Salford City Council

NHS

Salford Clinical Commissioning Group

Salford Child and Adolescent Mental Health Transformation Plan 2015 – 2020

December 2015

Contents

1 Executive Summary

1.1 We want children and young people in Salford to enjoy a happy, confident childhood and to achieve their potential. We want them to grow into resilient adults able to cope with the demands of daily life, and empowered to contribute to life in the city. This Child and Adolescent Mental Health Service (CAMHS) Transformation Plan sets out our initial ambitions to achieve this. Ultimately we want to support children, young people and their families at an earlier stage, ensuring swift access to services if they need it and support them back into communities when they are ready to move on. Therefore we want to re-profile our current spend, to move away from in-patient provision and focus on community support.

1.2 The report that follows outlines the background to this transformation work, with the Greater Manchester (GM) devolution agenda and the Salford 0-25yrs integration work, highlights the needs identified so far around emotional health, profiles current activity and spend and what has been achieved to date and sets out the plan for the next 18 months against Future in Mind priorities and our overall aim and outcomes for 2020.

2 Introduction

2.1 The report of the Children and Young People's Mental Health Taskforce published in March 2015, established a clear direction and some key principles about how to make it easier for children and young people to access high quality mental health care when they needed it. In line with this, NHS England (NHSE) is developing a major service transformation programme to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years in line with the proposals put forward in the Taskforce report *Future in Mind promoting, protecting and improving our children and young people's mental health and wellbeing.*

2.2 *Future in Mind* establishes a clear direction and some key principles on making access to mental health care easier for children and young people. In August 2015 additional guidance was published to support local areas to develop local transformation plans and specialist community eating disorder services:

- NHSE (2015) *Local Transformation Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas*
- NHSE (2015) *Access and Waiting Time Standard for Children and Young People with an Eating Disorder Commissioning Guide*

This was accompanied by additional monies identified nationally in the Autumn Statement (2014) and the Spring budget (2015). Local allocations will be based on the assurance of detailed, locally agreed transformation plans and have been set in line with standard Clinical Commissioning Group (CCG) allocation formula. An initial allocation was released with the publication of the guidance to fund eating disorder (ED) services and planning, with additional funding available when the transformation plan is assured. For Salford this is £160,639 and £402,096 respectively, total £562,736 recurrent from 2016/17 onwards.

2.3 The guidance on local transformation plans outlines a phased approach to service transformation and details how the extra funding will be used and how local areas should plan to meet their local needs and priorities. This is based on the integrated whole system approach outlined in *Future in Mind*. Improvements will be driven through building resilience, prevention and early intervention, a step change in how care is provided to focus on the needs of children, young people and their families, improved access as close to home as possible, a joined up approach with linked services, evidence-based service improvement

and transparency and accountability across the whole system. The plans should cover the whole spectrum of services for children and young people's mental health 0-18yrs from prevention to interventions, including in patient care (Tier 4) and transitions between services. They should address the full spectrum of need including children and young people who have particular vulnerability to mental health problems e.g. those with learning disabilities, Looked After Children (LAC) and care leavers, those at risk or in contact with the Youth Justice System, or who have been sexually abused and/or exploited. There is a clear emphasis on local level collaboration with children, young people and those who care for them as well as providers, commissioners and other key partners including local Healthwatch.

2.4 This plan is Salford's response to *Future in Mind* and the guidance mentioned above. The lead accountable commissioning body is Salford CCG. However, the development of the plan for children and young people's mental health rests on close collaboration with Salford Local Authority (LA) and wider partners, and it is part of an on-going integration agenda for children and young people 0-25yrs across the economy.

2.5 Children and Young People's mental health forms an integral part of the Greater Manchester wide Health and Social Care early implementation priorities. Devolution provides Greater Manchester with the opportunity to take advantage of it unique position and collectively respond to the challenges outlined within Futures in Mind and in doing so make a step change in the provision of services for the young people in Greater Manchester. Greater Manchester is developing an all age Mental Health and Wellbeing Strategy that will provide an umbrella for our work on Children and Young People's mental health and the locality Transformation Plans. Implementation of the strategy will redress the balance of services, increasing community based provision and early intervention reducing the need for higher level interventions and in turn delivering efficiencies through a reduction of high cost, intensive interventions and use of beds. The GM strategy will focus on prevention**,** access, integration and sustainability. Salford CCG will work with the Greater Manchester Health and Social Care Devolution programme to capitalise on any opportunities for collaborative working, joint commissions and investments and data collection and collation. We understand that a high level vision for IM&T is in development, as part of wider devolution work, to cover all aspects of the Health and Social Care Devolution priorities, and that Bury CCG have instigated a working group to consider the development of IT systems across a GM footprint and we will engage with this.

3 Background

3.1 Our ambition is to ensure that all children and young people in Salford enjoy a happy, confident childhood and achieve their potential. We want them to grow into resilient adults able to cope with the demands of daily life, and empowered to contribute to life in the city. When children and young people need help, we want them to find it easily, for it to meet their needs, be delivered by people who care and for services to listen to their views. In a crisis we want them to get help quickly and as close to home as possible. For this to happen, all services need to work together so that children and young people get the support they need at the right time and in the right place.

3.2 To support the achievement of this ambition, Salford LA, CCG and wider partners have committed to a broad transformation programme of integrated support for children and young people 0-25yrs. It involves the review and redesign of provision and commissioning of all services for 0-25yr olds to achieve the best outcomes for children and their families in the most cost effective way possible. The work is informed by the Salford 0 to 25 Strategic Review and involves whole-system alignment of resources, moving away from historical,

cultural and organisational constraints. The vision is to enable all children and young people in Salford to achieve their potential and it is built around the design principles in Appendix 1 that allow system transformation.

3.3 As part of the delivery of this work three tests for change have been identified, including one around emotional health and wellbeing into CAMHS. The test for change work has just commenced and aims to improve the effectiveness of emotional health and wellbeing support, and CAMHS, through improved commissioning and pathways. The current CAMHS Transformation Plan is part of this wider objective.

3.4 The governance for the integrated 0-25 work is through an 0-25 Integration Board that receives reports from the Programme Oversight Group, via organisations internal governance structures, that in turn receives reports from the test for change project groups (see diagram in Appendix 2). The Integration Board reports through to the Health & Wellbeing Board, Children's Trust and local Safeguarding Children Board. The governance for the CAMHS Transformation Plan will incorporate elements of this Structure, reporting through the CCG Children and Young People's Commissioning Group and Programme Management Group (meet monthly) to the CCG Governing body and the joint 0-25 Integration Board (meets bi-monthly) and ultimately to the Health and Wellbeing Board (meets monthly). Terms of Reference for these groups are available by request.

4 Needs Assessment

4.1 The following data is taken from a number of different sources to build a picture of emotional need within Salford. This includes information from the Children and Young People's Strategic Review (2015), highlights from local consultations undertaken so far and safeguarding reviews.

4.2 The 2015 Chimat Child Health Profile identified that Salford was significantly worse than the England average for hospital admissions for mental health conditions (0-17yrs) and hospital admissions as a result of self-harm (10-24 years). This highlights that there is work to be done across the pathway from prevention to treatment to ensure better emotional outcomes for children and young people.

4.3 This is endorsed within the following highlights on emotional need from the LA Children and Young People's Strategic Review (2015).

4.3.1 *Early Years Foundation Stage Profile*: the assessment of children's development at age 5 includes three measures under the heading Personal, Social and Emotional Development (self-confidence & self-awareness, managing feelings & behaviour and making relationships). Salford children are generally at the expected level, however fewer children are exceeding the expected level when compared to the England average. This follows deprivation.

4.3.2 *Bullying*: a survey of 5-13yr olds identified that 68% hadn't been bullied in the previous year, the majority identified that it happened in school, only 57% would feel comfortable to tell someone if they were bullied at school and 3% identified that they did not feel safe.

4.3.3 *Looked After Children*: in 2014 81% of Salford's 295 children looked after for at least 12 months (aged 5 to 16) had a Strength and Difficulties Questionnaire (SDQ) score submitted. The average Salford score was below the North West and England average and within the normal range, showing that smaller numbers in Salford indicating cause for concern with their emotional health.

4.3.4 *Alcohol:* Alcohol-Specific Hospital Admissions for under 18s is declining but Salford remains above the North West and England average.

4.3.5 *Substance Misuse:* Hospital admissions for substance misuse 15-24yr olds is increasing with Salford above the North West and England average.

4.3.6 *Youth Justice*: Between 2006/7 and 2012/3 there was a reduction in first-time entrants to the youth justice system. In 2013/14 there was an increase but Salford is not significantly higher than England.

4.3.7 *Self-Harm*: There has been a fall in the rate of hospital admissions for self-harm amongst 10-24yr olds but Salford remains higher than England.

4.3.8 *Mental health*: Hospital admissions for mental health among 0-17yr olds have fluctuated between 2010/11 and 2013/14 but are currently above the England rate.

4.4 A review of risk factors for mental disorders in children and young people was undertaken to inform the Emotional Health and Wellbeing Strategy for Children and Young People in Salford 2013-15, and was updated in October 2015 in support of the evidence base for both the CAMHS Transformation Plan and Salford's 0-25 Test Case for Emotional Health and Wellbeing (see Appendix 3). The framework used for this review was the *No Health without Mental Health: Analysis of the Impact on Equality,* (2011) which uses data from the Public Mental Health Review to demonstrate the impact of risk factors and risk groups on mental disorders. From this assessment it is evident that there are a number of key groups in Salford who experience a greater risk of mental health disorders and further work will need to be undertaken to review the extent to which current Tier 2 and CAMHS services are able to meet the needs of these. Part of this will be about collecting effective demographic monitoring data from services to ensure they are receiving referrals for, and supporting, the most vulnerable young people. The most vulnerable groups in Salford include children and young people living in poverty, especially those in households where parents claim out of work benefits and have no qualifications. Children and young people subject to child protection plans in Salford are at significantly increased risk of adverse mental health disorders where underlying risks include domestic violence, parental mental health problems and alcohol/substance misuse. Rates for hospitalisation due to Self-harm are also well above the England average, and are highest amongst Females aged 15-19 and those living in deprived areas. Children and young people engaging in risky behaviours are particularly vulnerable and hospital admissions for young people due to substance misuse are high, and admissions due to alcohol are above the England average. The number of LAC in Salford remains the second highest in GM, and although numbers of first time entrants to the Youth Justice system have reduced significantly, the numbers in Salford are still one of the highest. These will form the basis of an equality analysis of the plan and will help to determine priority areas to ensure equality of access to services.

4.5 Findings from local consultations also demonstrate an awareness of the importance of emotional health generally and views on local mental health services that mirror the opinions expressed by young people and their parents / carers in the Young Minds Report on Children, Young People and Family Engagement for the Children and Young People's Mental Health and Wellbeing Taskforce, December 2014.

4.5.1 The Manchester mental health improvement programme report on the care of young people experiencing a mental health crisis out of hours (July 2014), which included the views of young people from Salford, identified differences between the responses from 16 and17yr olds and young people and parents in core CAMHS. 67% of 16 and 17yr olds and only 10% of those in core CAMHS rated the experience of the service as not very helpful. This related to staff attitudes, length of wait and poor support offered. (N.B. The current crisis service for over 16 years is managed by Greater Manchester West Mental Health NHS Foundation Trust).

4.5.2 In 2012/13, NHS Salford (now Salford CCG) engaged with young people across the city to understand their health concerns and priorities, and mental health emerged as the number one priority for this group. In response, Salford CCG commissioned a 'Theatre in Education' production aimed at 13-14yr olds and the workshop was delivered in nine Salford schools and two Pupil Referral Units (PRUs) during March 2014. The aim was to

increase understanding and signpost to locally commissioned services and local and national support networks. The feedback from schools was very positive and data from 42nd Street also indicated a spike in the number of referrals, therefore the decision was made to re-commission the workshop in 2015. In March 2015, the drama workshop was delivered in six secondary schools and all three PRUs across the city. A total of 990 students participated with almost half completing evaluations (below). 96% said that the plays had significantly increased their knowledge of self-harm. Both students and teachers identified body image and drugs as issues they would like to see covered in future workshops. The workshops will be repeated again in 2016, incorporating an eating disorder theme.

4.5.3 Feedback from five members of the Salford Youth Council about their experience of CAMHS in April 2015 highlighted variations in the time it took to get an appointment with CAMHS and variations in what was offered while the young people waited; the young people acknowledged the stigma related to admitting to having mental health issues; some of the young people experienced gaps between appointments; there was variation in how the young people felt their treatment had gone (with some very positive) and there were comments about the need for schools to have a better understanding of mental health and for professionals to know the range of options out there for young people.

4.5.4 Mental Health was voted as the priority campaign issue by UK Youth Parliament for 2015, with Salford Youth Council commencing a mental health project called 'Frame of Mind'. At the launch event in August 2015, the following issues were raised as a catalyst to why they wanted to commence this piece of work: a lack of awareness of local support services; difficulties in accessing referrals to CAHMS; the length of time to get an appointment; feeling unsupported and abandoned whilst awaiting an appointment and a lack of signposting to local support services. The local campaign aims to educate young people and parents, signpost to appropriate services, support teaching staff and award secondary schools who excel in supporting young people who are experiencing poor mental health.

4.5.5 Feedback from 5 parents / grandparents of young people in the Eating Disorder in-patient service at Central Manchester Foundation Trust (CMFT) in September 2015 identified a lack of community support for eating disorders; long waits to access specialist services; poor understanding of the issues in schools and lack of support and information for parents. They felt that speed of access, to the right expertise and continuity of care were vital.

4.6 In addition, safeguarding concerns have been raised through two Care Quality Commission (CQC) reviews and a serious case review (SCR). The CQC review of Salford LAC and Safeguarding in May 2014 raised the following issues: a small number of young people aged 16 and 17 years who presented in crisis out of hours at adult A&E were being admitted to an adult mental health bed due to an appropriate Tier 4 CAMHS bed not being available and no robust pathway was in place for 16 and 17 year olds attending adult A&E as a result of self-harm. The actions were for Salford CCG and NHSE Area team, together with providers, to work together to ensure clear shared pathways of care underpin support for young people who present at the adult Emergency Department with self-harming behaviours with effective follow up to reduce the risk of further attendances, and to review the capacity of CAMHS community and inpatient paediatric services to prevent young people being placed on adult mental health wards. These actions have been completed and the action plan has been signed-off by the CQC. An audit will be completed in 2016 to ensure the effectiveness of these actions.

4.7 The SCR into Child N identified a number of issues relating to mental health services including a lack of referrals to CAMHS; a lack of agency understanding about mental health services for 16 and 17 year olds; NICE guidance on the management of depression in young people under 18 years was not followed by the GP Practice and 42nd Street not able to offer a

timely response due to a waiting list of 12 weeks. Action plans have been developed for the SCR and are being implemented to address these issues.

4.8 The CQC Mental Health Crisis Report for Salford published in June 2015 highlighted issues relating to children presenting at A&E with mental health concerns. This report states that PANDA (paediatric emergency department) staff did not feel confident in caring for such patients as they had not received mental health awareness training. Also, A&E and Mental Health Liaison Staff staff felt that effective handover to CAMHS was hindered by the lack of access to CAMHS information. Assurance is being sort that agencies are planning their responses to the issues raised.

4.9 In summary, the strategic review identifies a number of areas where Salford has worse outcomes than the England average. Young people themselves have expressed views on the difficulties in having an emotional need recognised and supported; problems in accessing services and support while waiting that endorse the findings of the national consultation for the mental health taskforce. In addition safeguarding reviews have identified particular issues around crisis care for 16 and 17yr olds, accessibility and referral pathways to appropriate services. All of which need to be addressed within the CAMHS Transformation plan for Salford.

5 Current Activity

5.1 The principle commissioned mental health services for children and young people in Salford are 42nd Street (Tier 2), core and targeted CAMHS (Tier 3) and in-patient services (Tier 4). In addition, there are a range of universal services that offer emotional support across the City. Information around these services will be collated but they are not presented here. The information that follows provides details on the above-mentioned commissioned mental health services, presenting the highlights from activity data for Salford, 2014/15; further information is available in Appendix 4.

