

‘Co-ordinated System’ Task and Finish Group Report

Children and Young People’s Mental Health and Wellbeing Taskforce

This report summarises proposals from the ‘Co-ordinated System’ Task and Finish Group of the Children and Young People’s Mental Health and Wellbeing Taskforce and has informed the report *Future in Mind: promoting, protecting and improving our children and young people’s mental health and wellbeing*. **It is not a statement of Government policy.** A full list of members and contributors is included at the end of the report.

Contents

Introduction	3
Use of Language	3
The vision.....	4
The case for change	5
Problems with Inpatient Provision	5
Problems across the Age Range	6
Economic Case.....	7
Co-ordinated Response	8
Summary of key proposals.....	8
Achieving the vision	9
Short term.....	10
Transformation Plan for Children and Young People’s Mental Health and Wellbeing	10
Short to Medium Term.....	12
Joint Commissioning.....	12
Funding and Longer Term Investment to Improve Sustainability	20
Better Information, on Need, Cost and Spend to Inform Payment Systems to Create Better Commissioning and Investment Decisions	25
Medium to Long Term	27
A Different Conceptual Framework, Based on Needs of Children and Young People	27
A National Ambition which is Interpreted Locally	32
Concluding Points	34
Membership	

Introduction

1. This report presents the views of the Co-ordinated System Task and Finish Group, one of the four Task and Finish groups of the Children and Young People's Mental Health and Wellbeing Taskforce. The focus of this Group was to consider the ways in which agencies and sectors should work together to ensure appropriate services are available to meet the needs of children, young people and their families across care pathways. This report has also been informed by the views of children and young people, their families and the professionals that work with them, through dedicated engagement exercises.
2. This report should be read alongside the work of the other Task and Finish groups, and in particular the report of the Prevention and Access Group, which looks at children and young people's access to services along the care pathway.
3. The Co-ordinated System Task and Finish Group identified 6 key challenges:
 - the system structure: the current system is complex and fragmented, with multiple bodies responsible for planning and contracting for services; describing services as 'tiers' can be confusing and restrictive; and the structure creates perverse incentives
 - lack of clarity: on roles and responsibilities of different parts of that system
 - lack of cohesion: children and young people can get shunted between services, and fall between gaps in service provision
 - lack of accountability to meet shared outcomes: if the system fails children and young people, there are inadequate arrangements to hold anyone to account
 - ill-defined and unclear funding arrangements: disinvestment in services and non-recurrent funding
 - lack of information: on cost, spend and prevalence, which limits the economic case for investment
4. This Task and Finish Group also highlighted that while these challenges do exist, there are also levers and opportunities which should be used to full advantage. There are numerous examples of initiatives, good practice and guidance already available, many of which have been referred to within this report.

Use of Language

5. In this report we refer to 'the system' as the wide spectrum of services and interventions necessary to meet the mental health and wellbeing needs of children and young people of all ages, and their families. This includes mental health and wellbeing promotion, prevention and early intervention services, as well as specialised mental health provision. These services are provided by a range of different agencies such as education, local authorities, public health, youth justice, voluntary and community sector as well as statutory and private sector healthcare services, and are provided in a range of settings.
6. There are mixed views regarding use of the term 'child and adolescent mental health services', or 'CAMHS'. 70% of children and young people involved in the Taskforce engagement exercise agreed with the statement *'it doesn't matter what CAMHS is called*

as long as young people know where to find it". However, it is the view of some that the term can be confusing, as there is no single, agreed definition of what CAMHS is and who provides these services. This Task and Finish Group wishes to shift away from this terminology, so in this report we have attempted to limit the use of this term. However, we have used it when we are referring to existing initiatives or reports.

7. Throughout the report we have used the term 'commissioning' to describe the process by which services are planned and contracts are issued to services. In many areas, the CCG and local council have created joint commissioner roles. In others, the commissioning is undertaken independently by commissioners based in separate organisations. Head teachers who contract for services such as counselling or outreach by NHS services into their schools are also 'commissioning'. Some schools have joined together to plan and contract for mental health services together to make best use of resources.
8. Throughout this report when we are referring to the 'education sector', we are including schools in the state and independent sectors, and further education colleges.

The vision

"Joined up care - if it works well, you shouldn't notice anything. Everyone knows their role and what they are doing to support the young person. Everyone communicates and meets up, works with the same language so everyone can understand. Maybe even goes to some of the same training. They wouldn't forget their key aims, why they were in the job in the first place: to help people."

