJG)		Amanda Glew	Sep-20	Green
We have a comprehensive training and development programme in place that meets the needs of the workforce and ensures children, young people and their family's needs are understood and met 05/11/19 - Training and development TFG have agreed the scope of the SEND workforce and categorised by tiers of involvement, commenced the collation of the current SEND workforce development offer across all partners and identify gaps in existing provision 23/12/19 - the Training and Development TFG has been expanded to include others with a training and development focus. An initial training matrix has been drafted consisting of all SEND related training and development activities. The next stage is to pull this into themes in order to identify opportunities for joint training across all partner agencies (AJG)		Amanda Glew	Sep-20	Green
KIDS to deliver more co-production days to staff 15/10/19 - query, is this training to staff? If so which staff. Not sure where this sits, need further discussion - Mellissa can you pick this up 03/12/19 - (This should focus on specific processes rather than a general workshop e.g. EHCP Planning, joint assessment etc...) This should result in a statement (SS)		Mellissa Mackell	Ongoing	Green
All Leaders across the system are committed to improving the quality and range of provision for children with SEND		TBD	TBD	Green
We take a one team approach by working in a joined up way to support children, young people and their families, including working collectively to review and improve existing processes and identification of opportunities for further training and development		Judith Nash	TBD	Green
We have a communication plan in place which uses a common language to ensure shared understanding of priorities, provision, progress and outcomes which also identifies opportunities for further engagement which supports children and young people and their families 05/11/19 - support from communications in relation to this action have been agreed		Hanna Bailey	TBD	Green
Success Criteria (Impact)				
There is a highly skilled, knowledgeable and confident workforce across all services and agencies in relation to SEND				
All partners understand coproduction and use when working with parents/carers				
Training delivered to primary and secondary settings using the toolkit				
Inclusion development SENCO's have measurable data of improved inclusion e.g.. Reduced exclusions				
Rate of EHCP's in settings and services better understood which enables the development of evidence based action plans				
Update on Progress and Impact				
Initial scoping undertaken at the Joint Planning Board meeting on 16.05.2019 in order to shape the strategy and plan.				
Initial training completed, second session planned for Autumn				
Evidence				
Co-production policy	KPI - reduced exclusions	Inclusion Framework (BB Jan 20)		
Workforce Development Strategy and Plan 2019/20 (AG) - pick up with Nina/Rachel D	Feedback from co-production event/s. Agreed process and key areas for application (SS)			