5.2 The organisation 42nd Street is a charity providing support services to young people aged 13-25yrs under stress in Manchester, Salford and Trafford. They provide a range of services including counselling, individual support, group work and volunteering opportunities. They had 206 new referrals in 2014/15. 110 young people were offered an initial assessment, and 83 attended with 27 Did Not Attend (DNA). 147 young people were offered individual community mental health support, 131 attended with 16 DNAs. The four most frequent presenting issues were anger management, depression, confidence / self-esteem and stress / anxiety.

5.3 Salford's core CAMHS service is delivered by CMFT, providing an outpatient service offering comprehensive assessment and treatment of significantly impairing mental health difficulties for children and young people aged 0-18yrs. The service is NICE compliant with clinical guidelines for those under 18 (specifically psychosis and schizophrenia, bi-polar, social anxiety, anti-social behaviour and conduct disorder, violence and aggression, self-harm, autism, ADHD, anti-social and borderline personality disorder). It also provides a wide range of evidence-based interventions, including Cognitive Behavioural Therapy, Dialectical Behaviour Therapy skills and groups, Eye Movement Desensitization and Reprocessing**,** Family Therapy, Parent Child Game, Parenting Interventions for Attention-Deficit / Hyperactivity Disorder **(**ADHD) and specialist parenting advice for other conditions (alongside other agencies) and Psychotherapy. The service also provides specialist medical (psychiatric) assessment and treatment of mental disorders and mental illness, including medication management and neurodevelopmental assessments e.g. ADHD / ASD (Autistic Spectrum Disorders); post diagnostic groups for ASD and other conditions e.g. Tourettes. In

addition, the service offers emergency provision both in and out of hours in response to requests from Salford Royal Foundation Trust PANDA unit and general practitioners; liaison with health and social care professionals and services via the Duty system and consultation and training.

5.4 The service received 1,326 referrals last year, 55% were from GP's (the graph in Appendix 4 shows the breakdown by practice). There were a total of 1,012 new attendances (DNA rate of 23.5%), and 9,015 review appointments (DNA rate 24%). The average waiting time was 10.5 weeks.

5.5 There are a series of targeted CAMHS services jointly funded by the CCG and the LA. These include a post within the Youth Offending Service (YOS) to offer a CAMHS resource within the health team; the Emerge team offering community based mental health services to young people aged 16-17yrs and services for looked after and adopted children and their carers (Salford Therapeutic Advisory and Referral Service for Looked After Children and CAMHS input into Salford Adoptive Families Support Service and Specialist Fostering). In addition there are some targeted services funded entirely by the CCG, these include a learning disabilities service and a BME service. The information that follows is a summary of some key performance data for 2014/15, with additional information available in Appendix 4.

5.5.1 There were 32 referrals into the YOS, with 24 direct assessments, 37 interventions (young person seen) and 106 intervention sessions. 20 young people were seen with 4 weeks. In addition, 53 consultations were offered to other professionals.

5.5.2 There were 181 referrals into the three LAC services (SAFSS, Specialist Fostering and STARLAC) with 1,495 appointments attended, 145 direct assessments and 1,463 intervention sessions. In addition 1,739 consultations were offered by the service to other professionals.

5.5.3 There were 221 referrals into the Emerge service, with 294 direct assessments offered and 145 of them attended. There were 1,355 interventions offered for 133 young people and 798 intervention sessions attended. All young people were offered an appointment within 4 weeks, and 43 consultations were offered to other professionals.

5.5.4 In 2013/14 in the learning disability team there were 78 appointments offered for developmental assessments and 66 were attended (85%) and parents and carers of 150 children and young people with autism were referred to the autism post-diagnosis groups, and the parents and carers of 86 children and young people completed the groups.

5.5.5 The part-time BME post received 39 referrals resulting in 35 BME children being worked with. A total of 457 sessions were offered, and 323 were attended (14% DNA and 12% cancelled by the patient).

5.6 NHS England commissions specialised services i.e. those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. This includes in-patient beds, including mental health beds, for children and young people. The specialised commissioning team has provided the following data around admissions (Ax) and occupied bed days (OBD) for under 18's in mental health beds (apart from the mother and baby unity). For children's beds there were two admissions with 92 OBD, for acute beds there were 16 admissions with 645 OBD and for mother and baby there was three admissions with 213 OBD. There was no available data for Paediatric Intensive Care, eating disorder, medium and low secure and learning disability secure beds for 2014-15.[1]

[1] The specialised commissioning team have highlighted that the data has been limited by timescales and provider response so would suggest that the data is treated as 80% accurate in relation to admission rates and costings. The main areas of concern would include out of area placements for learning disability, medium secure CAMHS and specialist eating disorder services.

5.7 In addition, IAPT Step 2 services are available for those 16yrs and upwards, consisting of Psychological Wellbeing Practitioners (PWPs) delivering low intensity Cognitive Behavioural Therapy (CBT). PWPs are trained to assess common mental health disorders and collaboratively devise treatment plans with people experiencing sub-threshold, mild, or moderate: depression, panic disorder or generalised anxiety disorder. The main focus of this treatment is supporting the use of a published self-help guide or other CBT self-help materials (sometimes via computerised CBT). In Salford the Step 2 service is provided by Six Degrees Social Enterprise, which aims to build resilient communities. The Step 2 IAPT service in Salford receives over 8,000 referrals a year and uses proven psychological treatments from a multi-disciplinary team. In 2014/15, 19 young people aged 16-17yrs completed a treatment programme with the service (7 male and 12 female), this represents just 1.07% of the total that completed a treatment (1,784).

5.8 The above data presents a number of issues. Within the core CAMHS service there are a significant number of DNA's, the review of failed appointments (see below) has identified some actions to improve this and this will continue to be monitored. The analysis of GP referrals to the service shows that there is significant variation in referral rates between practices, highlighting work to be done with practices to publicise the service. While the average wait is 10 ½ weeks, some wait significantly longer to access a particular service. This needs to be monitored to ensure that the additional investments in the service reduce this waiting time. Work needs to be done to improve the reporting of outcomes not just activity. 42nd Street were able to present some demographic data but unfortunately this is lacking from the other services. All monitoring data will be reviewed as part of the 0-25 integration work and the implementation of the CAMHS national minimum data set will offer significant opportunities to inform improvements around monitoring to ensure the accessibility of the service. There is a lack of robust data regarding tier 4 services, this has been raised with NHSE and is being reviewed and will hopefully enable an accurate baseline from which to measure progress.

6 Current Finances

6.1 The total investment in the above services in 2014/15 is broken down in the table below, with additional information supplied in Appendix 5.

Service	CCG Funding	LA Funding	NHSE funding	Total
42nd Street	£50,908	£61,800		£112,708
Core CAMHS	£2,487,866			£2,487,866
Targeted CAMHS	£305,416	£432,408		£737,824
In-patient beds			£569,756	£569,756
Total	£2,844,190	£494,208	£569,756	**£3,908,154**

In addition, the CCG funds accommodation costs at Pendleton gateway for CAMHS costing £440,651 in 2014/15.

6.2 The total above only reflects the commissioned specific mental health services, and does not reflect the provision within universal and community services. Work to identify the contribution (both through activity and financial) will be undertaken to try to reflect more accurately the totality of spend through prevention to commissioned services. In addition, the money invested in Step 2 IAPT has not been included as only very small numbers of 16-17yr olds access the service (see previous section) and it is not possible to present the cost for just these cases.

6.3 The investment by NHSE Specialist commissioning is a substantial reduction from 2013/14 when it was £1,293,462, however the caveat mentioned previously around accuracy of the data needs to be born in mind. Over the next five years the ambition is that the additional investment across the system will allow a re-profile of spend away from tier 4 inpatient services towards prevention and earlier intervention.

7 What has been accomplished so far

Resilience, Prevention and Early Intervention

7.1 Salford is committed to the principles of early intervention and prevention. An Early Help Strategy for Children, Young People and Families (2014-2017) was developed in 2014 on behalf of all the partners who make up Salford Children and Young People's Trust, and Salford Safeguarding Children Board. It aims to support children, young people, families and communities to help themselves whenever possible; make sure all services can quickly spot children, young people or families who might need extra help from them and make sure all services act quickly as soon as they know help is needed. The action plan identifies areas where organisations can make a difference including commissioning based on outcomes, exploring opportunities to work together, the development of the Multi-Agency Safeguarding Hub, better information provision, work with adult services and a training review. Any work going forward on building resilient communities happens in the context of this partnership working.

7.2 There is an existing Emotional Health in Schools Grant that has funded a range of provision. This includes projects in specific Schools (e.g. art therapy and a Primary Inclusion Team), an Emotional Friendly Schools conference which launched a resource for primary schools on this area (a further conference in 2016 is planned around bereavement/Loss/Separation), the parent counselling contract with Place 2 Be (complimenting the existing counselling service for young people funded by schools) and mindfulness training for primary schools. The remaining budget this year will be used to support a small grants pot as part of the Emotionally Friendly Schools (ESF) programme and to implement the good practice highlighted at the recent Emotionally Friendly Schools conference. There is a strong level of commitment from Salford schools, across the primary, secondary and special sector, as demonstrated by engagement, both in attendance and delivery of sessions, at the recent conference. A review of current schools-based counselling provision and future need will be included in the emotional wellbeing test for change. Work is on-going with schools to understand what they deliver as part of their core curriculum and externally commission across all three test for change areas as part of the 0-25 integration agenda, with a report due in March 2016, and we will have further consultation with schools to better understand growing needs to shape future service provision.

7.3 The CCG funded a Salford Healthy Schools Scheme delivered to Primary schools in the academic school 2014/15, building on the previously successful Healthy Schools Programme. The funding was available to deliver programmes to improve the health and well-being of children with a focus on promoting healthy weight, healthy lifestyles and improving children's emotional health and well-being (Health and Wellbeing Board priorities). The programme was for Primary schools to apply for their own sustainable health projects through a small grant funding round. Support was offered and a specific round of funding was also available for innovative projects. 48 primary schools (out of 78 – 62%) applied for the universal funding and 29 schools and 9 voluntary organisations applied for the innovation funding. An evaluation of the scheme is currently being undertaken which will determine the focus of any future work.

7.4 A piece of work is commencing as part of the 0-25yrs Integration programme, led by Salford

Council for Voluntary Service (CVS), to identify the range of current voluntary, community and social enterprise (VCSE) organisations and services supporting young people with their emotional health and wellbeing needs, including the costs and impacts of these activities thereby building up more detailed knowledge of community assets. The aim is to improve the effectiveness of emotional support, and assist in the development of an effective pathway. The results of this will inform the development of opportunities around early intervention and community resilience building.

7.5 The GM Early Years New Delivery Model (EYNDM) aims to increase the number of children arriving at school ready to learn through an eight stage common assessment pathway. It includes a catalogue of evidenced based assessments / interventions as a package of transformational support to families, with appropriate step-down packages of support and an integrated 2 year old progress check (for health and learning). As part of Salford's work around early years health visitors have introduced an antenatal contact with expecting mothers, maternal mood will be discussed at the antenatal visit then again at the new birth visit and at the 6-8 week check. The Edinburgh Post Natal Depression questionnaire will be completed and where concern is raised the health visitor will conduct listening appointments and refer for further support as required. Health Visitors are also trained in the Newborn Behavioural Observations system to help foster positive parent interaction. Early attachment is a main focus of the Wigan Model, (see Appendix 6 for more detail) which is being tested in the West Locality of Salford on a co-delivery model between Midwifery, Health Visiting and Children's Centres. Were early attachment issues are identified they are referred to the Parenting Team to complete Baby Incredible Years and/or further parenting support. Two of the prioritised pathways that are being looked at for development within the EYNDM are the Parent Infant Attachment/Parent Mental Health Pathway and the Maternal Health in Pregnancy Pathway. These pathways will be led by a Community Midwife and a Health Visiting Matron. In addition a Social, Emotional and Behavioural Pathway is being developed that will further support infant attachment.

Improving Access to Effective Support

7.6 Priorities for investment in the CAMHS Transformation plan have been identified through the needs expressed in section 4 above, and through the completion of a self-assessment against the recommendations from Future in Mind, completed with partners (see Appendix7).

Identified gaps and areas for further development from the self-assessment

Perinatal mental health (awaiting additional guidance and resources)

Single point of access for CAMHS advice (at early stage of problems occurring)

One stop shop services in community

Refined pathway for CAMHS involvement in SEND & EHCPs

Peer support programmes

Crisis / out of hours support 16-18yrs

Rapid access / home treatment options & step down provision

Training audit to understand training requirements of the wider workforce

These align to the principles established in Future in Mind around timely access, step change in provision, improved crisis care and care closer to home to reduce the use of in-patient beds, support for the most vulnerable and support and training for frontline staff.

7.7 There is a plan to re-specify the core CAMHS service, using the quality standards from NICE and moving away from a rigid tiered approach. In line with this our CAMHS provider has been accepted on to the i-THRIVE Accelerator Programme. THRIVE is a needs based model that enables care to be provided, determined by a patient's needs and preferences for care.

Emphasis is placed on prevention and the promotion of mental health and wellbeing. Patients are empowered to be actively involved in decisions about their care through shared decision making (SDM). As an i-THRIVE Accelerator CMFT will join the i-THRIVE Community of Practice along with the nine other successful sites. The i-THRIVE Community of Practice will provide support and access to training and shared learning events. As part of this, work will commence to establish a current baseline, conduct a needs and resources assessment, and a fit assessment and to develop a robust plan to guide implementation.

7.8 Salford submitted a successful bid to be part of the CAMHS and Schools Link Pilot Scheme, 10 schools (including primaries, high schools and a PRU) have been identified from 32 that expressed an interest and work is underway to deliver the pilot. However, because of the level of interest within Salford schools, the CCG has committed to working with the 22 schools that could not be part of the pilot to fund additional training places and school/CAMHS links subject to capacity within the national training provider. The learning from the pilot will be built into on-going work with schools.

7.9 A recent review of antidepressant use for mental health conditions in children and young people under 18 years within General Practice, following the SCR into child N, has identified some areas for further work. This includes consistent application of NICE guidelines, better communication with secondary care and promotion of correct ante-depressant choice. The findings from this review will be used to work with GP's and CAMHS around more joined-up approaches to the management of children and young people's care including refreshing and raising awareness of the shared care guidelines, and an action plan is being developed to facilitate this.

7.10 Salford CCG is working with Manchester CCG's to develop a community eating disorder service across the two localities in line with the access and waiting time standard and NICE Guidance CG9 and using the monies allocated for the treatment of children and young people with eating disorders up to the age of 18yrs. The aim is to ensure swift access to an appropriate service, with consistency and quality of care in the community from staff that are adequately trained and supervised in evidence based treatment.

7.11 The model and a service specification for the community eating disorder service for children and young people upto age 18yrs are currently in development, and this will include incorporating the views of children, young people and their families. The current plan is to address equity of access across Salford and Manchester through a hub and spoke model with all cases referred to a single point of access. The Hub will be in Central Manchester at CMFT with a spoke in Salford. This gives families to option of being seen within their locality (which could include home or the local Tier 3 CAMHS clinic) or within the hub – especially relevant if there are significant concerns about physical health or risk and an urgent paediatric assessment or psychiatric risk assessment is needed. This model is being further refined, and will include arrangements to ensure access to the services through suitable venues and times and identification of any resources released from core CAMHS that can be redirected to self-harm reduction in particular.

7.12 Work on transition between CAMHS and Adult Mental Health Services (AMHS) has commenced with two initial workshops in 2015. LA and CCG commissioners and representatives from CAMHS and AMHS met to explore the pathway arrangements between the two services for young people with psychosis and a mental health diagnosis transitioning into AMHS, and 'vulnerable children and young people' including young people with ADHD and Asperger's (see Appendix 8). Follow-up work to this is being identified.