A young person who took part in the Taskforce engagement exercises

9. The vision for the system is one which:
 - Provides seamless support to best meet the needs of all children and young people aged 0-18 years, and their families;
 - Ensures that regardless of the age a child or young person moves from services, they are supported to stay well and achieve their potential;
 - Is simple and easy to navigate and provides a range of outcome focussed, evidenced-based services;
 - Has clear leadership, under which everyone understands their roles and responsibilities and takes ownership of shared outcomes;
 - Is both underpinned by and generates information to rationalise investment and commissioning decisions;
 - Operates by principles that help guide change - such as developing social value, building resilient communities, and partnership and collaborative working;
 - Involves children, young people and families, as well as providers, in setting local strategies and offers.

The case for change

10. There is broad consensus that the current system of children and young people's mental health and wellbeing provision is failing many children, young people and their families and those working within it to plan, contract for (ie commission) and provide services.^{1 2}
11. The Health Select Committee (HSC) Inquiry into Children's and Adolescents' Mental Health and CAMHS considered many pressing issues including: a reduction in early intervention services; lack of education about mental health and wellbeing in schools; long waiting times; young people being admitted onto adult units, as well as other inappropriate settings or long distances from home; poor experiences of transition between services; and poor experiences of information sharing and communication.³

Problems with Inpatient Provision

12. Effective community based mental health provision can go a long way to prevent children and young people's mental health deteriorating and to support those with the greatest need. However, there will always be some children and young people who require more intensive and specialised care within inpatient settings.
13. NHS England's CAMHS inpatient report, published in 2014, is the most recent description of the provision and access arrangements around the country.⁴ It is clear from this report that some areas had undertaken considerable work under the previous commissioning arrangements to create local systems with the 'right' amount of inpatient capacity. However, other areas needed more beds to be provided and commissioned to meet local need.
14. When national commissioning was introduced in 2013, many of the underlying capacity issues remained. As a consequence, there have continued to be too many occasions when children and young people were treated at hospitals far away from their homes and, occasionally, in adult facilities. Both of these are unacceptable.
15. NHS England's report outlines different provision, access arrangements and fragmentation around the country. It also notes how the new arrangements for commissioning had the potential to deter local commissioners investing in community based prevention and alternatives to admission, since any financial benefit would not necessarily be gained locally.
16. Specialised children and young people's mental health services (Tier 4) are concerned that community based services (Tiers 2 and 3) do not have the capacity to intervene

¹ Chief Medical Officer (2013) Annual report of the Chief Medical Officer: our children deserve better: prevention pays. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf

² Health Select Committee (2014) Children's and adolescents' mental health and CAMHS. London: The Stationery Office Limited. <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/14-11-04-camhs-report-substantive/>

³ *Ibid*

⁴ CAMHS Tier 4 Steering Group (2014) Child and adolescent mental health services (CAMHS) Tier 4 report. London: NHS England. <http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

when problems first emerge, and that there is also a lack of services offering alternatives to admission.⁵ Failing to intervene early often results in the deterioration of a child or young person's problems, and can lead to a crisis, which may require inpatient admission which could have been avoided.

17. NHS England's Report also raised concerns about delayed discharge. This was due to a number of factors, but the top three were social care issues, lack of alternative inpatient placements and lack of community aftercare.⁶
18. This Task and Finish Group supports investment in effective targeted and specialist community provision, including admission prevention and 'step down' provision with clear pathways for young people leaving inpatient care to reduce unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care.

Problems across the Age Range

19. Problems in the system cut across the whole age range and across different agencies and sectors.
20. There is considerable evidence concerning the importance of promoting mental health and addressing concerns during infancy.^{7 8 9} However, the HSC Inquiry into Children's and Adolescents' Mental Health and CAMHS and other reports have highlighted wide variation across the country in the provision of perinatal and infant mental health services.^{10 11 12} The 2014 NHS CAMHS Benchmarking exercise found that only 23% of those who participated in the exercise provided ante-natal and post-natal specific support.¹³ It has been reported that there is little or no integrated commissioning for children under 5s.¹⁴
21. Problems facing young people as they make the transition from child and adolescent mental health provision to adult mental health services are not new. Many young people transferring from child and adolescent mental health provision find that adult mental health services do not provide the services they need. This is particularly the case for young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder. Even where the presence of a long term condition suggests

⁵ *Ibid*

⁶ CAMHS Tier 4 Steering Group (2014) *Op. Cit.*

⁷ Wave Trust, 1001 Critical Days, HSC, Centre Forum Wave Trust (2013) Conception to age 2 – the age of opportunity. Croydon: Wave Trust. http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf

⁸ Health Select Committee (2014), *Op. Cit.*, p. 47.

⁹ Centre Forum (2014) The pursuit of happiness. London: Centre Forum. <http://www.centreforum.org/assets/pubs/the-pursuit-of-happiness.pdf>

¹⁰ Health Select Committee (2014) *Op. Cit.*, p. 47.