PRIORITY: Achieving Financial Balance	**We will develop greater resilience in the High Needs Block budget and wider schools funding and aim to meet the needs of SEND pupils within available resource**			
OBJECTIVE	**To ensure value for money and improve financial planning and controls**			
Overall Progress:	**Amber**	**Owner:**	**Richard Lynch**	
Actions		**By who?**	**Timescale**	**Progress**
Improve financial controls in relation to placement decision making 20/11/19 - financial colleagues starting to be involved in placement decision making, more work needed regarding this, including consideration of attendance of financial colleagues at panel meetings. Can we move the date on? also management oversight of high tariff placements in mainstream and special schools needs improving. Monitoring and reporting of high needs pressures has improved but more work to be done.		Richard Lynch Joshua Amahwe	Nov-19	Amber
Develop a proposal to schools forum to transfer additional funds from DSG to High Needs Block for 20/21 financial year onwards 20/11/19 - currently consulting with schools on a 2% funding transfer proposal. This has been to SMT to discuss and consider the transfer options. Schools forum meeting planned on 12 Dec 19 to approve the funding transfer proposal		Joshua Amahwe	Dec-19	Green
Develop financial recovery plan to articulate approach to managing down High Needs Block over commitment 07/11/19 - check the rag status of this one with Josh 20/11/19 - recovery plan not yet started, work is planned over the next 4 weeks		Joshua Amahwe Richard Lynch	Jan-20	Green
Review financial commitments in line with EHCP annual reviews		Judith Nash	Mar-20	Green
Review INMSS (Independent Non-Maintained Special School) placements with a view to local reintegration where appropriate 14/11/19 - Judith to include more detail within the annual review page re this (JN)		Judith Nash	Mar-20	Green
Develop and implement school placement contracts with local special schools and providers 07/11/19 - check the rag status of this one with Sarah 03/12/19 - this is on track to be completed (SS)		Sarah Sinclair	Jul-20	Green
Success Criteria (Impact)				
Improved forecasting enables more accurate financial planning				
High Needs Block deficit reduces				
Reliance on INMSS placements reduces				
Measurable outcomes of the forecasting tool allows us to forecast and model for future years				
Financial impact is better understood which allows us to assess impact of improvement actions				
Improved understanding of the financial impact of placement decision making				
Schools forum agree the funding transfer proposal of 2% which will reduce the forecast deficit in 20/21 by £1.6m				
Update on Progress and Impact				
First draft of financial modelling complete				
Improved monitoring of out of borough spend developed and implemented				
Contracts in place with providers of resourced provisions				
Evidence				
Financial modelling and forecasting tool (JA Nov 19)	School Placement Contracts	Financial Recovery Plan (JA Jan 20)		
Financial Commitments Tracker (JA Nov 19)	Complex Case Tracker	SEND Sufficiency Strategy (SS/RL Apr 20)		
Schools Consultation Document - high needs funding transfer (JA Nov 19)				



Communication/sharing of information between all key agencies to be maintained at all times. At any point a child could move between the four tracks if circumstances change.

.10 Children At Risk Where A Parent Has A Mental Health Problem

print

Contents

Introduction

1. The mental health of a parent or carer does not necessarily have an adverse impact on a child but it is essential to assess the implications for the child. If any agency has concerns that a child is at risk of harm because of the impact of the parent/carer's mental health they should check to see if the child is subject to a **Child Protection Plan – see Recording that a Child is the subject of a Child Protection Plan Procedure**.

2. Children are at greatest risk when:

    - the child features within parental delusions
    - the child becomes the focus of the parent's aggression.

    In these circumstances the child should be considered at immediate risk of harm and a referral made to Children's Social Care Services in accordance with the **Referrals Procedure**.

3. Where it is believed that a child of a parent with mental health problems may be at risk of significant harm, a **Strategy Discussion/Meeting** should be held and consideration should be given to undertaking a **Section 47 Enquiry**

4. In circumstances whereby a parent/carer has mental health problems it is likely there are a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent's mental health, their parenting, and the impact on the child. Any assessment should include an understanding of the needs of the family and children and an identification of the services required to meet these needs.

Guidelines for Joint Working

6. It is essential that staff working in adult mental health and child care work together within the application of child protection procedures to ensure the safety of the child and management of the adult's mental health.

7. Joint work will include mental health workers providing all information with regard to:

    - treatment plans
    - likely duration of any mental health problem
    - effects of any mental health problem and medication on the carer's general functioning and parenting ability.

8. Child protection workers must assess the individual needs of each child and within this incorporate information provided by mental health workers.

9. Mental health professionals must attend and provide information to any meeting concerning the implications of the parent/carer's mental health difficulty on the child. These will include:

    - **Strategy Meetings**
    - Initial and Review **Child Protection Conferences**
    - **Core Groups.**

10. Child care professionals must attend Care Programme Approach (CPA) and other meetings related to the management of the parent's mental health.

11. All plans for a child including **Child Protection Plans** will identify the roles and responsibilities of mental health and other professionals. The plan will also identify the process of communication and liaison between professionals. All professionals should work in accordance with their own agency procedures/ guidelines and seek advice and guidance from line management when necessary.