7.13 For children and young people in crisis, those under 16yrs who attend a Paediatric A&E receive an assessment and response from CAMHS, 16-17yr olds who attend an adult A&E

will be seen by the adult Mental Health Liaison Service (MHLS), with a CAMHS response the following day. There is a shared pathway of care for those young people who present at adult A&E with a self-harm risk that was developed following the CQC Review of Health Services for LAC and Safeguarding in Salford in March 2014. There are plans to audit this pathway for assurance going forward.

Care for the Most Vulnerable

7.14 There are a number of targeted CAMHS services within Salford jointly funded by the CCG and LA. These include:

7.14.1 A part time post within the YOS to provide an accessible CAMHS resource integrated with the YOS multi-agency health team; including screening, assessment and interventions.

7.14.2 The Emerge team offering accessible community based mental health services to young people aged 16-17yrs, providing a range of direct therapeutic interventions from individual talking therapies and group work to specialist psychological and psychiatric assessments and medication and appropriate transition to follow-on services as necessary.

7.14.3 The Learning Disability Team ensures that the mental health needs of children and young people with learning disabilities are identified, assessed and treated. The service assesses and diagnoses development delay, autism spectrum conditions and ADHD. A range of evidence-based therapeutic interventions are offered and work is on both an individual and group basis.

7.14.4 A range of services for LAC and adopted children and their carers including Salford Therapeutic Advisory and Referral Service for Looked After Children (STARLAC) providing a CAMHS service for LAC, their families, carers and significant adults in their lives; CAMHS input into Salford Adoptive Families Support Service (SAFSS) providing specialist adoption support for children placed for adoption and LA approved adopters and CAMHS input into Specialist Fostering providing specialist placements for children and young people with complex therapeutic needs who need specialist approaches and support to manage in a family placement.

7.14.5 A part-time Black and Multi-Ethnic (BME) post to address the mental health needs of these populations due to difficulties accessing mainstream mental health services, the need for culturally sensitive provision, the need to use interpreters and the high level of mental health need among minority groups, migrant families and particularly refugees and asylum seekers. Going forward this needs to link to work underway around female genital mutilation (FGM).

7.15 There are a number of strands of work being undertaken around the health and justice agenda. These include:

7.15.1 The GM Mental Health Crisis Care Concordat Action Plan is currently focussed more on the adult population. However, the requirement to reflect the needs of children and young people has been recognised and is being addressed and there has been recent engagement with CAMHS. There is an action to review police custody support for young people with mental health conditions, particularly those aged 16-18yrs and work has begun to clarify the current landscape. Outcomes are currently being defined and agreed and will be monitored going forward. For young people in Police custody there is a CAMHS Admission Pathway for those under 16 years to ensure that there is a timely mental health assessment and admission to a mental health bed if appropriate (see Appendix 9 for a copy of the pathway). If a 16/17yr old was held under section 136 by the Police then the Adult MHLS would assess them, and the section 136 suite would be used at Meadowbrook Psychiatric Unit if appropriate (Meadowbrook is an assessment and treatment unit for the general adult population who are experiencing acute mental health problems). Regardless of whether the person is in the custody of the Police or not, if the assessment reveals that an inpatient admission is required then there would be liaison with the Junction 17 service (an assessment and treatment unit for young people with significant mental health needs) who would take responsibility for locating an appropriate

bed. Occasionally when there is bed crisis, a suitable young person's bed cannot be identified. In this scenario the policy is for an adult bed at Meadowbrook to be used for the admission, with the 16/17yr old transferred at the earliest opportunity to a younger person's bed.

7.15.2 There is a part-time CAMHS worker based within the YOS, who has contact with young people in the community and in custody, and with health staff based within secure establishments. The worker can offer a ranger of treatments and will refer to core CAMHS and other services e.g. Forensic Adolescent Service, if appropriate. The CAMHS worker supports the YOS case workers to reduce the risk of a young person reoffending, attends Complex Cases Panel, can take cases through the diversion panel and will contribute to Court reports to explain a young person's behaviour and offer intervention / medication to reduce the risk of further offending where appropriate. The CAMHS post resumes contact with the young person on release and contributes to the Child Health Assessment Tool (CHAT) that goes into custody with the young person and they receive a copy on release which details any physical / mental health concerns or input that has happened.

7.15.3 Young people in secure welfare settings are LAC and so will have access to a STARLAC worker if required (CAMHS service for looked after children). STARLAC is part of a range of CAMHS services for looked after children (see above) that work with the local authority to support looked after young people to remain in their placements. CAMHS workers sit on Salford's Local Authority panel that discuss returning young people and plan for their transition.

7.15.4 CAMHS is part of the weekly children and young people's domestic abuse meeting to identify and respond to identified need, and the planned CAMHS post within the Bridge (Salford's single point of access and Multi-Agency Safeguarding Hub) will support screening and response.

7.15.5 CAMHS has a joint access pathway with the Sexual Assault Referral Centre (SARC) so that any referrals are seen by CAMHS within a week; CAMHS joins the SARC session and vice versa. AIM assessments (for the assessment of adolescents who display sexually harmful behaviour) are completed by YOS workers or social workers, and interventions are offered to low risk of harm cases. Medium or high risk of harm cases are referred to Lucy Faithful Foundation (commissioned at a GM level).

7.15.6 Salford Safeguarding Board has a Child Sexual Exploitation (CSE) Strategy and the work of the strategy is taken forward by the CSE strategic subgroup of the Safeguarding Board. It is a multi-agency group including membership from CAMHS. The action plan to deliver the strategy aims to prevent CYP becoming victims of CSE, to support CYP when CSE is identified and to disrupt and prosecute offenders. CAMHS has actions around staff training, supporting a rolling programme for the secondary prevention targeted group (ACE – Assertive, Confident, Empowered) for looked after children in years 6, 7 and 8 and providing appropriate screening measures to the Protect team and School Health Advisors to allow CYP where CSE is identified to be screened for emotional health and wellbeing difficulties. The Protect team, a multi-agency CSE team have developed a specific training session for all CAMHS staff and this will be rolled out from January 2016, and there is a similar access Pathway with Protect to that of SARC (see above). All CAMHS clinicians are required to do level 3 Safeguarding training.

7.16 Good practice guidance for commissioners and service providers across Greater Manchester, Lancashire and South Cumbria on *Delivering Effective Services for Children and Young People with ADHD* has recently been published. This aligns with some local investment that has been identified to develop an integrated care pathway to improve the management of ADHD within Salford. This is being led by providers and the aim is to create a bespoke integrated care pathway by the end of 2016, to meet the analysed needs of the Salford under 18 population, in keeping with the design of Salford's health and social care systems. The project work and resultant pathway will be approached from a multi-agency perspective involving school health, community paediatrics, GPs, social care and the voluntary sector. This group will ensure that the GM, Lancashire and South Cumbria

good practice guidance forms the basis of the pathway development. In addition, work is currently underway in Salford to develop an overarching multiagency strategy for the diagnosis and management and support of children with an autistic spectrum disorder. To date this has focussed on developing an autism education strategy but over the next year the aim is to develop a multiagency diagnostic pathway followed by an integrated care pathway. The presence and acceptance of comprehensive pathways by the health economy will improve the care, experience, prognosis and outcomes from referral through to diagnosis and ongoing management of children suffering from ASD / ADHD.

7.17 All medicines supplied via the CAMHS service are assessed for how initiation and continued supply to the child / young person is made with a focus on how to transfer to primary care (if appropriate) and any supporting frameworks required. Current medications used within ADHD have been reviewed by the Greater Manchester Medicines Management Group (GMMMG) and they can be prescribed in primary care under a shared care arrangement. This supports the recommendations from NICE guidance CG72. Shared care protocols (SCP) for atomoxetine, methylphenidate, lisdexamfetamine and dexamfetamine have been developed for use across all GM CCGs and providers. These support the safe transfer of prescribing and monitoring from CAMHS services to the patients GP. For the new eating disorder service we are currently assessing the medications that the service will use and any shared care implications that may arise. It is likely that the current SCP for antidepressant and antipyschotics will need to be amended to include this client group. This will be facilitated via a subgroup of GMMMG.

7.18 A review of failed appointments within CAMHS (DNA / CNA) was undertaken in October 2015 looking at implementation of the policy and an sample of service users were contacted to provide further information on the circumstances that contributed to their missed appointments, including any recommendations to improve attendance. The review showed that the policy was implemented fairly consistently across all the localities. With regards to failing to attend appointments, one of the reasons identified for missing appointments was service users feeling they no longer needed the service, due to improvements during the waiting period. Another reason identified was service users not receiving their appointment letter or forgetting that they had an appointment booked. Three recommendations were made: To contact all service users before the appointment to remind them, To engage with children and young people during the waiting period from initial acceptance into service to first appointment to establish whether the child still requires the use of the service and to provide a leaflet / information explaining what to expect from CAMHS at the 'opt in' stage of any referral including the maximum wait time and access to self-help information. Further work with schools and referrers is planned to understand the context and purpose of the referrals, to enable schools and other services to manage expectations around CAMHS support and enable them to support attendance at appointments.

7.19 There is a wealth of evidence to demonstrate how Integrated Care Pathways (ICP's) provide opportunities for sustained quality improvement in the delivery of care services. ICP's are a way of managing, monitoring and recording an episode of care. Essentially, an ICP is a statement of anticipated care placed in an appropriate time frame, written and agreed with the patient, his/her family and a multidisciplinary / multiagency team. A number of pathways are currently being developed (see Appendix 10 for a full list). Once the ICP's are completed they will be tested via small scale pilots, adjusted as necessary and then circulated to the Clinical Effectiveness Group for final sign off and implementation across CAMHS services and the wider health and social care economy. The ICP's will be made available to professionals in other services areas and Trusts as a resource and to support service development.

Accountability and Transparency

7.20 The CAMHS service measures satisfaction on discharge through outcome tools like CHI-ESQ, and a large-scale review across all the services is conducted annually. This results in a specific action plan for each locality and progress is reported back to service users through 'you said: we did' posters. There is on-going consultation with existing CAMHS services users and their families to review experience of services and facilitate service improvement; this includes user participation groups, involvement of service users in appointing new staff, feedback forms in waiting rooms and a family, child and young person participation report. Additional consultation work with young people is being undertaken by Salford Healthwatch through a questionnaire (designed with young people), focus groups and 1:1 work. This will explore young people's views and experiences on emotional wellbeing and mental health services. The report is due in December 2015.

7.21 Salford has had an Emotional Health and Wellbeing Strategy for Children and Young People since 2013. This is owned by the Salford Children and Young People's Trust, and overseen by the multi-agency Emotional Health and Wellbeing Partnership. The strategy was updated in April 2015, and this includes a summary of the principle achievements and an outline of the work still to do. This includes universal actions to review the needs around perinatal and infant mental health in Salford, ensure frontline workers are aware of services available to children and young people to support their emotional health and wellbeing and ensure third sector providers are aware of and actively engage in workforce development opportunities around emotional/mental health, and specialist actions to ensure systematic outcome-based monitoring of CAMHS, better management of self-harm for post-16 in A&E and improve the assessment and intervention around emotional health within the Child Protection and Child in Need Service. In addition a Services Directory was also published in 2013 and this is being reviewed with an idea to aligning this with the Local Offer.

7.22 The scope of the 0-25 integrated programme has been agreed, and the governance arrangements have been approved. The test for change (emotional health and wellbeing) project team across the CCG and LA has been set up and an expert reference group has been identified in the existing multi-agency Emotional Health and Wellbeing Partnership.

Workforce Development

7.23 The CAMHS provider is part of the children and young peoples' IAPT (CYP-IAPT) project, and the training and tools have been rolled out across staff within core and targeted CAMHS. 20 CMFT staff have been trained in Cognitive Behavioural Therapy / Interpersonal Psychotherapy for depression, 12 staff have been trained in Family Therapy, 11 staff are Parenting graduates and 10 are accredited supervisors. Eight CAMHS staff are seconded over to Salford CYP IAPT Course to teach on it and provide course supervision for all modalities. In addition, a LAC social worker from Salford Childrens Services and two staff from 42nd Street have accessed CYP IAPT training, and this will continue to be offered to appropriate partner agencies.

8 What we plan to achieve in the next 18 months

8.1 Over the next 18 months there are a number of key areas of work that will begin the Salford transformation programme. These include:

8.1.1 The development of the whole school approach to emotional wellbeing and work with the VCSE sector following the results of the scoping work to improve early intervention and prevention.

8.1.2 The development of a CAMHS presence in the Bridge (Salford's single point of access to services), a new community eating disorder service across Salford and Manchester, a rapid access and home treatment service and improved transition pathways will improve access to services.
8.1.3 The use of the peer researcher model and the response to the audit of DNAs will improve access and care for the most vulnerable.
8.1.4 The re-specification of the Core CAMHS service, work on commissioning arrangements and the publishing of the Salford CAMHS Transformation plan will support accountability and transparency.
8.1.5 The training audit and any subsequent training will help to deliver improved workforce development.
These initiatives are described more fully below.

Resilience, Prevention and Early Intervention

8.2 Continued work with schools will be a priority area, particularly in relation to effective communication between schools and other agencies. This will include reviewing the current schools-based counselling provision and future need; appraising the report on what schools deliver on emotional wellbeing as part of their core curriculum and what they externally commission; assessing the continued involvement in the Healthy Schools programme following the evaluation and implementing the learning from the CAMHS and Schools Link Pilot Scheme.

8.3 In addition, the recent review of the Salford School Nursing Service and re-specification has identified opportunities for development around emotional support. The role of the school nurse will be developed to promote and support schools to introduce a 'whole school approach' to Emotional Health and Wellbeing. This will involve changing a culture of referring onto specialist services and up skilling the wider workforce and building resilience in the school and introducing new school led interventions. This will also be extended to resourcing children and young people with skills to manage their own wellbeing and raising awareness of support available to them. Opportunities for interventions will be explored further with particular focus on engagement with secondary aged children via the drop clinic contacts.

8.4 The results of the scoping work by Salford CVS to identify the range of current VCSE services supporting young people with their emotional health and wellbeing needs will determine a future approach to support the development of these community assets. This may include work on peer support or community one-stop shops as highlighted in Future in Mind.

8.5 Work on the Early Years New Delivery Model (EYNDM) is on-going, including the piloting of the Wigan model, which incorporates actions to support the development of peri-natal mental health. The results of this pilot, the wider work within the EYNDM and the anticipated guidance (and resources) on peri-natal mental health expected later this year will determine further work on this area.

8.6 Work will begin to specify the activity and investment in universal services that contribute to emotional wellbeing of children and young people e.g. health visiting, school nursing, children's centres etc. to inform the declaration in future years. Ongoing work is required to enable a system wide recognition of the roles and responsibilities around emotional health and wellbeing. Each partner needs to understand their role in the pathway and have routes to seek advice and guidance and manage down incidents or issues which can be dealt with in lower tiers of intervention. Communication is the key in ensuring all partners have realistic

expectations of service provision. This will be facilitated through the 0-25 Integration programme.

Improving Access to Effective Support

8.7 The Designated Medical Officer (DMO) for special educational needs and disability (SEND) role is well developed in Salford. However a piece of work needs to be completed to develop a refined pathway for CAMHS involvement in the assessment process for Education Health and Care Plans, to ensure more timely access to information.

8.8 Work is well developed on the Salford single point of access, through 'the Bridge' (see Appendix 11). Discussions are commencing around potential CAMHS involvement in the Bridge to facilitate a single point of access for services to CAMHS expertise. This would enable a multi-agency approach and wrap around offer to mental health related referrals that may not require a CAMHS (tier 3+) offer. It would therefore provide a wider step down support to children and families to address issues impacting on mental / emotional health and wellbeing. Additional expertise in the Bridge (including around emotional health) would improve the capacity of wider team to manage issues and step down rather than refer on / up.

8.9 In addition there are two significant service additions requiring the development of a clear specification and recruitment to posts. These are the community eating disorder service and the rapid access / home treatment team. Both of these involve Salford CCG working closely with Manchester CCGs on a joint service offer.

8.9.1 The eating disorder service is in response to the access and waiting time standard for children and young people upto age 18 with an eating disorder, and will be compliant with those guidelines. The model and service specification under development will outline the capacity released within the system that can be redeployed to support the core CAMHS service response for those who self-harm or present in crisis.