¹¹ Centre Forum (2014) *Op. Cit.*, p. 26.

¹² Maternal Mental Health Alliance (2014) Mapping of UK Perinatal Mental Health Provision. http://everyonesbusiness.org.uk/?page_id=349

¹³ NHS Benchmarking Network (2014) CAMHS benchmarking report. Not publically available.

¹⁴ Centre Forum (2014) *Op. Cit.*, p. 26.

transition should be automatic, the reality is that it is not.¹⁵ One study found that less than 5% of transfers fulfil all the criteria of optimal transition.¹⁶ There are even more challenges at transition for those young people who have a range of complexities that, taken together, make them highly vulnerable, yet do not meet the threshold for adult mental health services. For other young people, the nature of adult mental health services and their emphasis on working with the individual rather than a more holistic approach including the family, means that young people prematurely disappear from services altogether¹⁷ despite needing further support.¹⁸ These problems have been recognised for some time, and there are a number of resources that detail good practice.¹⁹

Economic Case

22. Whilst the impact of mental health problems on the individual and their family and friends is of the greatest importance, it is also essential to consider the wider economic impact of mental health problems.

23. These costs do not impact on health alone, as we know that children and young people's mental health problems are associated with a wide range of adverse outcomes, including educational underachievement, unemployment, crime and violence.²⁰

24. For example:

- The estimated annual short term health, social care and education costs of emotional, conduct and hyperkinetic disorders among all children aged 5–15 in the UK are £1.58 billion and the long-term costs £2.35 billion.²¹
- Data from the Chief Medical Officer's Annual Report indicates that the total annual costs for children and young people aged 5-16 years with a mental disorder in England are estimated at £118 million for health, £67 million for social care and £1,390 million for education (it should be noted that the education costs are high because they are not limited to specialist mental health services, but includes costs associated with frontline education and special education).²²

¹⁵ Singh, S.P. et al. (2010) Transition from CAMHS to adult mental health services (AMHS): a study of service organisation, policies, process and user and carer perspectives. http://www.nets.nihr.ac.uk/_data/assets/pdf_file/0010/64288/FR-08-1613-117.pdf

¹⁶ Paul, M. et al. (2013) Transfers and transitions between child and adult mental health services. *British Journal of Psychiatry*, 202 (S36-40). <http://bjp.rcpsych.org/content/202/s54/s36.full>

¹⁷ Singh, 2010 - http://www.nets.nihr.ac.uk/_data/assets/pdf_file/0010/64288/FR-08-1613-117.pdf Singh, S. P. et al. (2010) *op. cit.*

¹⁸ McLaren, S. et al. (2013) 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research*, 13:254. <http://www.biomedcentral.com/content/pdf/1472-6963-13-254.pdf>

¹⁹ Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of mental health services for young people making the transition from child and adolescent mental health services. <http://www.jcpmh.info/good-services/young-people-in-transition/>

²⁰ HM Government (2011) No health without mental health: a cross-Government mental health outcomes strategy for people of all ages. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

²¹ Strelitz, J. (2013) The economic case for a shift to prevention, in Chief Medical Officer (2013) *Op. Cit.*, Ch. 3, p. 2.

²² Strelitz, J. (2013) *Op. Cit.*, p. 18.

- Those who go on to develop long term mental health problems may require lifetime NHS and social care support.²³ Approximately half of children with early onset conduct disorders have serious problems that continue into later life.²⁴ It has been estimated that the overall lifetime costs associated with severe behavioural problems add up to £260,000 per child.²⁵

25. There is a strong case for 'investing to save'. Although the case for investment in prevention and early intervention is developing, this has not been supported by a shift in resources, with many areas suffering disinvestment in services that support children and young people's mental health and wellbeing.

Co-ordinated Response

26. There are a wide range of factors that contribute to the development of mental health problems in children and young people.²⁶ Whilst health professionals have a key role in supporting children and young people with mental health needs, they neither can nor should do everything. There is a whole network of other professionals and agencies that also have important roles in identifying and supporting children and young people to build resilience and achieve their potential. In addition to the details below, the report of the Prevention and Access Task and Finish Group contains further information.

27. Specialist and crisis services will always be required to support children and young people with the most severe needs. However, more can and must be done to prevent and reduce this need and ensure that when children and young people need specialist services they are available and acceptable.

28. The whole system must work together in the best interests of the child or young person, to provide:

- More interventions that promote mental health, and prevent mental ill health, in children and young people
- A choice of interventions that are attractive to children, young people and their families
- Interventions that are evidence-based, cost-effective, and meet the needs of the local population.