Contingency Planning

12. Child care and mental health professionals should always consider the future management of a change in circumstances for a parent/carer and the child and how concerns will be identified and communicated. This may include:

Mentally ill parents and children's welfare

By Richard Green (February 2002)

Key points

The extent to which parental mental illness effects the standard of parenting and children's safety or welfare hinges on a number of factors. A small number of children die or are seriously harmed by a mentally ill parent. Many more children suffer less dramatic effects as their own development or mental health becomes compromised. There is a *'hidden problem'* around children who care for a mentally ill parent ('young carers') who may miss out on many opportunities. The *'scale of the problem'* is not known but it has been estimated that psychiatric morbidity amongst parents is about 16%. There are many barriers - legal, structural, professional, financial - to the creation of services which tackle both parental mental illness and children's welfare but some interesting initiatives have been set up.

The impact upon children

Parental mental illness takes many different forms. Its impact upon children varies according to a host of factors. One is the severity and duration of the illness. For instance, a temporary and minor illness handled by primary care services is likely to be much less disruptive to family life than a severe and chronic psychotic illness requiring lengthy hospitalisation. Other variables include the child's age and resilience, the presence or absence of a *'well'* parent/ carer and the extent to which the illness pervades all aspects of family life (Rutter, 1989). It is tempting, but inadvisable, to give undue weight to the psychiatric diagnosis. As Reder et al (1993) point out, the telling factor is not the diagnosis as such but the parental *behaviour*.

So, how does parental mental illness affect children? The research can be distilled into three sub-headings the impact upon parenting, direct effects on children and children who care for a mentally ill parent.

Effects on parenting

There is a body of literature and research (Murray, 1996; Ethier et al, 1995; Dore, 1993; Sheppard, 1993) which points to those suffering mental illness having impaired social performance and disproportionately conflictual relationships. Parenting may be adversely affected. Ethier et al (1995), for instance, found that clinically depressed mothers were more likely to speak less often to children, enforce obedience unilaterally and react in more hostile and irritable fashion. Murray (1996) produced similar findings of social disadvantage, relationship problems with children and the latter having increased levels of behaviour difficulties.

A small study of parents who use mental health services (Hugman and Phillips, 1993) showed that all thought their relationships with their children had suffered at some point. It is generally held that parental mental illness is a risk factor in respect of child abuse (Sheppard 1993). Forthcoming research into serious injuries sustained by children under 24 months suggests many parents had poor mental health (Dale, Green and Fellows, forthcoming) though a formal diagnosis of mental illness was relatively rare. Research (cited in Dore, 1993) which has inquired into causal relationships between parental mental illness and abuse has produced mixed findings

Direct effects on children

There is a second body of literature/ research which has covered much of the same territory but from the perspective of child welfare. A pioneering paper by Kempe et al (1962) posited that psychiatric factors were probably *'of prime importance'* (Kempe et al, 1962, p.17) in the aetiology of child abuse. Subsequent research has suggested that the causes of child abuse are generally more complex and multi-factorial. Nonetheless, Bell et al (1995) found parental mental illness recorded as a factor in 13% of cases referred for child protection concerns. A number of children suffer permanent injury or die at the hands of mentally ill parents (Falkov, 1995), typically during an acute

phase of an illness. Also a small number are seriously harmed or die as a

consequence of a carer, generally the mother, suffering from Munchausen's Syndrome by Proxy (see e.g. Bools et al, 1994).

Nonetheless, the greatest risk to the majority of children is not one of life and limb. It is rather the threat to their own attachments, development and mental health (Rutter, 1989). Rutter and Quinton (1984) concluded that one-third of the children of new psychiatric cases exhibited a persistent disorder, this being twice the rate found in the control group. A recent study (Singer et al, 2000) found high rates of psychiatric disturbance within a small sample of children of psychiatric in-patients, many of these children being unknown to services. Reid and Morrison (1983) suggested that young children are particularly vulnerable, as are the children of psychotic parents. The issue of whether psychosis poses more risk than, say, depression is a typically complex one within this field and, as with many issues, best treated with caution. For instance, Cassell and Coleman (1995) posit that children are at increased risk if incorporated into parental psychotic ideation conversely, other research (see Dore, 1993) showed no differences in outcomes between children of psychotic and depressed parents.