8.9.2 The development of a CAMHS rapid access / home treatment team would seek to facilitate care as close to home as possible and prevent unnecessary admissions to in-patient beds through out of hours access to support. This work is built around comments from young people and parents. Work will be undertaken to review the impact and scope the service. The audit of the actions following the CQC review of Salford LAC and Safeguarding in 2104 may generate considerations for this service in relation to crisis support and liaison.

The creation of these additional services will ease pressures within the core CAMHS service and will assist with reduction of waiting times into the core service. In addition, the training audit will identify the support required by frontline staff to enable them to manage more young people without referral, in conjunction with the additional support of the CAMHS advice within the Bridge. Development of clear thresholds for escalation, self-management and assisted support will also enable demand management into the service.

8.10 Transition is a key topic for the 0-25 integration agenda. Regarding transition in CAMHS, the two workshops already held (see Appendix 8) have raised a number of questions, including whether there is sufficient resource in CAMHS, the nature of assertive engagement between AMHS and CAMHS, the step down provision for vulnerable young people with complex needs, the possibility of pooling budgets / joint working protocols, the consistency of management of need between different CAMHS, the management of the provider market and numbers of staff involved in transition. Children and Young adults who are transitioning between school years or services, or are approaching 18 years of age and who are being supported by CAMHS should, along with their parents and carers know well in advance what the arrangements will be for transfer to services of any type and be involved in those planning arrangements. They should have confidence that services will focus on need, rather than age, and will be flexible and that the services are based on best

evidence of what works for children and young adults, and which have been informed by their views. All these considerations need to form a plan for discussion going forward.

8.11 The action plan to deliver the findings from the recent review of antidepressant use for mental health conditions in children and young people under 18 years within General Practice will be monitored, and will be part of a wider programme of awareness-raising with GP practices. The need for this was highlighted by the wide disparity in referral rates to CAMHS from GPs (see section 5 above). In addition, work needs to begin with other primary care providers like pharmacy and dental to ensure pathways are in place for effective referral from these services into emotional wellbeing support. This is better recognised within secondary care where services like the Children's Community Nursing Team have access to Clinical Psychology as the psychological and emotional needs of children with chronic and life limiting conditions and their families are well documented. This needs to be further publicised within primary care to ensure the links between poor health generally, and mental wellbeing are better recognised, and referrals generated.

Care for the Most Vulnerable

8.12 Children and young people and their families who are vulnerable (such as children in care, children with disabilities and children with behavioural, emotional and social difficulties) should be confident that their mental health needs will be assessed alongside all their other needs, no matter where the need is initially identified. An individualised package of care will be available to them to meet their personal circumstances. For those experiencing complex, severe and ongoing needs, the packages of care will be commissioned collaboratively and delivered, where possible, in the local area.

8.13 A programme will be developed to ensure the roll-out of the ICP across CAMHS services and the wider health and social care economy. The ICP's will be made available to professionals in other services areas and Trusts as a resource and to support service development.

8.14 The findings and recommendations from the review of failed appointments within CAMHS will be presented to the CMFT Service Managers Management meeting. Following this an action plan will be produced and monitored through the CAMHS Performance Management meetings.

8.15 42nd Street are currently externally commissioned to deliver the 'We Tell You Project', in response to the fact that young black men are under-represented in accessing mental health and wellbeing support but over–represented in the adult mental health services, The project, has recruited and trained 12 young black peer researchers. They have interviewed and transcribed the experiences of young people across the region, researched national and international approaches to service design, delivery and impact and have travelled across England to visit different projects to understand the potential approaches to engaging young black men in mental health services. They are producing recommendations for how services could be better configured to engage young black men and build resilience across communities and reach young black men before their issues escalate and persist into adulthood. The final report will be available in Spring/Summer 2016 and the model of peer research could be applied to other aspects of targeted support. In Salford the proposal is to utilise this model to understand the needs of the significant Orthodox Jewish community.

8.16 The non-recurrent money to develop adequate and effective levels of all-age liaison mental health services in emergency departments will be used to support the already well-established 16yrs+ Mental Health Liaison Service in Salford, and to explore and plan the

provision for under 16s with the CAMHS provider over the next year. There is a Mental Health Liaison group involving membership from Greater Manchester West Mental Health Trust, Salford Royal Foundation Trust and commissioners, and membership of this group will be expanded to offer a useful opportunity to discuss children, young people and perinatal issues in 2016. In addition we propose to conduct a baseline audit of the shared pathway of care for young people presenting at adult A&E with mental health issues to ensure that it is operating correctly, and that all 16 and 17 year olds referred to the adult MHLS are receiving safe and effective care, including required referrals to CAMHS for follow-up and support after the MHLS assessment. This will report in January 2016, and following this further work may be identified.

8.17 When the commissioning of Police custodial health services and Liaison and Diversion services transfers to NHSE next year as planned, we will ensure CAMHS works in partnership with the commissioned providers to ensure integrated referral pathways into CAMHS where appropriate. In addition Salford commissioners and providers will work with NHSE on publication of the expected sexual assault pathway to ensure that the local offer meets the requirements of the pathway and that there is a smooth transition between different elements of the pathway.

Accountability and Transparency

8.18 The re-specification of the Core CAMHS service in line with the Thrive model, quality standards from NICE and a pathway and outcomes focus, rather than rigid tiers, will be completed.

8.19 Work on the 0-25 integrated agenda will continue, with an aim to review lead commissioning arrangements and commissioning options.

8.20 An Engagement Plan will be developed in partnership with Healthwatch aligned to the development cycle i.e. assessing needs, prioritising actions and evaluation. In relation to the first phase, the insight work carried out by Healthwatch (above) and previous engagement with secondary schools will be utilised to ensure any new service developments, and any re-design of existing services is based on the needs of young people in relation to access and support. In terms of developing priorities and services, there will be consultation and engagement with a wide range of groups going forward around any new service proposals like the community eating disorder service. Work will continue with secondary schools through the drama workshops to deliver key messages in relation to mental health, self-harm and body image. To support ongoing partnership work with young people to evaluate the plan long term, the potential of a young person's wellbeing forum linked to existing structures for engagement will be explored. We will also gather patient experience data from service users to monitor quality and access of services.

8.21 The Salford CAMHS Transformation plan, including investments and activity, will be published on the Salford CCG and Partners in Salford webpages by the end of December 2015. There will also be an adapted easy read summary (with the option to have this translated if requested) and a communication programme with children, young people and their families to ensure widespread awareness. This will include a news article on the CCG website and use of social media. CCG staff and members will be informed through internal news bulletins. The plan will also be distributed to partners through the Health and Wellbeing Board, the Children and Young People's Trust and the Emotional Health and Wellbeing Partnership.

Workforce Development

8.22 Work will commence on a training audit to understand the training requirements of the wider workforce and this could be completed for April 2016. Manchester have already completed a similar exercise and we will look to replicate this across the Salford economy. The results of this may generate training requirements to help facilitate better understanding of mental health issues and appropriate referrals to services.

Financial Allocation

8.23 The above would generate a proposed spend of £563,000 per year, split according to the table below:

Scheme	**Recurrent Funding**	**Spend 2015/16**
1. Community Eating Disorder Service	£250,000	£62,500
2. Rapid Access / Home Treatment	£110,000	£27,500
3. Single Point of Access in the Bridge	£53,000	0
4. Whole School Approach to Emotional Wellbeing	£75,000	£100,000
5. Prevention, early intervention & community support	£45,000	£40,000
6. Capacity Building (inc. training)	£30,000	£7,000
7. Project implementation support		£30,000
Total	**£563,000**	**267,000**

Please note this is an indicative breakdown and these figures may be subject to change as the service modelling is finalised.

The spend for 2015/16 is reduced to allow for commencement part way through the year, generally a quarter of the overall cost. Item 3 is zero as funding has already been identified to pilot this Jan-March 2016. Item 4 is an increase to denote non-recurrent monies to extend the Schools / CAMHS pilot to allow up to an additional 22 schools to participate. Item 5 is a one-off investment into 42nd Street to facilitate some research into the needs of vulnerable groups (principally the Orthodox Jewish community). Item 7 is also a one-off request to support the initial implementation of the project (creation of an action plan, service specifications, business cases etc.).

9 What we plan to achieve by 2020

9.1 Our ambition is to ensure that all children and young people in Salford enjoy a happy, confident childhood and achieve their potential. We want them to grow into resilient adults able to cope with the demands of daily life, and empowered to contribute to life in the city. When children and young people need help, we want them to find it easily, for it to meet their needs, be delivered by people who care and for services to listen to their views. In a crisis we want them to get help quickly and as close to home as possible.

9.2 The sustainable outcomes that we want to achieve over the next five years are:

- Improvements in foundation stage assessments on personal, social and emotional development
- Improved attendance and engagement of young people within schools and improved educational attainment
- Effective engagement of children, young people & families in self-care and services
- Effective pathways of support in universal services to reduce escalation
- Improved confidence of frontline staff to respond and reductions in inappropriate referrals

- Reduced waiting times for treatment and improved contact while waiting
- Improved access to services and reduced numbers of DNAs through services
- Shorter times spent in treatment, cases closed with mutual consent and effective step down
- Improved outcomes for young people in treatment, and reduction in re-referrals / re-admissions
- Planned and smooth transitions between services
- Reduced admissions to in-patient beds

9.3 Specific performance indicators and SMART targets will be set when the service specifications for all new services, and any re-specifications, are undertaken, using guidance like Public Health England's *Measuring Mental Wellbeing in Children and Young People*. However the performance indicators are likely to include measures such as:

- Foundation Stage assessments on personal, social and emotional development and SEN audit data for children / young people with behavioural, emotional and social difficulties.
- Numbers of young people achieving five A* to C grades, including english and maths
- Numbers of young people not in education, employment or training
- Number of appropriate referrals to services & where these are from
- Waiting time to treatment (compliance to national standards)
- Number of young people in treatment and their demographic profile (to compare to Salford profile to ensure accessibility of services)
- Number of DNA's and reasons
- Reasons for treatment and acuity measures
- Variety of treatments offered linked to NICE guidelines and pathways
- Number of treatments offered / length of time in treatment
- Number of transitions form CAMHS to AMHS
- Improvements in individual outcome measurements, young person's experience of treatment & evidence that their experiences influence future treatment
- Service development based on above outcomes
- Staffing levels

There is less information available on the extent and outcomes of promotion and prevention work across children's services. Therefore there is a need to develop an outcome measurement process which will utilise validated assessment tools and ensure they are utilised across all tiers of support for CAMHS. In addition, this needs to be informed by the voice of children and young people through the engagement plan referred to in Chapter 4 above.

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Appendices to Accompany Salford CAMHS Transformation Plan

Appendix 1: Design Principles

Transformation Programme Design principles

Work in Partnership

- Services will work with partners to achieve the best possible outcomes for the people of Salford

Be creative and Innovative

- Services will challenge the status quo, employing affordable strategies informed by innovative thinking.
- They will ask 'what if…' to generate new ideas and ways of working to optimise what they do.
- Services will be able to change quickly through testing and learning.

Better by Digital

- Services will be available digitally as the first choice.
- Better does not mean by default – services will work with people who are digitally excluded to address this inequality

Customer focus

- Services will work with local people to assess their needs, taking account of equality of opportunity.
- Data will be used (both qualitative and quantitative) to demonstrate impact on outcomes and the effectiveness of our services

Use Community Assets

- Services will enable people to be more self-reliant, by developing and using the knowledge, ideas and resources that exist in families and communities in the city

Focus on early intervention and prevention

- Services will focus on the root causes of problems and work across organisations to support individuals and families before they reach crisis point

Open, integrated and accessible data

- Services will turn data into information, intelligence and Customer Insight, which can be used in decision making and to design services. This data will be 'open' and integrated unless there are legal reasons why not.
- We will take a single system approach

The right people, skills and behaviours

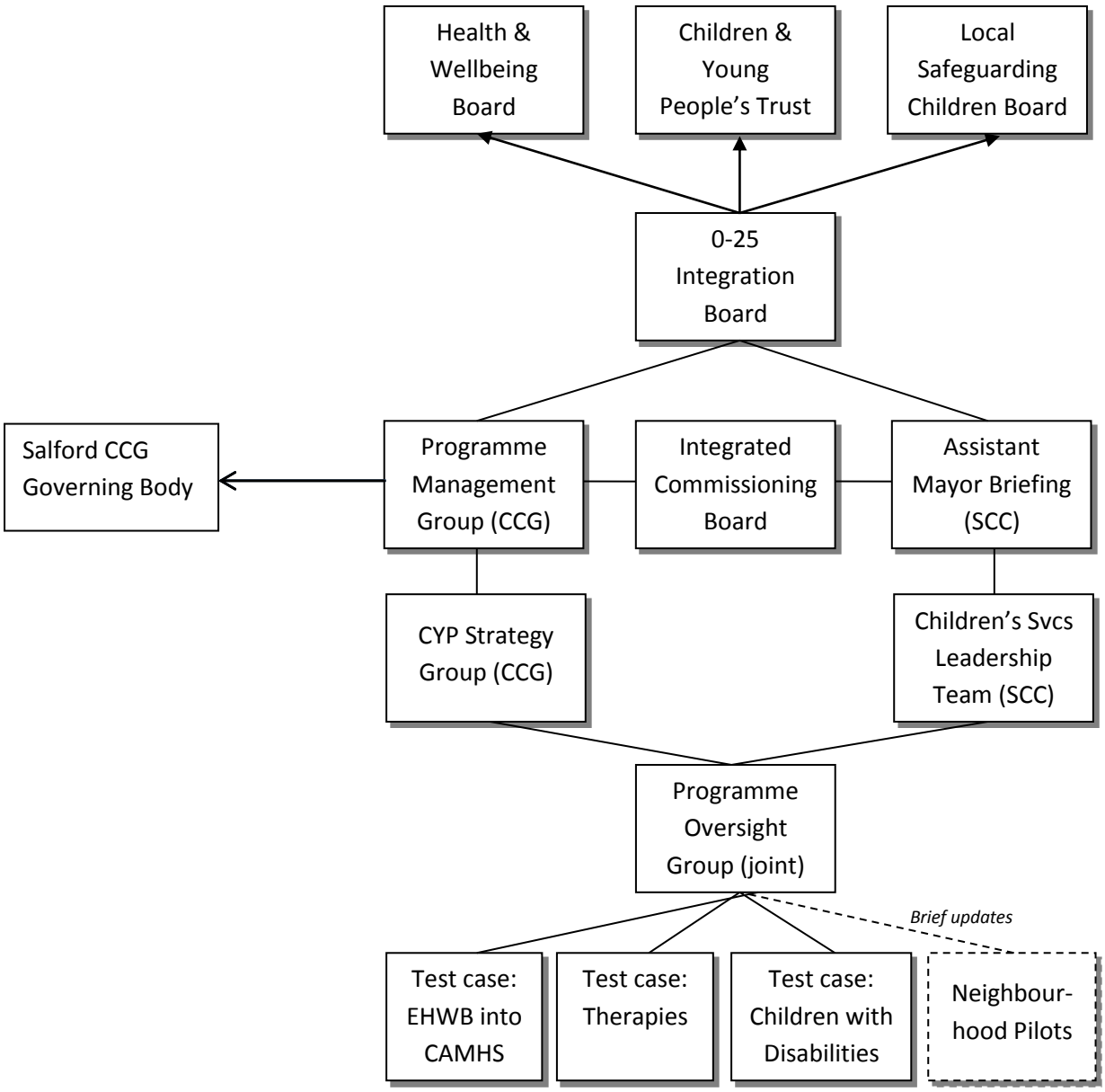
- Services will develop the skills and behaviours our employees need now and in the future, creating a work environment where people can reach their full potential and be allowed to learn from failure.