Summary of key proposals

29. Development of a **Transformation Plan for Children and Young People's Mental Health and Wellbeing** to help improve transparency and accountability across the wider system.

²³ Chief Medical Officer (2013) Op. Cit.

²⁴ NICE -(2013) Antisocial behaviour and conduct disorders in children and young people: costing report. London: NICE. <http://www.nice.org.uk/guidance/cg158/resources/cg158-conduct-disorders-in-children-and-young-people-costing-report2>

²⁵ Parsonage, M. et al. (2014) Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/building_a_better_future.pdf

²⁶ World Health Organization and Calouste Gulbenkian Foundation (2014) Social determinants of mental health. Geneva, World Health Organization. <http://www.instituteofhealthequity.org/projects/social-determinants-of-mental-health>

This would build on the approach taken by the Mental Health Crisis Care Concordat, which is a shared, agreed statement and action plan, signed by senior representatives from all organisations involved.

30. **Joint commissioning based on shared outcomes** between health, social care, education and youth justice, and, at local level, **a lead commissioner** to be identified and agreed, to co-ordinate care between and within organisations, including statutory, voluntary and private sectors.
31. **Transparent alignment or pooling of budgets** across health, education and social care, youth justice, and potentially adult mental health commissioners to support early intervention and prevention; improve transitional arrangements; reduce the impact of current perverse incentives; and improve the sustainability of services. There are many examples to learn from where budgets have been pooled or aligned. As well as pooling or aligning budgets there are models such as LEAN and the Care and Partnership Approach (CAPA) which may be used to **identify efficiencies within local systems** and consolidate care around the young person and family.
32. **Collection of data locally** is crucial to making the case for investment and hence sustainability. A new co-ordinated system needs to be transparent, clearly defined, and with measurable outcomes to build the case for investment based on real improvements in long term health and wellbeing, and social and economic benefits.
33. **Whole system redesign** over a planned period of time, moving away from the rigidity of the service-designed tier structure, to a more flexible system which is needs-based and has a children and young people centred approach. There are various emerging models, some in practice, some theoretical, but the important feature will be a local, cross-organisational, seamless, integrated care pathway.
34. **Multiagency, single point of access arrangements for referrals**, advice or consultation for universal services and self-referral. This may initially be by phone, to support maintaining the young person in their home/school/ community environment, or to provide more help if required.
35. **A Universal National Ambition should be described**, encompassing precisely what the elements of best care are, so that this can be translated at local level into a system in which children, young people, families and all professionals understand how to get help and know what "good" looks like.

Achieving the vision

36. Some of the suggestions made here require additional investment and would need to be considered by the next Government and in the next Spending Review, while other proposals could be achieved with existing systems and resources.
37. The 94 applications submitted to NHS England, following their offer of funding to accelerate collaborative commissioning arrangements between health, social care, local authorities and education, demonstrate that there is already considerable interest in working jointly and in many areas this work is already underway.
38. The proposals set out a phased approach to change, from short-term changes which could start immediately and lay the groundwork, to medium (by 2018) and longer term (2020) proposals which would generate significant system transformation.

39. The challenge in realising this vision is how existing levers can be used to their full potential, how innovative solutions can be identified, and how we achieve cross agency and sector agreement to drive these proposals forward.
40. Whilst we have set-out a phased approach, areas can start to implement some of the proposals from this report in the shorter term rather than waiting. For instance, some areas are already redesigning their pathways to cover 0-25s, or already have a single commissioner or commissioning group.

Short term

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

“With integrated accountability structures comes the necessity to agree mental health outcomes and plan to work towards them. If we are all working towards the same outcomes, planning in an integrated way to meet them, using clear accountability structures and a person-centred planning approach, then joint ownership of outcomes is inevitable. This is not easy to do – but... we can start.” - A community services manager who took part in the Taskforce engagement exercises)