Children who care for a mentally ill parent

Finally, there is a third germane body of literature/research which focuses on children who care for a mentally ill parent. These are commonly referred to as young carers though this is mostly employed as a generic term encompassing children who care for parents for a number of different reasons, including parental physical disability or physical illness. Estimates of the numbers of young carers nationwide vary between 10,000 and 40,000, of which about one-third care for a mentally ill parent (Dearden and Becker, 995). Care is more likely to be provided by girls than boys and may well have a physical and emotional component. It is also likely to be provided to younger siblings as well as ill parents. A number of personal accounts (Marlowe, 1996) and reports (SSI, 1996) point to the difficulties experienced by a proportion of young carers. The problem is not the caring per se - indeed, many young carers report a wish to undertake this role. It is the missing out on educational, social and leisure activities that is sometimes concomitant with this role. Young Carers are something of a *'hidden problem'*, being either unknown to services or being left to cope.

Our own study (NSPCC, 1997) contained some poignant accounts of children acting as carers and of the costs thus incurred. It also showed that many of these children had significant experiences of loss, self-blame and stigma.

The scale of the problem

Accurate data as to the percentage of mentally ill parents who have dependent children is not systematically recorded (Falkov, 1997). Indeed, at the point of first contact with mental health professionals many recipients of mental health services are not identified as parents (Blanch et al, 1994). Thus, information as to the scale of the problem is largely based on estimates. Within this context, Gopfert estimates that one half of all mentally ill adults are parents living with dependent children (Gopfert et al, 1996). Meltzer et al (1995) estimate the psychiatric morbidity among parents nationally to be 16%.

There are a number of studies which examine the prevalence of mental illness amongst adults (not necessarily parents) which suggest that prevalence is governed to some extent by gender, ethnicity and class. It is known, for example, that twice as many women as men suffer from depression (Sheppard, 1993) and that depression is a particularly common disorder amongst women of child-bearing age (Downey and Coyne, 1990). A seminal work established that working class women were four times more likely to suffer from a psychiatric disorder than their middle class counterparts (Brown and Harris, 1978). There are differential rates of prevalence within different cultures. This may reflect a link between social stress (racism unemployment, poverty etc) and mental illness (see e.g. Littlewood and Lipsedge, 1989). However, the picture is complex as there is not a clear one-to-one relationship between social disadvantage and mental illness. One difficulty is that the term *'mental illness'* is itself culturally-bound; mental health may manifest itself differently in different cultures. Community based studies suggest that prevalence rates are about 1% for schizophrenia, 5% for depression, 10% for personality disorders and 10-30% for anxiety disorders (quoted in Cleaver et al, 1999).

Research into the field of mental illness is mired in definitional / methodological difficulties. For instance, a number of studies might all examine *'mental illness'* but be looking at very different phenomena. Some studies are drawn from samples of psychiatric in-patients whilst others are drawn from the community at large, depending mostly on respondents' self-report. It does not necessarily follow that the findings drawn from a psychiatric sample examining psychosis can be compared or integrated with those examining those suffering depression in the community. Equally, some studies include alcohol and substance abuse whilst others exclude these.

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Recommended reading

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Mayes, K., Diggins, M. and Falkov, A. (1998) *Crossing bridges: training resources for working with mentally ill parents and their children*. London: Department of Health.

Other organisations to contact

- **Association for Child and Adolescent Mental Health**

www.acamh.org.uk

- **Mental Health Foundation**
  www.mentalhealth.org.uk
- **MIND**
  www.mind.org.uk
- **YoungMinds**
  www.youngminds.org.uk

This research briefing is based on a review of research and literature. It reports the findings and views of a range of authors. These views are not necessarily the views of the NSPCC.