Integrated Support 0-25: Principles for delivery model

Locality	Support levels	How we work with Children and Families	Systems and processes
• Integration – working with partners • Teams working in 4-5 localities • Single family intervention worker • Physical co-location • Service hubs (eg schools) • Empower communities • Asset based approach • Cut duplication of services • Build on success, learn from failure	1: Community - Empower families - Asset based approach - Peer Support 2: Universal - Digital/access it yourself - How to deliver cheaper - Invest in prevention 3: Non-universal - Triage/filtered into system - No wrong front door - Assessment and help • Relate first, intervene second • Reduce emphasis on high need provision • Ensure there are points where support is assessed to move to cheaper (reduce dependency) or stop • Cut duplication • Build on success, learn from failure	• Empower families and reduce dependency • Positive reinforcement • Holistic view of family • Improve relationship and trust with families • Single family intervention worker – right person for right family • Cut duplication • Build on success, learn from failure • Multi-disciplinary • One assessment / plan	• Seamless pathways • Doing it safely • Sharing data and information • Utilise early indicators • Evidence based interventions • Identify thresholds for intervention or multiple risk factors consistently as early as possible and trigger a referral into an appropriate evidence-based pathway • Cut duplication • Build on success, learn from failure

Appendix 2: Governance Arrangements

Governance Diagram



Appendix 3: Risk factors for mental disorder in children and young people and Level of increased risk of mental health problems in children and young people from high risk groups

Table 1: Risk factors for mental disorder in children and young people

Risk factor	Impact on risk of mental disorder	Prevalence in population
Use of alcohol, tobacco or drugs during pregnancy	Increased risk of a wide range of poor outcomes including long-term neurological and cognitive-emotional development problems	Smoking status at time of delivery: ▪ Salford 15.1% ▪ NW 15.3% ▪ England 12.0% *(Source: Public Health England)* **National:** **Drugs:** Around 1 in 12 (8.6%) adults aged 16 to 59 had taken an illicit drug in the last year. This equated to around 2.8 million people. Around 1 in 5 (19.4%) young adults aged 16 to 24 had taken an illicit drug in the last year. This proportion was more than double that of the wider age group, and equated to around 1.2 million people. This level of drug use was similar to the 2013/14 survey (19.0%), but significantly lower compared with a decade ago (26.5% in the 2004/05 survey). *(Source: Drug Misuse: Findings from the 2014/15 Crime Survey for England & Wales)* **Alcohol:** In 2013/14, there were an estimated 1,059,210 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (broad measure). This is 50,360 (5%) more estimated admissions than 2012/13 (1,008,850) and 565,450 (115%) more estimated admissions than 2003/04 (493,760). *(Source: HSCIC Statistics on Alcohol, 2015)*
Maternal stress during pregnancy / Poor maternal mental	Increased risk of child behavioural problems	**National:** Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both.

health	Impaired cognitive and language development Maternal depression in pregnancy is a key vulnerability factor for offspring depression in early adulthood. Adult offspring exposed to maternal depression in pregnancy were 3.4 times more likely to have a DSM-IV depressive disorder, and 2.4 times more likely to have experienced child maltreatment, compared with non-exposed offspring. *(Source: The British Journal of Psychiatry, 2015)*	During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history. *(Source: Antenatal and postnatal mental health: clinical management and service guidance, NICE 2014)* **National:** 5.7% of mothers experience depression 2 months post-natally, 6.5% at 6 months and 21.9% at 12 months.
Low birth weight	Associated with increased risk of common mental disorder (Colman et al, 2007) 4-5 fold increased risk in onset of emotional/conduct disorder in childhood	**National:** Birth weight is measured to identify children who are most at risk of dying young or experiencing health-related problems in childhood. Low birth weight is linked to maternal age, smoking in pregnancy, prematurity, multiple births and ethnicity. On average, the proportion of low birth weight in Salford has been steadily decreasing over the past 10 years and has been consistently lower than both England and NW figures in the last 2 years from 2012 to 2013. In 2012 Salford had 221 births classified as being of low birth weight, (6.3%: significantly lower than the national rate) *(Source: Office for National Statistics)*
Unemployed parent	2-3 fold increased risk of emotional/ conduct disorder in childhood	**National:** there were 2.18 million children living in an out-of-work benefit household. Around a third of children (735,000) are living in an out-of-work benefit household were aged under 5. The majority of children (1.08 million) in out-of-work benefit households lived with Income

		Support claimants. **Salford:** May 2014, the number of children living in out-of-work Benefit claimant households was: • Age 0-18: 12,640 • Age 0-15: 11,270 *(Source: DWP Data and Analytics, June 2015)*
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood	**Salford:** Teenage parents known to IYSS who participate in parenting support programmes (engagement with this service is voluntary so some teenage parents will not be known to this service): 2015/16 Q.1 – 194 cases with Teenage Pregnancy Team, of which 20 (10.3%) are attending parenting courses. *(Source: Salford CYP Trust – 2015/16 performance report)* The percentage of Salford children achieving a good level of development in 2014 was 56.8%, compared with national average of 60.4% *(Source: Salford 0-25 Strategic Review)*
Parents with no qualifications	4.25 fold increased risk of mental health problem in children	% with no qualification, Jan-Dec 2014 data: ▪ Salford – 10.0% of WAP ▪ GM – 10.6% ▪ NW – 10.6% ▪ England – 8.6% *(Source: Annual Population survey, ONS)*
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups (15% vs 5%)	Children in poverty (under 16 years) Definition: The proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. **Salford:** 12,330 children (26.8%) were classified as being in poverty in 2012; this is a fall from 28.3% in 2011. This rate is still significantly higher than that of the UK (19.3%). *(Source: HMRC)*
Four or more adverse childhood experiences (ACEs)	12.2 fold increased rate in attempted suicide as an adult	**Alcohol:** Under 18s admitted to hospital with alcohol specific conditions per 100,000 population:

	10.3 fold increased risk of injecting drug use 7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year 2.2 fold increased risk of smoking	2011/12-2013/14: Salford 87.3; NW 60.4, England 40.1 *(Source: Public Health England)* **Substance misuse**: **England**: Under 18's accessing substance misuse services, 2013/14 – 19,126. Of which, 13,359 (71%) had problems with cannabis. *(Source: Public Health England)* **Salford:** Under 18's using the YP substance misuse treatment service: ▪ March 2014/15: 98 ▪ March 2013/14: 95 ▪ March 2012/13: 83 *(Source: Salford CYP Trust – 2015/16 performance report)*
Child abuse (physical, emotional and/or sexual abuse and/or neglect)	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult PTSD 5.5 fold increased risk of substance misuse/ dependence	**Salford:** as of the 31st March 2015 there were 357 children and young people subject to a CP plan. The underlying risk factors identified were: ▪ Adult Learning difficulty (13) ▪ Domestic violence (108) ▪ Mental health (93) ▪ Parental alcohol misuse (51) ▪ Parental substance misuse (34) ▪ Sexual exploitation (8) ▪ Underlying criminal activities (21) *(Source : SSCB, Oct 2015)* **CSE** **National:** Ann Coffey's report into CSE across Greater Manchester identified 260 'live' investigations into CSE in June 2014, with 14,712 recorded episodes of children missing from home and care between January and September 2014. The Office of the Children's Commissioner's two year Inquiry into CSE found that a total of 2,409 children were known to be victims of CSE by gangs and groups between August 2010 and October 2011; the equivalent of every pupil in three medium sized secondary schools. It is generally agreed that these figures are an under-estimate. *(Source: Tackling child sexual exploitation, LGA)*

Adolescent dating violence (i.e. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality	**National:** The prevalence of intimate violence was higher for younger age groups. Women aged 16-19 (13.1%) and 20-24 (10.1%) were more likely to be victims of any domestic abuse compared with those aged between 45-54 (7.1%) and 55-59 (5.9%). Younger men were also more likely to have experienced domestic abuse than older men. Men aged 16-19 (7.5%) and between 20-24 (6.5%) were more likely than men aged between 45-54 (3.5%) and 55-59 (2.4%) to have experienced domestic abuse in the last year. *(Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14)* **Salford:** MARACs (domestic abuse risk assessments) which involve under 18s: ▪ 2014/15 – 394 (64.3%) ▪ 2013/14 – 343 (66.9%) Figures from a NSPCC study showed abuse in relationships affecting both girls and boys: ▪ 25% girls and 18% boys experienced physical abuse ▪ 75% girls and 14% boys experienced emotional abuse ▪ 1 in 3 girls and 16% boys experienced sexual abuse. ▪ 76% of girls and 14% of boys stated that the physical violence had negatively impacted on their well-being *(Source: NSPCC: (2009) Partner exploitation and violence in teenage intimate relationships)*
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia	**National:** 2014 data: - 7.2% of children aged 11-15 years reported using cannabis 6% of 11-15 year olds reported using drugs on a frequent basis *(Source: HSCIC - Smoking, Drinking and Drug Use Among Young People in England – 2014)*
Self Harm	The phrase 'self-harm' is used to describe a wide range of behaviours. Self-harm is often understood to be a physical response to an emotional pain of some kind, and can be very addictive. An episode of self-harm is most commonly triggered by an argument with a parent or close friend. When	**National:** Females aged 15-19 had the highest rates of hospitalisation for self-harm with 76 admissions per 10,000. The rate was higher in more deprived areas with 93 per 10,000 compared with 52 per 10,000 in the less deprived areas. Amongst males the age group with the highest admission rate was 20-24 years with 45 per 10,000. The rate was 53 per 10,000 in more deprived areas and 33 per 10,000 in the less deprived. *(Source: Salford 0-25 Strategic Review)*

	family life involves a lot of abuse, neglect or rejection, people are more likely to harm themselves. Young people who are depressed, or have an eating disorder, or another serious mental health problem, are more likely to self-harm. So are people who take illegal drugs or drink too much alcohol. *(Source: Royal College of Psychiatrists)*	Hospital admissions as a result of self-harm, 10-24 years (directly standardised rate per 100,000): ▪ Salford – 647.2 ▪ England average – 412.1 *(Source: PHE, Child Health Profile 2015)* In 2014, figures were published suggesting a 70% increase in 10-14 year olds attending A&E for self-harm related reasons over the preceding 2 years. *(Source: Selfharm UK)*
Bullying	Bullying can have damaging consequences for the social, emotional and mental health of affected CYP. Some children may be more vulnerable, e.g. if they have SEN, are carers or are experiencing a difficult life or family event. CYP whose emerging sexual identity is LGB or who are questioning their gender identity are often targets.	**Salford bullying - Survey 2014** A survey of 2,204 pupils from 71 of 98 primary and secondary schools was conducted. There were 33 schools with at least 20 respondents. There was an even split between male (50.1%) and female (49.9%) and between primary (49%) and secondary (51%) with years 5, 7 and 9 most strongly represented. Two thirds of respondents reported having been bullied in the previous year. Most (44%) of those who reported being bullied were bullied in school, under half (44%) were bullied out of school and one in seven (14%) reported online bullying. Around two-thirds (64%) reported feeling safe at school compared to only one third in the community (34%) or online (31%). *(Source: Salford 0-25 Strategic Review)*

Table 2: Level of increased risk of mental health problems in children and young people from high risk groups

Risk group	Impact on risk of mental disorder	Prevalence in population
Children with learning disability	6.5 fold increased risk of mental health problem	Children with moderate learning difficulties known to schools (proportion per 1,000): England - 15.58; NW – 15.96; Salford – 15.40 Children with severe LD known to schools (per 1000 pupils): England – 3.73; NW – 4.23; Salford - 4.85 Children with autism known to schools (per 1000 pupils): England - 9.12; NW – 8.76; Salford 4.27 *(Source: Public Health England – LD Profiles 2013/14)* **National:** It is estimated that there are 286,000 children (180,000 boys, 106,000 girls) age 0-17 in the UK with a learning disability. Approximately 200,000 children in England are at the School Action Plus stage of assessment of SEN or have a Statement of SEN and have a primary Special Educational Need (SEN) associated with a learning disability. *(Source: People with Learning Disabilities in England 2011)* **Salford:** CYP – Special Educational Need: 1,309 *(EMS/School Census)* No. places at special schools: 545 *(School Census)* Children's disabilities team: 208 open cases *(Children's Services)* There is currently not a consistent audited process or single register to record disabled children in Salford. There are however an existing range of sources where this is recorded.

<table>
<tr><td></td><td></td><td>From searches of existing information sources and including chronic health conditions there are likely to be a minimum of 2192 disabled children and young people up to age 25. If asthma and auditory disabilities are included the number increases significantly and could add 12,000 children. (Source: SCC)</td></tr>
<tr><td>Children with Special Educational Needs</td><td>3 fold increase in conduct disorder</td><td>Pupils with SEN statements:
<table>
<tr><th></th><th>2012</th><th>2013</th><th>2014</th></tr>
<tr><td>Salford</td><td>977</td><td>998</td><td>1,011</td></tr>
<tr><td>NW</td><td>30,605</td><td>30,845</td><td>30,915</td></tr>
<tr><td>England</td><td>226,125</td><td>229,390</td><td>232,190</td></tr>
</table>
Pupils with SEN without statements:
<table>
<tr><th></th><th>2012</th><th>2013</th><th>2014</th></tr>
<tr><td>Salford</td><td>5,462</td><td>5,294</td><td>5,696</td></tr>
<tr><td>NW</td><td>177,660</td><td>169,620</td><td>164,535</td></tr>
<tr><td>England</td><td>1,392,215</td><td>1,316,220</td><td>1,260,760</td></tr>
</table>
Source: DofE, Statistics – Special Educational Needs (SEN), July 2015</td></tr>
<tr><td>Children with physical illness</td><td>2 fold increased risk of emotional/conduct disorders over a 3 year period</td><td>National: In general, one in seven young people aged 11-15 has a long-term medical illness or disability affecting many aspects of their life.
(Source: Salford 0-25 Strategic Review)

2013/14 Hospital admissions for asthma (under 19 years):
Salford - 179 emergency hospital admissions for CYP under 19 years for asthma, equating to an emergency hospital admission rate of 325.0 per 100,000 population aged 0-18 years
England - emergency hospital admission rate for asthma was 197.0 per 100,000 population aged 0-18 years
(Source: Child Health Profile, PHE June 2015)</td></tr>
<tr><td>Homeless young people</td><td>8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation</td><td>National: In England, more than 14,000 households headed by young people (aged 16-24) were accepted as homeless and in priority need during 2013/14.
(Source: DCLG Homelessness Statistics)</td></tr>
</table>

		Salford 2014/15: No. of homelessness presentations - 960 *(Source: Salford Annual Housing Key Statistics)* **Vulnerable Households:** Across the city almost a third (32.7%) of all households are described as vulnerable, in Broughton the rate is 50%. Walkden North, Langworthy, Little Hulton and Kersal all had rates over 40%. The survey shows that the highest level of vulnerability is found in single parent households and households containing a single pensioner. 69.9% of lone parent households are vulnerable; however lone parent households only constitute 7.5% of all households. *(Source: Salford Private Sector Stock Condition Survey 2010)* *Vulnerable Households definition - the probability or risk **today o**f being in poverty or to fall into deeper poverty in the future.*
Young LGBT	7- fold increased risk of suicide attempts in young lesbians 18- fold increased risk of suicide attempts in young gay men Lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self harm 41% of trans people reported attempting suicide compared to 1.6% of the general population.	**National:** Estimates of the size of the LGB population vary, but surveys designed to capture sexual orientation and behaviour show 5-7% of the population is LGB, which is the figure the Government used when modelling the affects of civil partnership legislation. Taking 6% as the mid point and using the most recent population estimate of 52.2m people in England, we can reasonably estimate that the LGB population of England is 3.1m people. *(Source: LGBT foundation)* **Salford:** Using a number of sources, the estimated number of LGBT over-18's in Salford is between 1,855 and 8,146 (although it may be higher). This is a higher proportion of the population than estimated for England as a whole, which is likely to be made up of a similar percentage of lesbian and bisexual women and a higher proportion of gay and bisexual men than nationally. In younger age groups more individuals identify as LGBT, probably due to the increase in social acceptability of minority sexual orientation. This may account for the higher percentage of LGB people in work and lower percentage retired than for the heterosexual population of Salford. This is likely to change over time, as these individuals age, leading to an overall

		increase in the percentage of the population. *(Source: LGBT in Salford Needs Assessment – Jan 2015)*
Young offenders	18 fold increased risk of suicide for men in custody age 15–17 40 fold increased risk of suicide in women in custody age < 25 4 fold increased risk of anxiety/ depression 3 fold increased risk of mental disorders	**National:** July 2015 - Custody population for children and young people under 18 was 1,003. The gender breakdown was as follows: ▪ 966 Male ▪ 37 Female The average population in custody (under 18) in 2013/14 was 1,216, down by 21% from an average of 1,544 in 2012/13. In 2013/14, the number of self harm incidents per 100 young people increased compared with both 2010/11 and 2012/13 (from 4.1 in 2010/11 and 5.2 in 2012/13 to 6.6 in 2013/14). *(Source: MoJ – Youth Justice Statistics Jan 2015)* **Salford:** First time entrants to the criminal system (10-17 year olds): ▪ 2012/13 -108 ▪ 2013/14 -165 ▪ 2014/15 - 101 Rate of re-offending per 1,000: ▪ 2010/11 – 1.06 ▪ 2011/12 – 1.21 ▪ 2012/13 – 1.58 Definition: The Youth Justice Board calculate the re-offending rate by tracking a yearly cohort of young people 10-17 years old to see whether they re-offend; the rate is calculated by dividing the number of offences they commit in the following year by the number in the cohort. *(Source: Salford CYP Trust – 2015/16 performance report)* **Salford:** CAMHS YOS, 2014/15 the service supported 32 young people