41. **Each area should develop and sign-up to a Transformation Plan for Children and Young People's Mental Health and Wellbeing as a way of improving transparency and accountability across the wider system. This Transformation Plan will encourage an integrated approach that will improve transparency and accountability across the wider system. This would build on the approach taken by the Mental Health Crisis Care Concordat, which is a published shared, agreed statement and action plan, signed by senior representatives from all organisations involved.**
42. While we can identify many of the problems within the system of children and young people's mental health and wellbeing, such as lack of centrally flowing data and problems with access to services, we do not have a full national picture of investment at local level. We believe there to be wide variation in spend and provision. For example, some local authorities invest significant funds in specialist services, and some schools invest portions of the pupil premium into children's wellbeing and resilience programmes. However, in other areas pressures on local council funding has led to disinvestment in services, such as parenting interventions, or the withdrawal of support for specialist services. Not all schools have maintained the support that was developed under the Targeted Mental Health in Schools Programme. Transformation will not be possible without greater transparency and accountability throughout the whole system, and a clearer understanding of the baseline.
43. A similar approach to the 'Transformation Plan', has recently been applied for Mental Health Crisis Care, and much can be learnt from this. In summer 2013, Minister of State for Care Services, Norman Lamb, asked the relevant national organisations for the professions that respond to mental health crises (including NHS England, the Association of Chief Police Officers, the Association of Police and Crime Commissioners, the Royal College of Psychiatry) to agree a Mental Health Crisis Care Concordat. This was set up in response to the wide variation in the quality of service response provided to individuals in mental health crisis within different localities across the country. The concordat required central organisations to sign up to a set of shared principles. While covering crisis care for all ages, it also asked local commissioners to take steps to commission services that meet the particular needs of children and young people in mental health

crisis, and specifically that police custody should not routinely be used as a place of safety just because other more suitable services might not be available.

44. The success of the Concordat is reliant on local ambition, and there is an expectation that local areas commit to delivering their own mental health Concordat Declaration. The Crisis Care Concordat is currently being rolled out across the country and serves as a useful starting point for the development of a Transformation Plan for Children and Young People's Mental Health and Wellbeing. It is important to learn from what has and has not worked with the Crisis Care Concordat. For instance, a Transformation Plan for Children and Young People's Mental Health and Wellbeing would require sign-up from national bodies to ensure uptake and implementation at local level. Organisations such as Ofsted and the Care Quality Commission could be responsible for tracking the achievement of agreed milestones and improvement.

- The design and scope of this Transformation Plan should be determined by local partners, including providers and commissioners, and, crucially, it needs to involve children, young people, and their families. It should be designed jointly against whatever commissioning footprint makes sense locally and should be informed by a national outcomes statement and vision. As a minimum it could include a commitment to achieving parity of esteem for mental health by 2020 in line with the Five Year Plan for Mental Health²⁷
- A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing
- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information
- A requirement for all partners, commissioner or provider, to sign up to a series of agreed principles regarding: the range and choice of treatments and interventions available; collaborative practice with children, young people and families; using evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision
- A statement of the steps the partners are taking to deliver more effective services, for example, action planning regarding crisis care or the use of section 136; early intervention services; other recommendations from the other Task and Finish group reports, such as the Vulnerable Children Task and Finish Group
- Any information about existing quality markers – for example complying to ACE-V or the Quality Network for Community CAMHS quality standards and inclusion in the Youth Wellbeing Directory, and the You're Welcome criteria for young person friendly services (see the Data and Standard Task and Finish Group report for other standards)
- Development of a shared action plan and a commitment to review, monitor and track improvements
- Evidence of strong leadership and sound local governance arrangements

²⁷ Department of Health (2014) Achieving better access to mental health services by 2020.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

45. This Transformation Plan should cover the whole spectrum of services concerning children and young people of all ages: from promotion work and resilience building through to treatments and interventions for those who have existing or emerging mental health problems. It should include the full range of services that contribute to the children and young people's mental health and wellbeing agenda including health, youth justice, education (including schools in the state and independent sectors, and FE colleges), as well as voluntary sector and private sector provision. It should also include perinatal and infant mental health staff. Some members of the Task and Finish Group have suggested that it should also focus on addressing the mental health needs of the family as a whole, which would require both children's and adults' mental health commissioners and providers working together.
46. There was some discussion in the Group concerning whether the Transformation Plan should cover young people up to the age of 25. This would mean that adult mental health services would need to be involved and sign up to the Transformation Plan as well. It is suggested that the Transformation Plan covers children and young people up to 18 in the first instance, but with a view to extending it to 25 years in the longer term. In any case local areas will want to carefully plan for transition at age 18, and local partners may choose to cover support up to 25.
47. NHS England received 94 bids from 149 CCGs for the collaborative commissioning pilots, indicating an appetite within local areas for a fundamental shift in culture and ambitions to do more for children's mental health and wellbeing.²⁸
48. Signing up to the Transformation Plan could be further incentivised through use of the new £150 million allocated for eating disorders over the next five years, making allocation of these funds conditional on local areas signing up to the new Transformation Plan (ie using this as a lever to drive traction across the country).
49. If implemented, the Transformation Plan could serve as a springboard for transformation of children and young people's mental health services across the country.

Short to Medium Term

Joint Commissioning

"Serious consideration should be given to joint commissioning arrangements between social care and health... to promote better understanding, better allocation of resource and reduce the futile arguments about 'is it social care or mental health?' - which is really about who will pay and rarely about the needs of the child."