Although the websites listed here are checked regularly the constantly changing nature of the internet means that some sites may alter after we have viewed them. The NSPCC is not responsible for, nor does it necessarily endorse, the content of these external websites.

Help for children & young people
0800 1111

Help for adults
0808 800 5000

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Future in Mind – Local Transformation Plan Implementation Group

Terms of Reference

NHS Barnsley Clinical Commissioning Group
Future in Mind – Local Transformation Plan Implementation Group

1. Introduction

1.1 Barnsley CCG and partners have established a Future in Mind Implementation Group to ensure delivery of the assured Barnsley Local Transformation Plan. Oversight of the performance of the higher level support CAMHS services (previously referred to as Tier 3 services), within the Barnsley system of care and support for children, young people and their families will be undertaken via the normal contractual mechanisms and the appropriate Clinical Quality Board.

2. Purpose

2.1 The primary purpose of the 'Future in Mind' Group is to work collaboratively with all parties to ensure effective implementation of and continuous monitoring of the Barnsley Local Transformation Plan to enable delivery of sustained improvement in the emotional Health and Wellbeing of the Children and Young People in Barnsley. The 'Future in Mind' Group will also further develop plans for continued delivery of these improved outcomes over the next five years.

3. Responsibilities

3.1 The responsibilities of the Group will be as follows:-

- To provide a forum for open, honest and transparent dialogue to ensure implementation of the actions outlined within the Local Transformation Plan.

3.2 To agree who/which organisation will lead the delivery of each of the Local Priority Streams outlined in the LTP and to work collaboratively to ensure organisational barriers do not impede effective delivery of the desired outcomes of the Plan;

- To develop metrics/KPIs against which effective delivery of the LTPs objectives can be measured;

- To provide quarterly assurance to NHS England of the appropriate investment of FiM monies and the impact this investment has on the emotional health and wellbeing of children and young people in Barnsley.

4. Stakeholders

(a) Barnsley CCG Chief Nurse (Chair)
(b) Barnsley CCG Head of Commissioning Mental Health, Children's and Specialised Services
(c) Barnsley CCG Clinical Lead

(e) BMBC Family Centres & Early Years
(g) BMBC Education Psychology
(h) BMBC Youth Offending Team
(i) Public Health
(j) Secondary Schools Representative
(k) Primary Schools Representative
(l) SWYPFT District Director – Forensics & CAMHS and/or SWYPFT Deputy Director CAMHS
(n) SWYPFT Clinical Lead/Senior Clinician

(q) School Nursing Service

The Group will be serviced by the administrative support to the Chief Nurse.

5. Meetings

5.1 There will be 2 Stakeholder Engagement Events held each year (March and September).

5.2 Local Priority workstream leads will meet on a monthly basis and these meetings will be facilitated by the CCG

6. Governance

6.1 The Group will be a Sub-Group of the Children & Young People Executive Commissioning Group.

7. Reporting Arrangements

7.1 Agendas and papers will be distributed to Stakeholders / workstream leads by email, one week prior to the relevant meeting.

7.2 The minutes/action log will be distributed to stakeholders / workstream leads, by the administrative support to the Chief Nurse, no later than two weeks after the relevant meeting.

7.3 A highlight report will be agreed and submitted to the Children's Executive Commissioning Group following each Stakeholder Engagement event. A verbal update as to progress of the implementation of the Transformation Plan will be given at every ECG.

7.4 Trackers will be submitted by the Chief Nurse's administrative support to NHS England on a quarterly or as required basis.

9. Duration

9.1 The Stakeholder Events and monthly workstream leads meetings will continue until such time as the members agree that a system wide sustainable low level emotional health & wellbeing support for Children & Young People exists in Barnsley and is delivering desired outcomes.

Last Reviewed: July 2016
Next Review Due: July 2017