Looked after children (LAC)	5 fold increased risk of any childhood mental disorder 6–7 fold increased risk of conduct disorder 4–5 fold increased risk of suicide attempt as an adult 45% are likely to have a diagnosable psychiatric disorder. (*Ford, Vostanis, Meltzer, Goodman 2007*). Figure increases to 72% of children and young people in residential care. For ages five years and below it has been estimated that 25% exhibit signs of emotional and behavioural problems at point of becoming looked after (*Sempik, Ward, Darker 2008)*	**National:** As of 31st March 2015 there were 69,540 LAC in England, Salford had 585 LAC, the second highest number of LAC within GM. **Salford:** ▪ 2014/15 average – 572 LAC ▪ June 2015 – 592 LAC 2014/15: CAMHS for LAAC (Looked After and Adopted Children) had 142 referrals
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes Twice as likely to suffer from mental health problems that their peers *(Action for Prisoners' Families / NOMS, June 2012)*	**National:** Approximately 200,000 children in England and Wales had a parent in prison at some point in 2009. *(Source: MoJ – Prisoners childhood & Family Backgrounds 2012)* During their time at school an estimated 7% of children experience their father's imprisonment. *(Source: Every Child Matters 2003)* Parental imprisonment approximately trebles the risk for antisocial or delinquent behaviour by their children. *(Source: Murray, J., & Farrington, D. P. (2008) 'The effects of parental imprisonment on children')*

Table 3: In addition to the high risk groups identified by the Department of Health in the table above, Salford's Emotional Health and Wellbeing Partnership would also recognise the following groups as being pre-disposed / at risk of mental health problems

Risk group	Impact on risk of mental disorder	Prevalence in population (latest data)
Young carers	The definition used here for a 'young carer' includes children and young people under 18-years-old (aged 5 to 17), who provided unpaid care for family members, friends, neighbours or others because of long-term physical or mental ill-health, disability, or problems relating to old age. There is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly in young carers. While providing emotional support for others, the young people often experienced difficulties with stigma and isolation, schooling (from poor attendance to being bullied), lack of time for leisure activities, and a lack of recognition for their contribution to the family *(Butler, Astbury 2005)*.	**National:** In 2011, there were 177,918 young unpaid carers (5 to 17-years-old) in England and Wales. Of these, 54% were girls and 46% were boys. Within England, the North West had the highest proportion of young carers providing unpaid care at 2.3%. There was an increase in the number of unpaid carers aged 5 to 17 across all regions between 2001 and 2011. With the North West seeing a 7.2% increase in young carers. *(Source: Census 2011)* **Salford:** 1.5% of young people are carers compared to 1.3% nationally, however, this is likely to be an underestimate due to an unknown number of "hidden carers". ▪ A BBC study estimates that 8% of young people are carers - an estimate of 3759 young carers in Salford ▪ 55% of young carers are female and 45% of young carers are male. ▪ Just under one in ten young carers provide over 50 hours care per week. ▪ Young carers care mostly for people who have a physical disability or mental health problem. ▪ The majority of young carers care for their mother. ▪ 56% of young carers live in lone parent families

<table>
<tr>
<td>Not in Employment, Education or Training (NEET)</td>
<td>Spending time not in employment, education or training (NEET) has been shown to have a detrimental effect on physical and mental health. This effect is greater when time spent NEET is at a younger age or lasts for longer.

The link between time spent NEET and poor health is partly due to an increased likelihood of unemployment, low wages, or low quality work later on in life. Being NEET can also have an impact on unhealthy behaviours and involvement in crime.
(Source: PHE report - Reducing the number of young people not in employment, education of training, Sept 2014)</td>
<td>National:
Key characteristics of people who are NEET:-
Young people who have achieved five or more GCSEs grade A-C are less likely to be NEET than those who have not.
Those eligible for free school meals are more likely to be NEET than those not eligible.
Those who have been excluded or suspended from school are more likely to be NEET than those who have not.
Those with their own child are more likely to be NEET than those without.
Those who have a disability are more likely to be NEET than those who do not.
(Data source: Department for Education, Longitudinal Study of Young People in England, July 2011)
Nationally, at the end of Qu.1 (2015) the NEET figures were as follows:
16-18 NEET – 7.1% (134,000)
16-24 NEET – 12.3% (738,000)
19-24 NEET – 14.7% (604,000)
Salford: the number of NEET for the 16-18 year old cohort at the end of March 2015 was 7.9% (554).
(Source: Salford Connexions)</td>
</tr>
<tr>
<td>Asylum Seekers</td>
<td>These are children who are separated from their country of origin who are without the care and protection of their parents or legal guardian.

The child will not have a parent, relative or other suitable adult carer in the United Kingdom, and will likely to have to be accommodated under section 20 of the Children Act

The status, age and circumstances of these children may all be uncertain, in addition to their having experienced or witnessed traumatic events, and they may be suffering the most extreme forms of loss. The situations in which they are accommodated, albeit on a temporary</td>
<td>National: The majority of decisions on asylum applications by unaccompanied children under the age of 17 are grants of discretionary leave. In 2011 47% of all grants of discretionary leave were to children aged 17 and under, although they accounted for only 5% of total decisions.

For decisions on unaccompanied children who have reached the age of 18 there was a refusal rate of 83% in 2011.

Asylum applications by Unaccompanied Asylum Seeking children:
<table>
<tr><th></th><th>2009</th><th>2010</th><th>2011</th></tr>
<tr><td>Applications</td><td>3,174</td><td>1,717</td><td>1,277</td></tr>
<tr><td>% change to previous year</td><td>-26%</td><td>-50%</td><td>-26%</td></tr>
</table>
Top 5 child asylum applicant producing countries:
<table>
<tr><th></th><th>2010</th><th>2011</th><th>2010-2011 (% change)</th></tr>
<tr><td>Afghanistan</td><td>547</td><td>388</td><td>-29%</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>basis, may be less than adequate.
(Source: Children in need census – DfE Feb 2015)</td>
<td>
<table>
<tr><td>Iran</td><td>202</td><td>180</td><td>-11%</td></tr>
<tr><td>Eritrea</td><td>138</td><td>116</td><td>-16%</td></tr>
<tr><td>Albania</td><td>36</td><td>108</td><td>+200%</td></tr>
<tr><td>Vietnam</td><td>122</td><td>83</td><td>+32%</td></tr>
</table>
(Refugee Council, May 2012)
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<tr>
<td>Young runaways</td>
<td>A quarter of children who run away are at high risk of harm, as they may be hurt or harmed, sleep rough or beg and steal to survive.

Children who had recently run away experienced:
▪ Poorer quality friendships compared to other children.
▪ Unhappier school life - they may also be disengaged from education, which is likely to affect their future life chances.
▪ Low levels of subjective well-being - they are four times as likely to be unhappy with their lives as other children.

(Source: Still Running 3, Children's Society)</td>
<td>National: Approximately 200,000 incidents of children going missing or absent are reported to the police each year, of which:
▪ 70% children are never reported missing.
▪ A fifth of missing children identified in the study 'Off the Radar' had been sexually exploited. All of the children in the study took drugs and alcohol to some extent. Two thirds admitted having mental health concerns and a further two thirds had suffered on street violence.
▪ One in five children and young people missing from home or care are at risk of serious harm including Child Sexual Exploitation – Joint All Party Parliamentary Report on Missing from Care.
(Source: NCA (2014) 'Missing Persons: Data and Analysis 2012/2013').

Children and young people missing from care
2011 data shows that 930 individual children went missing. Using this measure of going missing for over 24 hours, police figures suggest 17,000 incidents and 5,000 individual children going missing from care every year. (Source: House of Commons Written Answer 106451, 16 May 2012, Catherine McKinnell MP)

The Inquiry heard evidence of the risks involved in going missing for any period of time, including shorter periods. So, if shorter periods of missing are included, the recent study of missing persons reports by the UK Missing Person's Bureau shows that there were 42,000 missing incidents relating to children going missing from care, involving an estimated 10,000 individual children in a year.
(Source: UK Missing Persons Bureau (2012) Children Missing from Care NPIA)
Both taken from the Parliamentary Report from the joint inquiry into children who go missing from care - June 2012

Salford:
The Missing from Home service delivers a range of interventions for children, young people, parents and carers, during 2014/15 a 159 young people were referred to the service.</td>
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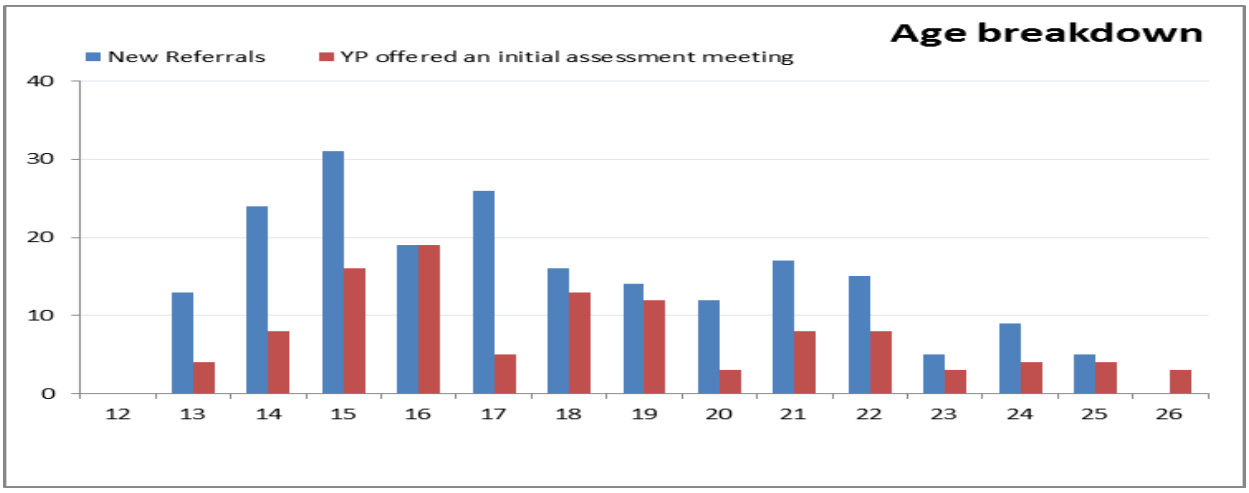
Black and Minority Ethnic Groups	In general, people from black and minority ethnic groups living in the UK are: • more likely to be diagnosed with mental health problems • more likely to be diagnosed and admitted to hospital • more likely to experience a poor outcome from treatment • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health *(Source: Mental Health Foundation)* A recent study of young people of Asian origin in the UK found that the suicide rate of 16-24 year old women was three times that of 16-24 year old women of white British origin. Amongst 11–15-year-old boys, white, black and Indian adolescents showed very similar prevalence rates (around 5% in each group), whereas Pakistani and Bangladeshi adolescents had a prevalence rate of over 12% for emotional disorders. *(Source: Young Minds)*	**Salford:** The ethnic diversity of Salford has changed significantly in recent few years. Not only has there been a rapid growth of the BME population as a whole, but a much greater diversity of communities exists now than ever before. In 2001, the Census results recorded only 3.87% of the population of Salford came from a non-white background; in comparison the 2011 Census recorded 14.4% of the population being from a BME group. **0-25:** the 2011 Census shows that 82% of all 0 to 25 year olds in Salford were White British. The youngest children were the most ethnically diverse with 78% of 0-4 year olds identified as belonging to the White British grouping. There were between 800 and 900 0-4 year olds from each of four other broad categories: Asian/Asian British (849), Mixed/multiple ethnic group (875), Black/African/Caribbean/Black British (802) and non-British White (consisting of Irish, Gypsy or Irish Traveller and Other White (800). *(Source: 2011 Census)*

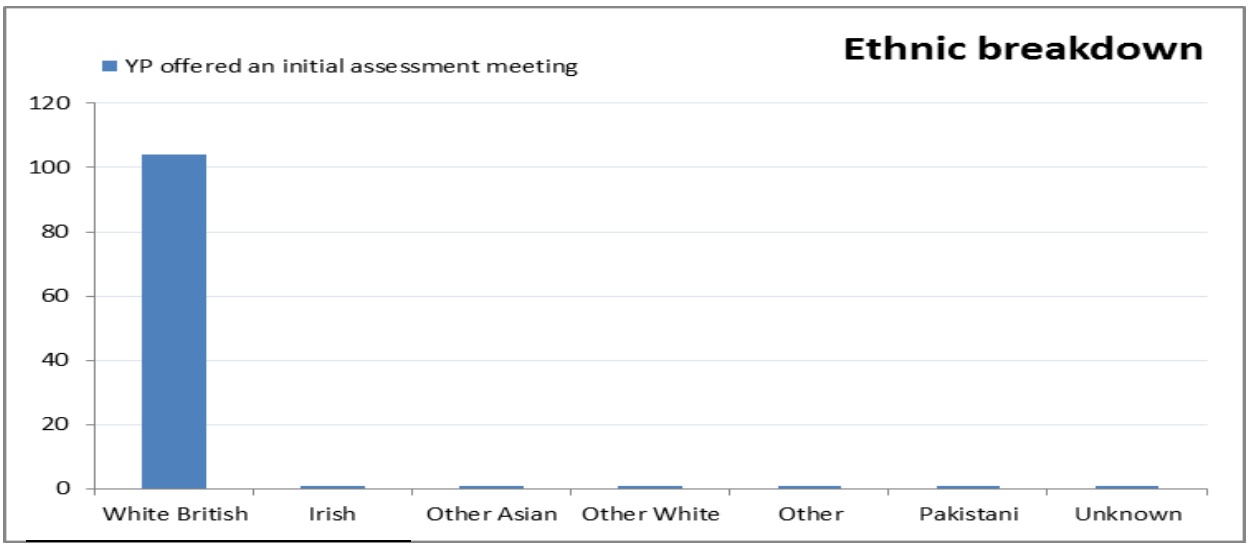
Appendix 4: Salford Services Activity Data 2014/15

Quarterly monitoring data is received from CAMHS, although monitoring is through Manchester as the lead commissioner. Quarterly monitoring meetings are held with Targeted CAMHS services and 42nd Street, led by the Local Authority.