A social worker who took part in the Taskforce engagement exercises

50. A system that is accountable for shared outcomes through joint commissioning of services. This Task and Finish Group advises joint commissioning between relevant agencies including: health; social care; education; youth justice; and, if the pathway extends to age 25 or includes perinatal mental health, adult mental health services as well. At local level, a lead commissioner should be identified and agreed, to co-ordinate the commissioning of care between organisations, including statutory, voluntary and private sectors.

²⁸ NHS England (2014) Eight pilots to lead innovation in children's mental health

<http://www.england.nhs.uk/2014/12/11/innovation-pilots/>

Background

51. As highlighted in the recent Health Select Committee (HSC) inquiry²⁹ and by the Chief Medical Officer (CMO) in her annual report,³⁰ there are concerns about the lack of coordination of services and about evident problems concerning the commissioning of mental health provision for children and young people, from pre-referral and resilience building through to specialist services.
52. Since April 2013, responsibility for commissioning has been shared across a wider range of agencies. The budgets for services to improve children's and young people's mental health are the responsibility of NHS England, CCGs, local authorities, schools and in some areas Police and Crime Commissioners (PCCs). Many commissioners work hard to ensure that a comprehensive range of services are available. However, the sheer number of commissioners involved, the variation in expertise amongst commissioners, and the variability in types of services available make the commissioning of a seamless pathway extremely challenging. This leads to fragmentation and gaps in provision.
53. **Collaborative or joint commissioning is widely considered to be the ideal method of ensuring that services are integrated across health, social care, schools and youth justice to deliver a seamless pathway for children and young people in their area.** A collaborative approach to commissioning can lead to a more integrated system that places children and young people's mental health, and/or physical health at the centre, but also addresses the wider social determinants that impact on the child or young person.

Collaborative commissioning and what's already happening

54. Whilst we have set-out a phased approach, many areas are already collaboratively commissioning and redesigning their care pathway. Building on their experiences of co-commissioning, Liverpool has brought together local health, the local council, schools and social care commissioners to develop an outcome based, comprehensive, integrated pathway for children and young people aged 0-25. This pathway provides access to a range of services provided by both statutory and voluntary sector services. It also provides an offer of public mental health support including web-based information, early help, access to a range of interventions, and supports transitions. Services are delivered by a range of providers from the NHS and the voluntary and community sector (VCS), in order to ensure a choice between different models of support which are both clinical and youth based. This builds on the Youth, Information, Advice and Counselling (YIAC) model.
55. Other areas, such as Birmingham, are looking to commission a seamless pathway for children and young people aged 0-25 years, which promotes emotional resilience, enables early intervention and improves the transition for young people when moving from children and young people's provision into mainstream adult provision. This work is led by Birmingham South Central CCG, on behalf of the three CCGs that work across the city and in partnership with Birmingham City Council.
56. Norfolk has realigned its services to develop a 0-25 NHS mental health service through a combination of services previously within child and adolescent and adult mental health services. They now have a series of interlinked services under one management line,

²⁹ Health Select Committee (2014) *Op Cit.*

³⁰ Chief Medical Officer (2013) *Op. Cit.*

which offers evidence-based, developmentally appropriate services. Their service offers treatment via a perinatal service, a 0-14 service, and a youth service, which extends to include the model of the successful early intervention psychosis into work with all young adults. The South West Strategic Clinical Network is developing a CAMHS pathway for their area through a co-commissioning process, which will involve CCG's and the specialised commissioning team. They are also developing a work programme to improve transition for children and young people moving to adult mental health services.

57. NHS England's planning document for 2015-16 encourages CCGs to work with other local commissioners to invest in children and young people's community mental health provision. They are seeking to ensure mental health spending will rise in real terms in every CCG.³¹
58. NHS England and the Department of Health have recently announced funding for eight areas to accelerate co-commissioning arrangements for children and young people's mental health.³² These schemes cover the whole care pathway, from universal services provided in locations like schools through to specialised provision such as inpatient services. **As these projects develop, they will provide good examples of what can be achieved, and the learning from these projects should be shared across areas, using professional networks such as the Association of Directors of Children's Services (ADCS) and other existing mechanisms.**

Views of young people, families and professionals

"Privilege the voice of children and young people in all care planning activities so this is at the centre of our work. This can be achieved through more meaningful service user participation which should engage young people in a way that fits with their interest and experiences. Each service should be clear and transparent about what their core business is, with clarity about what they are commissioned to provide and where the gaps in services lie."

A family therapist who took part in the Taskforce engagement exercises

59. **One of the key features of collaborative commissioning must be the active and systematic involvement throughout the commissioning cycle of the views of children and young people, their families and providers from the full range of sectors.** Co-production between children and young people and commissioners can help ensure that appropriate services are commissioned, but it needs to be properly supported to ensure that it is not tokenistic. There are several examples already across the country where young people have successfully inputted into commissioning processes. For example: Chilypep in Sheffield;³³ North West London has co-produced an out of hour's service with children and young people; and the Right Here projects, where children and young people being directly involved in commissioning resulted in the development of some imaginative approaches such as using boxing to engage young people in mental health support.³⁴

³¹ NHS England (2014) The forward view into action: planning for 2015/16. <http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf>

³² NHS England (2014) Eight pilots to lead innovation in children's mental health <http://www.england.nhs.uk/2014/12/11/innovation-pilots/>

³³ Chilypep - <http://www.chilypep.org.uk/our-organisation/>

³⁴ Right Here projects - <http://www.right-here.org.uk/>

60. Tower Hamlets is taking an outcomes-based approach to their commissioning arrangements. Services are co-commissioned by the CCG and the local council, and education is a key partner as both commissioner and provider. They have worked with children, young people and parents/carers to find out what is important to them and what outcomes they want to see.
61. Strategic Clinical Networks can also play a valuable role by bringing the right stakeholders together. For instance, the South West Strategic Clinical Network have produced a guide, informed by various stakeholders including children and young people to outline what 'good CAMHS' provision should look like, and how it should be commissioned.³⁵
62. The children and young people who YoungMinds engaged with on behalf of the Children and Young People's Mental Health and Wellbeing Taskforce, highlighted that they:
- Prefer services they use to feel 'non-clinical'
 - Want the professionals they access to be empathic, compassionate, and caring
 - Want the buildings and staff they visit to be friendly and welcoming
 - Prefer having a variety of services on offer, choice in the timing and location of appointments, and access to informal as well as formal support
 - Often look online for information about their mental health, and can find the anonymity of online services appealing, although they sometimes worry about the quality of online resources
 - Believe that schools can play a vital role in improving how informed they are about their mental health
 - Thought that teachers could play a bigger role in recognising when pupils are struggling and helping them to access support.
63. Many of these views were also shared by professionals who engaged with the work of the Taskforce online and at regional events. Professionals from a range of sectors and agencies described: the benefits of, and their concerns about, online services; greater use of the voluntary sector and private sector; and the important role that GPs and schools play in supporting children and young people's wellbeing.

Commissioning a seamless pathway

64. **When commissioning jointly across the care pathway, commissioners must consider the full range of services from a range of providers, including those online and in the voluntary sector.**
65. Children and young people, and professionals, acknowledged **the value of a range of services being available to meet local need, which draw on statutory, voluntary and independent sectors, and are supported with an evidence base.** NICE guidelines, Quality Standards, and other relevant and robust evidence, as well as feedback on the needs of children and young people, should all be used to inform and shape the commissioning of an integrated mental health and wellbeing pathway for children and young people.
66. Inevitably within this digital era there is a growing shift towards online access to advice, information and support. A recent systematic review, commissioned by the MindEd

³⁵ South West Strategic Clinical Network (2014) Commissioning better CAMHS in the South West.
<http://www.swscn.org.uk/wp/wp-content/uploads/2014/10/commissioning-better-camhs-final-draft.pdf>

Consortium, reviewed the evidence on e-therapy support for children and young people's mental health. This concluded that while many of these tools may be beneficial for children and young people, ongoing, robust analysis is needed to ensure that any intervention is evidence-based and cost effective.³⁶ There needs to be clear kite marking of sites so people know which are considered to offer good quality advice and have safeguards around safety and so on built in.

67. **While digital support can encourage an individual's autonomy over their treatment, online services should be commissioned in a way that is integrated and complementary to face-to-face support.** This supports the principles of some services which are already established in this field such as *Kooth*, an online service providing counselling and group support to 11-25 year olds, which when commissioned can work and cross refer with face-to-face services provided in a local area to promote integrated support.³⁷
68. There is also an ever-growing body of evidence that supports the role of the voluntary sector, schools and private sectors in ensuring a seamless care pathway is provided for children and young people. NHS England has outlined the need to form stronger partnerships with voluntary and community sector organisations (VCS).³⁸ *Youth Information, Advice and Counselling Services* (YIACS), for example, respond to over one million enquiries a year on a diverse range of issues, including mental health, homelessness, benefits, debt, sexual health and relationships.³⁹ Some YIACS, such as Off the Record in Croydon, already provide online counselling as part of their offer.⁴⁰ *Place to Be* is another strong example of the voluntary sector providing effective, integrated support for children's wellbeing in schools.⁴¹ The BOND Consortium was funded by DfE to build capacity in the voluntary and community sector to provide early intervention mental health support for children and young people.⁴²
69. Slough has developed six new pathways based on NICE guidance and NHS Choices to aid transparency for parents/carers and young people. These include a health visitor pathway which promotes perinatal mental health, and attachment between mother and child; and an autistic spectrum disorder care pathway. Slough has also been working collaboratively with young people to develop a self-help, CAMHS deck - web based materials and an app that is compliant with MINDTECH⁴³ (criteria established to evaluate digital mental health tools). Their next step is to pilot an integrated support package supported by a new wellbeing hub that comprises a multidisciplinary team (spanning Tiers 2 and 3), which supports the training of social care staff as well as schools and GPs.