1. 42nd Street (Tier 2 commissioned service)

2.	New Referrals[2]	YP offered an initial assessment meeting[3]	YP seen for individual community mental health support[4]
Male	70	38	54
Female	133	72	93
Trans	3	0	0
Total	**206**	**110**	**147**
	Of those offered	83 attended	131 attended
	DNA	27	16





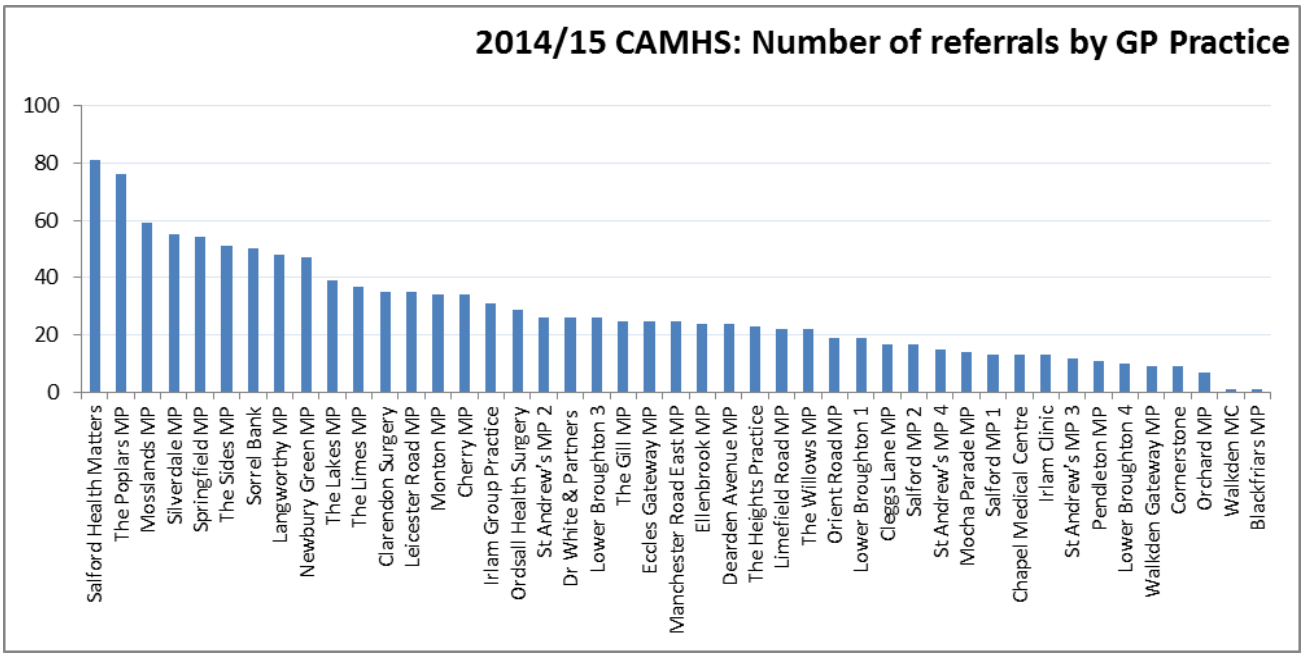
[2] There are a higher number of referrals to those actually offered an assessment as referrals may not be seen immediately as they will need to be processed. Some referrals are not offered an assessment but this number is generally low (around 15%) because the referral is inappropriate or they change their minds etc. Alternative support is offered wherever possible.
[3] Assessments can take up to 3 hours and sometimes young people disengage at this point as they feel their needs have been met
[4] Young people seen is a cumulative total which includes a rolling number of young people on the caseload accessing support i.e. ongoing cases. Some young people disengage between assessment and one to one engagement.

Presenting Issues	YP offered an initial assessment meeting**	YP seen for individual community mental health support***
Anger Management	20	35
Bereavement/Loss	6	8
Bullying	1	1
Confidence/Self esteem	10	18
Depression	21	30
Disability Issues	1	0
Domestic Violence	0	0
Eating Problems	1	1
Family Problems	5	7
Hearing voices/intrusive thoughts	0	0
Loneliness/Isolation	0	0
Other	1	0
Physical Abuse	1	3
Pregnancy/Termination	0	0
Racism	0	0
Relationships	0	0
Self-Harm	2	3
Sexual Abuse	3	5
Sexuality Issues	0	0
Stress/Anxiety problems	8	13
Suicidal Thoughts	2	7
Unknown	28	16
Total	**110**	**147**

2. CMFT Core CAMHS Activity Data (taken from PAS)

Item		Q1	Q2	Q3	Q4	2014/15
Referrals	GP	194	158	194	186	**732 (55%)**
	Total	351	319	328	328	**1326**
Attendances	New	253	243	273	243	**1012**
	DNA	57	82	51	48	**238**
	% DNA (New)	22.5%	33.7%	18.7%	19.8%	**23.5%**
	Review	2058	2079	2316	2562	**9015**
	DNA	523	593	550	501	**2167**
	% DNA (Review)	22.6%	28.5%	23.7%	19.6%	**24.0%**
	Total Attendances	2311	2322	2589	2805	**10027**
Inappropriate referrals/opt outs*		41	6	4	37	**88**
Waiting Times	Average no. of days	74	71	74	76	**74 (10.5 wks)**
	Range (in days) for different teams	66-110	43-116	46-117	47-143	

*Difference between referrals & 1st attendance + DNA's



3. CMFT Targeted CAMHS

LAAC Activity Data (SAFSS, Specialist Fostering and STARLAC)

Number of referrals	181
Number of appointments attended	1,495
Number of DNA's	99
Number of cancellations	145
Number of direct assessments	145
Number of intervention sessions	1463
Number of consultations offered	1739
Number of cases receiving consultation	219

YOS Activity Data

Number of referrals	**32**
Number of direct assessments	**24**
Number of interventions (i.e. YP seen)	**37**
Number of intervention sessions	**106**
Number of cognitive screenings	**16**
Percentage of cases (new referrals) seen within 7 days.	**4**
Percentage of cases (new referrals) seen within 4 weeks.	**16**
Number of consultations offered	**53**
Number of cases receiving consultation	**38**
Number of 'other contacts' where advice/support is given	**21**
Number of training sessions.	**1**
Number of staff attending training sessions	**2**

Emerge Activity Data

Number of referrals	221
Number of direct assessments.	294 offered / 145 attended
Number of interventions (i.e. YP seen)	1355 intervention offered for 133 YP
Number of intervention sessions	798 intervention sessions attended
Number of cognitive screenings	102
Percentage of cases (new referrals) seen within 7 days.	17%
Percentage of cases (new referrals) seen within 4 weeks	Offered 83%
Number of consultations offered	43
Number of cases receiving consultation	19
Number of training sessions	Provided x 4
Number of staff attending training sessions	Approx. 50

4. NHSE Specialist Commissioning

	Childrens				**PICU**			
	2013/14		2014/15		2013/14		2014/15	
North of England commissioning region 2015	No of Ax*	OBD	No of Ax	OBD	No of Ax	OBD	No of Ax	OBD
Greater Manchester Area Team								
Salford CCG	3	509	2	92	2	13		

	Acute admissions				**Mother and Baby**			
	2013/14		2014/15		2013/14		2014/15	
North of England commissioning region 2015	No of Ax	OBD	No of Ax	OBD	No of Ax	OBD	No of Ax	OBD
Greater Manchester Area Team								
Salford CCG	9	1301	16	645	4	353	3	213

ED / Medium Secure / Low Secure / LD Secure were blank. There were issues with the data collection and work is underway to improve the depth and breadth of the data provided.

* AX refers to admissions and OBD is occupied bed days

The ED data relates to eating disorder only units but some young people with eating disorders will be admitted to acute units (and depending on the severity of need they can sometimes be managed in generic units).

The Children's units relate to Dewi Jones and Galaxy House.
The PICU (Paediatric Intensive Care) is for under 18's

5. 6 Degrees Step 2 IAPT service

Below is some approximate data for 16/17yr olds referred in 2014/15.

1.Number of 16-17 year olds referred	105
2. Numbers completing treatment (Number Recovered)	19 (8)
3. Numbers stepped-up for further input (to GMW)	9
4. Seen 1 session only	27
5. Not seen (either DNA or not suitable)	50
2+3+4+5 = Total Referred	

Appendix 5: Salford Financial Investment in Emotional Wellbeing Services

1. 42nd Street

From April 2015 this is entirely funded through the CCG at an annual cost of £112,706.

2. Core & Targeted CAMHS

Central Manchester University Hospitals NHSFT

Summary of costs for years 2014-15 P1-12

Salford CCG - Costs v's Income

Area	Budget		Total Service Cost	
	Wte	2014-15	Wte	2014-15
	No	£	No	£
Costs				
Salford				
Salford Outpatients	30.62	2,262,225	31.32	2,342,419
Salford LAC	3.20	227,380	3.20	227,960
Salford LD	1.45	150,450	1.45	146,435
Salford Treatment Foster Care	3.10	228,000	3.27	202,821
Total costs for Salford CCG & CC	**38.37**	**2,868,055**	**39.24**	**2,919,634**
Salford Emerge				
Emerge Salford 16/17 year old Service	2.60	216,787	2.60	216,625
Total costs for Emerge Mcr and Salford	**2.60**	**216,787**	**2.60**	**216,625**
Total costs Salford	**40.97**	**3,084,842**	**41.84**	**3,136,259**
Income				
Salford City Council Income				
Emerge 16/17 Year Old Service		(75,000)		(75,000)
Salford Core Outpatients - Youth Offending Service		(43,871)		(43,871)
Salford Core Outpatients - Child Protection post E Samuels (NR)		(61,537)		(61,537)
Salford LAC - Salford Adoptive Families Support Service (SAFSS)		(62,000)		(62,000)
Salford MTFC - Salford Multidimensional Treatment Foster Care		(190,000)		(164,821)
Total income received from Salford CC		**(432,408)**		**(407,229)**
Salford CCG Income				
Salford Outpatients Salford CCG - BME Post - S Wilson		(25,664)		(25,664)
Salford Outpatients Salford CCG - Dr Orchando Salford ADHD (NR)		(43,780)		(63,003)
Salford LAC Salford CCG - Looked After Children		(54,377)		(54,377)
Salford LD Salford CCG - Salford LD		(125,375)		(40,527)

Emerge 16/17 Year Old Salford CCG		(100,000)		(99,998)
Outpatient Income (Actuals) - see sheet Income Outpts for detail		(2,424,866)		(2,424,866)
		(2,774,062)		**(2,708,435)**
Other Income				
Salford Outpatients - David Lewis - H Lloyd - 1 PA		(7,080)		(7,080)
Salford Outpatients - Salford Royal - Diana Nurses		(9,500)		(9,500)
Salford Outpatients - Salford Royal - Diabetes monies - M Perkin		(7,368)		(7,371)
Salford Outpatients - Action for Children E Samuels		(4,094)		(4,091)
		(28,042)		**(28,042)**
Total income Salford		**(3,234,512)**		**(3,143,706)**
Net total Loss + / Profit (-) for Salford	**Profit**	**(149,670)**	**Profit**	**(7,447)**

3. NHSE Specialist Commissioning

North of England commissioning region 2015	All Services		Children's		PICU		Acute Admissions		Mother & Baby	
GM Area Team	2013/14 OBD	2014/15 OBD	2013/14 OBD	2014/15 OBD	2013/14 OBD	2014/15 OBD	2013/14 OBD	2014/15 OBD	2013/14 OBD	2014/15 OBD
CCG										
NHS Salford CCG	1,293,462	569,756	272,315	49,220	11,583	-	823,533	408,285	186,031	112,251

Eating Disorders / MSU / Low Secure /LD Secure were blank

Appendix 6: Wigan Four Stage Antenatal Workshop Programme

This is a 4 stage programme of group workshops run in partnership between Midwifery services, Health Visiting services and the Wigan Breastfeeding Network Peer Support Service. The workshops are offered in each Locality on a monthly basis (or more depending on demand) across the Borough. All workshops are delivered from Children Centres with the support of children centre staff and offered at a range of different times, afternoons, evenings or weekends to give parents greater availability. Mothers, fathers, partners, extended family and any friends who may be supporting the family are encouraged to attend the workshops. The Wigan Breastfeeding Network Peer Support Service provides a central telephone booking hub for all four sessions. This enables conversations with clients to encourage them to book on to all four sessions and to sign post clients to sessions elsewhere in the Borough that may be more convenient to them. The central booking hub can also monitor demand in order to increase the number of sessions provided if necessary.

The overall aim of the programme is to help parents, their family and friends to understand and prepare to meet the physical, cognitive, social and emotional needs of their baby and family.

The Programme is divided into 4 workshops:
1. Nurturing your bump and baby
2. Labour and birth
3. Breastfeeding work shop
4. Getting it Right for you and Your Baby

In recognition that not all parents may attend all sessions a common subject matter is included in all sessions to a greater or lesser extent. These include attachment and bonding, infant feeding, safer sleeping, the role of fathers. The 4 stage antenatal workshop programme forms part of the Perinatal Parent and Child mental health pathway (in development) and the Infant Feeding Pathway. All workshops are performance managed and feedback from the evaluations informs the further development of the groups.

Appendix 7: Salford Self-Assessment against recommendations from Future in Mind

Identified gaps and areas for further development

Perinatal mental health (awaiting additional guidance and resources)
Single point of access for CAMHS advice
One stop shop services in community - role for VCS
Refined pathway for CAMHS involvement in SEND & EHCPs
Peer support programmes - role for VCS
Crisis / out of hours support 0-18yrs
Rapid access / home treatment options & step down provision
Training audit to understand training requirements of the wider workforce

Resilience, prevention & early intervention	**Salford Responses to Recommendations**
1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.	Salford Early Help Strategy. **Perinatal mental health is an area for further development.** Awaiting results of GMLSC SCN scoping work on Perinatal Mental Health Services across Greater Manchester, Lancashire and South Cumbria
1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.	HV ante-natal contact Needs to be addressed as part of GM maternity spec
1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.	
1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.	Health Visitors will have access to updated training and it will be disseminated across the team.

1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents	The Healthy Child Programme is delivered universally across Salford and all updates are included within the current specification
2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	Emotional Health in Schools grant (inc. Place 2 Be counselling) & TAMHS investments
2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.	Salford has successfully bid to be part of CAMHS / Schools Link pilot
2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision that improves children's outcomes and achieves value for money. This will be published in spring 2015.	Exploring co-ordinated approach to counselling in schools
2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.	National approach
2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.	Salford SN have received training on EHWB previously – review through audit
2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.	National approach
3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.	Local campaigns (building on national resources) to be explored as part of 0-25 integrated programme e.g. Mind Ed
4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.	GM Early Years New Delivery programme
4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.	To be explored further when national guidance and resources are released

4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.	GM Early Years New Delivery programme
5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.	Local campaigns (building on national resources) to be explored as part of 0-25 integrated programme. Mind Ed
Improving access to effective support	
6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.	Need to revise the CAMHS service specification. CMFT CAMHS has applied to be i-thrive accelerator site.
7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.	**Area for further development**
7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.	**GAP** - explore option of CAMHS presence in the Bridge (Salford MASH & single point of access).
7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.	See above - will need to develop formal referral pathway.
7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).	See above
7.4 Young people and parents are able to self-refer into the single point of access.	Explore self-referral into Bridge. CMFT CAMHS to offer self-referral by Jan 2016.
7.5 Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop services, based in the community.	Current VCS asset mapping being completed by CVS. Build response following results of this.
8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.	**Area for further development**

8.1 There is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices.	Incorporate the learning from Salford CAMHS / Schools Link pilot. Explore option of CAMHS presence in the Bridge to provide contact point for GP's
8.2 There should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals.	Incorporate the learning from Salford CAMHS / Schools Link pilot
9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	National Pilot
10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).	DMO / DCO role well developed in Salford but **Area for Development** - see below
10.1 There is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND)	If CAMHS is working with a child / family, the medical advice will identify this and additional info maybe sought. However, this is an informal arrangement with no timescales. Need more defined pathway.
10.2 There should be involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)	See above
11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.	**Area for further development**
11.1 Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with	**Potential gap -** explore as part of VCS asset mapping being undertaken by Salford CVS
11.2 Further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision.	See above
12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.	**Area for further development**

12.1 CYP experiencing mental health crisis receive appropriate support/intervention as outlined in the Crisis Care Concordat	24/7 CAMHS assessment & response to Paediatric A&E but 17/18 yr olds seen in adult A&E & by Adult Crisis Team, no CAMHS response until following day. Review audit of CQC inspection
12.2 There is an out-of-hours mental health service available for children and young people experiencing mental health crisis	Explore development of rapid access / home treatment service
12.3 Supporting a CYP in a crisis includes a swift and comprehensive assessment of the nature of the crisis.	See above
12.4 There are dedicated home treatment teams for children and young people.	**GAP** - see above
12.5 The national development of all-age liaison psychiatry services in A&E Departments should mean that appropriate mental health support in A&E is more readily available.	National approach
13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.	**Area for further development**
13.1 There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision.	**Gap** - would be part of rapid access / home treatment model above
13.2 This are clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care	**Gap** - would be part of rapid access / home treatment model above & community ED provision
14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.	Under development
14.1 There is a robust admission gateway processes for CYP with learning difficulties	
14.2 There is a challenge process that checks that there is no alternative to admission for CYP with learning disabilities and/or challenging behaviour.	
14.3 The creation of an agreed discharge plan on admission for CYP with learning disabilities and/or challenging behaviour is standard practice.	
15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.	**Area for further development**
15.1 There is flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.	Local review of transition from CAMHS to AMHS. Age extension to be explored as part of 0-25 Integrated programme

16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.	See above
17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.	National approach - CMFT is compliant with current standards
18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.	National approach
19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.	National approach
19.1 No child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.	GM pathway for this
19.2 Develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning.	National approach
19.3 CQC should carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.	National approach
Caring for the most vulnerable	
20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.	Currently if DNA then discharged back to GP unless there are safeguarding / other vulnerabilities when they will be followed up. DNA once in service is followed up by practitioner.
20.1 Not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up	Graduate to audit for DNAs to look at why people didn't attend
20.2 Services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer	Could be role for rapid access / home treatment service to follow-up DNA.
20.3 It may be necessary to find alternative ways to engage the child, young person or family.	See above
21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that	Targeted CAMHS (joint funded between CCG &LA) for 16/17 yr olds, LAC (inc. fostering & adoption), LD, YOS, BME and

those with protected characteristics such as learning disabilities are not turned away.	into Diana team.
21.1 Health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes	To be addressed as part of review of core CAMHS service specification planned.
22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.	Integrated care pathways have been developed and due to go live Jan 2016. Shared pathways with external agencies are being developed to widen the front door (SARC & Place 2 Be already signed up).
23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.	Covered in initial assessment. CAMHS involvement in weekly Young Persons Domestic Abuse Panel (YP as perpetrator or victim).
24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.	Referral pathways with SARC (Sexual Assault Referral Centre) are being developed.
25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.	See 23 above & development of CAMHS in Bridge.
26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.	CPA principles are used.
26.1 A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way.	CMFT apply CPA principles, including lead clinician, to the assessment, planning and coordination of care.
27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate	National approach

evidence-based interventions.	
28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.	Targeted CAMHS service available (see 21 above)
28.1 Specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties.	See above
28.2 Consultation and liaison teams are used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved above and beyond the level of existing cross-agency provision (including specialist services).	See above
28.3 There is an identified specialist point of reference, including a senior clinician with specific expertise within mental health services.	
29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.	Protect team (multi-agency CSE team) for Salford & M/cr. CSE training in CMFT (half day every 3 yrs - due in Dec 15 / Jan 16). SARC team across GM. CAMHS worker in YOS.
29.1 This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel. This model shall incorporate the necessary governance structures essential for success.	CAMHS worker in Bridge may help to facilitate this. Training audit planned to facilitate development of appropriate MH training
29.2 Develop a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.	See above
To be accountable and transparent	

30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.	This whole area to be reviewed as part of 0-25 integrated test case on emotional health & wellbeing & MH workstream as part of Devo Manc. In additional core CAMHS service spec to be reviewed.
30.1 There is a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care.	See above
30.2 There is a single, separately identifiable budget for children's mental health services.	See above
30.3 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/ carers.	Salford EHWB Strategy / CAMHS Transformation Plan / 0-25 Test case
30.4 The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health.	Salford CYP Trust - mental wellbeing sub-group & 0-25 test case report into HWBB
30.5 Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing.	See above
30.6 As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.	EHWB Partnership includes active involvement of schools, as does CYP Trust
31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.	See above
32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.	National approach
33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions	Will be incorporated into any revised service specs
34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.	National approach
34.1 CQC and Ofsted should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people's mental health	National approach

outcomes and how this area should be monitored in future (34).	
35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.	National approach
35.1 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence based interventions to support evaluation of the effectiveness of the care commissioned (35).	National approach - will be incorporated into local spec & CMFT will be compliant with this when introduced from 01/01/16
35.2 Routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.	National approach - will be incorporated into local spec
36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.	National approach
36.1 The introduction of the first ever waiting time standards in respect of early intervention in psychosis.	National approach
36.2 Access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes.	National approach
37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.	National approach - will be incorporated into local spec
38. Making the investment of those who commission children and young people's mental health services fully transparent.	National approach
38.1 NHS England will be able to identify the overall children's mental health spend by the NHS.	National approach
38.2 Further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment.	National approach
39. Committing to a prevalence survey being repeated every five years.	National approach
Developing the workforce	

40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments	CMFT have training programme for staff. Part of CAMHS / Schools link pilot. Training audit to be developed across agencies.
40.1 Professionals trained to be able to: Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.	See above
40.2 Professionals trained to: Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.	See above
40.3 Professionals trained to be able to: Identify mental health problems early in children and young people.	See above
40.4 Professionals trained to be able to: Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.	See above
40.5 Professionals trained to be able to: Refer appropriately to more targeted and specialist support.	See above
40.6 Professionals trained to be able to: Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.	See above. Will be incorporated into revised service spec
40.7 Professionals trained to be able to: Work in a digital environment with young people who are using online channels to access help and support.	See above
41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.	National approach
42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.	National approach
42.1 Attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services	National approach
43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.	CMFT has adopted CYP IAPT approaches across CAMHS
43.1 The workforce in targeted and specialist services need a wide range of skills brought together in	See above

the CYP IAPT Core Curriculum.	
43.2 All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability.	See above
43.3 Skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE shall be addressed.	See above
43.4 Skills gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings shall be addressed.	See above
43.5 Counsellors working in schools and the community will receive further training to improve evidence-based care	See above recommended training audit
44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.	Salford has CYP IAPT
45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.	Will be part of service specs & contracting
Making change happen	
46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.	Will be submitted 16/10/15
46.1 Develop agreed Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer. These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.	Will be submitted 16/10/15
47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.	National approach
48. Enabling more areas to accelerate service transformation.	National approach
49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.	National approach

Appendix 8: Transition

Workshop 1: Pathways for young people with psychosis and young people with a mental health diagnosis transitioning into AMHS 02/07/15.

For young people with psychosis, transition work appears to be quite systematic in that GMW's Early Intervention in Psychosis (EIP) service jointly works with CAMHS, usually with the EIP service care coordinating but remaining under the CAMHS Consultant until they reach 18.

Regarding other young people transitioning into AMHS the aspiration is to begin transition 6 months before the 18th birthday, but in reality it is often 3 months for three principle reasons.

1) There is not felt to be sufficient resource in CAMHS to undertake this transition any earlier. Staffing levels are an issue, and staffing at the right level, there doesn't appear to be enough Care Coordinators to implement a 6 month transition.
2) It can be difficult engaging people earlier than three months as there is often apprehension and stigma of AMHS, fear of change, attachment difficulties that the young person may have that may slow down proceedings. Work can be undertaken in AMHS to more assertively engage with CAMHS and young people to better inform them about AMHS and myth-busting with young people and their families to help alleviate any concerns.
3) Sometimes people may have only been in EMERGE for 6 months so immediately beginning the transition process might not be beneficial for the young person. These caveats will always remain.

Workshop 2: Pathways for those 'vulnerable children and young people' including young people with ADHD and Asperger's, and in particular young people in high cost out of area placements 25/09/15. While these are fewer in number than the cohorts previously discussed the pathways are less clear

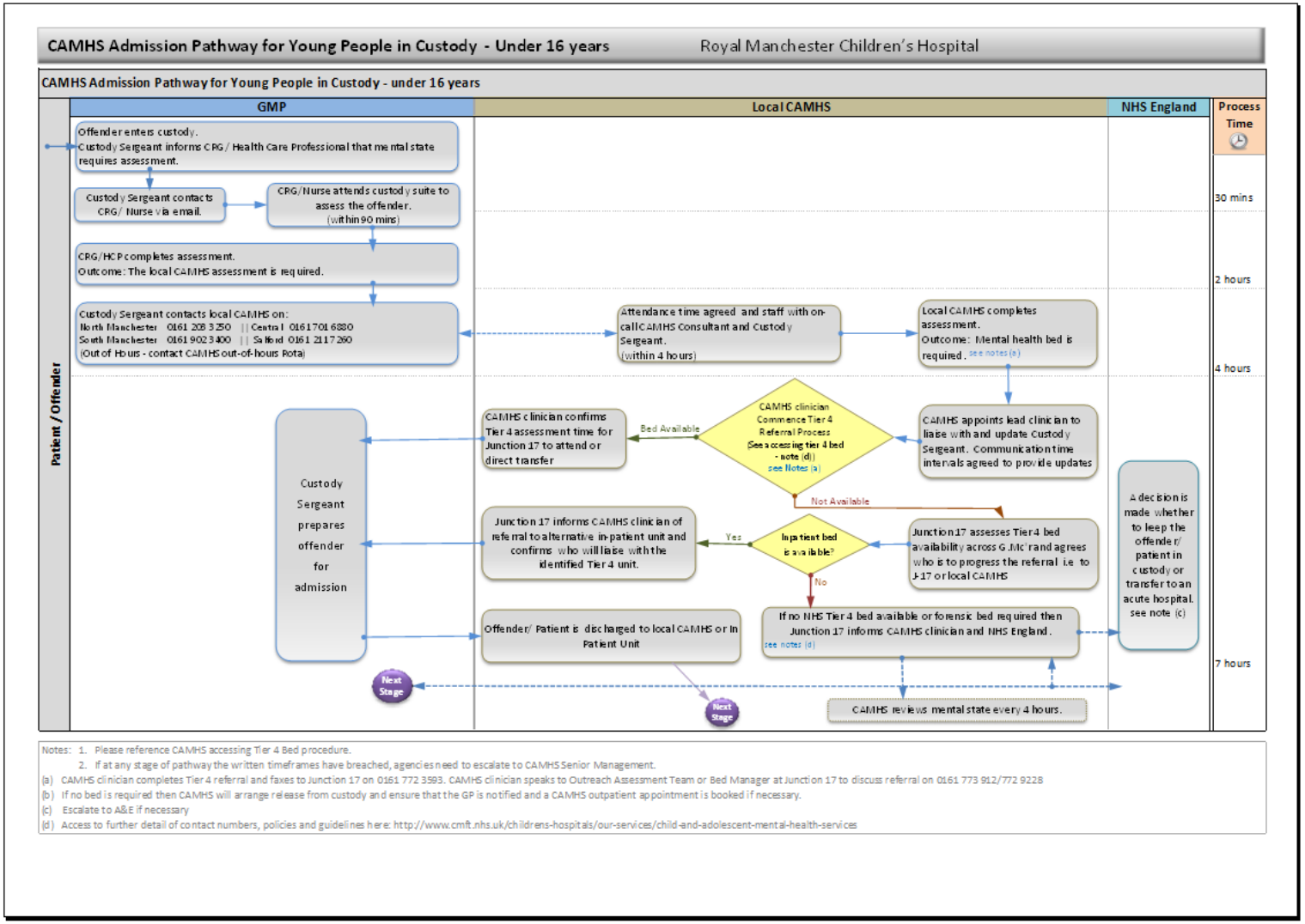
At the age of 16 there is a transition allocation meeting, within a month there is a joint visit (including AMHS) and within a further month this would come to the AMH funding panel where a decision is made regarding eligibility. This decision would then be fed back to the transition allocation meeting a month later. Consequently, if the decision by AMHS at this stage is that the person does not meet AMHS eligibility then this leaves a considerable timeframe (21 months) to take next steps and identify the package of care needed by this young person when they reach the age of 18. However, from recent experience there is not a sufficiently clear 'next step' that can be taken. A gap in step down provision was identified. This is because the needs of this cohort do not always fit neatly into a MH or LD category (there may be clinical needs better met by one team and social care needs better met by another). It was raised as to whether budgets could be pooled and joint working protocol be established for this cohort

It was also highlighted that for young people in out of area placements it would be the CAMHS service in that area that would be responsible. Since many of the young people are placed out of area this means that there are going to be a range of CAMHS involved. This is different for adults placed out of area where, while on occasion the MH service in that area might be asked to provide certain interventions, responsibility for Care Co-ordination remains with the Salford District Service. It was acknowledged that for young people placed out of area this is a provider led market, and a lot of people were involved in the process from different agencies.

Transition social workers are going to be recruited by the Local Authority and the Job Description is being developed. It was recognised that this should make a significant difference and that GMW need to be fully engaged in the development of these posts.

The above raises questions around the step down provision this group of young people, the possibility of pooling budgets / joint working protocols, consistency of management of need between different CAMHS, management of the market and numbers of staff involved. These considerations and the ones raised above in the first workshop, need to form a plan for discussion going forward.

Appendix 9: CAMHS Admission Pathway for Young People in Custody under 16 years



Appendix 10: Integrated Care Pathways

The following pathways are being developed by CMFT CAMHS:

- Referral to and Access to CAMHS – an integrated Joint Access Pathway for all Health, Social Care and 3rd Sector Organisations e.g. SARC/Early Intervention in Psychosis/42nd Street.
- Assessment
- Discharge
- Transition to other services/agencies
- Emergency referral
- Attention Deficit Hyperactivity Disorder
- Generalised Anxiety
- Attachment Disorder
- Behaviour Problems
- Bi-polar Affective Disorder
- Psychosis
- Depression
- Anorexia
- Bulimia
- Clinical Service for Children with Disabilities
- Post-Traumatic Stress Disorder
- District CAMHS Paediatric Referral
- Clinical Psychology Interventions for Paediatric Diabetes
- Obsessive Compulsive Disorder
- Specialist Paediatric Service-Referral and Access
- Specialist Paediatric Service-Assessment Only
- Specialist Paediatric Service-Therapy
- Specialist Paediatric Service-Group Therapy
- Specialist Paediatric Service-Palliative Care/End of Life
- Emerging Borderline Personality Disorder
- CAMHS Admission Pathway for Young People in Custody

The benefits of ICP's are:

- Clearly defined plan and duration of care for the child/young person and parents
- Goal and outcome focused
- Improved communication between professionals and agencies-at any point in time it is clear where care is up to
- Demonstrates evidence based best practice
- Defensible practice
- Auditable process of care
- Dynamic document that can be adapted and revised to incorporate service and practice developments
- Improved access and no waiting times for specialist CAMHS assessment when families and young people have mental health needs identified within other agencies

Appendix 11: Salford Bridge

Purpose

The front door service, which has a developing remit in respect of children, young people and families that is primarily about safeguarding and minimising crime but is becoming increasingly linked to early help. The aims are to continue to develop and improve the Multi-Agency Safeguarding Hub processes and to develop a single front door for receipt of contacts and requests for support for families and single vulnerable / complex adults.

Function

To handle all contacts, whether electronically or by telephone and either allocate to the correct Triage team, signpost to information or refer to a relevant service. Children's Social Workers are currently doing the triage work but the aspiration is to involve other agencies. There are two Triage teams: Complex Team and Standard Team. Where there is an immediate safeguarding concern the contact is to be passed immediately to the Complex Team by the Contact Centre where the case will be profiled and passed to the most appropriate team for the nature of the contact. Where there is no immediate safeguarding concern, but the contact meets the threshold for service provision the contact centre will pass the contact to the standard team. Each contact will have an assessment and be prioritised according to this and the nature of the contact. A profile will also be completed. Once a case has been allocated a case coordinator and team will be assigned to the family to help provide the required support (as per Helping Families procedures).

There is a meeting every morning involving various partner agencies including Health / Project Gulf / Housing and the Police that review the cases. This meeting is a forum for decision making.