³⁶ National Collaborating Centre for Mental Health (2014) E-therapies systematic review for children and young people with mental health problems. <https://www.minded.org.uk/course/view.php?id=122>

³⁷ Kooth - <http://www.xenzone.com/kooth.html>

³⁸ NHS England (2014) Five year forward view. <http://www.england.nhs.uk/ourwork/futurenhs/>

³⁹ Youth Access - <http://www.youthaccess.org.uk/>

⁴⁰ Off the Record - <http://www.offtherecordcroydon.org/>

⁴¹ Place2Be - <http://www.place2be.org.uk/>

⁴² BOND - http://www.youngminds.org.uk/training_services/bond_voluntary_sector

⁴³ Mindtech et al. (2014) Toolkit for appraising digital mental health projects. <http://www.mindtech.org.uk/projects/71-digital-mental-health-tools-evaluation-criteria-technology-theme.html>

A lead accountable commissioner

"[We need] designated leaders to drive change across service and agency boundaries, and trained commissioners who know and understand how this would work and what they need to be commissioning. The Health Select Committee CAMHS report showed that many local authorities still do not consider children's emotional health and wellbeing and mental health as their core business. But of course it is! Their activity and priorities are the very foundation of building resilience and emotional intelligence in children."

Office of the Children's Commissioner, as part of the Taskforce engagement exercises

70. Commissioning complex services in a multi-agency context is challenging, particularly within the current fiscal environment and requirements to comply with competition rules. To ensure truly seamless support, strategic planning and accountability, **a single lead commissioner or a commissioning group should be identified to take responsibility for commissioning along the entire pathway.** In many cases this will be the CCG, but the decision must be taken locally and with an approach that considers the needs of the child or young person. There would need to be a jointly agreed report, performance and governance structure for these arrangements.
71. Commissioners, whether a single lead commissioner or a commissioning group, need to be able to lead change, understand how to set strategic direction, work in partnership, understand data and have excellent communication and motivation skills. This is because commissioners may receive unclear or unhelpful messages as to what should be commissioned in their area, and are asked to prioritise a number of different health and social issues at any one time. **Central Government has a key role to play in ensuring that it sets clear priorities and long-term strategic direction, to allow commissioners at local level to make similarly long-term and strategic decisions** (see paragraph 118 on a National Ambition).
72. There is no recognised standard development programme for those who commission children's mental health services and yet the expectations on commissioners are high. However, there are some **programmes and resources that support commissioners, and these should be rolled-out further.** The recent commissioning and leadership programme developed by NHS England includes a module on CAMHS. There are some basic e-learning modules in MindEd for new commissioners, which can be supplemented with further modules in areas of particular importance such as how to interpret outcome data, and how to support services to put in place demand management models (eg LEAN or CAPA). Other helpful resources include the CHiMAT e-bulletins which are free and provide regular updates on policy and research. There are existing resources such as guidance from the Joint Commissioning Panel for Mental Health, which help with commissioning a range of different services including CAMHS, services for 16-25, perinatal and mental health services, primary mental health care, and so on.⁴⁴
73. However, the current issues cannot be resolved through commissioner development alone. There is a need for greater accountability and oversight across the whole system, and the co-production of shared outcomes to provide direction. Commissioners, where necessary need to involve subject experts in commissioning arrangements. There are many existing levers in place which may help to address these issues, and their use should be maximised.

⁴⁴ Joint Commissioning Panel for Mental Health - <http://www.jcpmh.info/>

Other levers

74. **Health and Wellbeing Boards are in a strong position to have oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing.** These boards are still maturing and work will be required to ensure that children and young people's mental health is promoted on their agendas. There are concerns that stakeholders such as schools and academies are not adequately represented on all Health and Wellbeing Boards. To address this, some areas already have an additional advisory panel or partnership board who oversee commissioning arrangements. **This Group suggests that all areas should have some form of panel or partnership board, which has representation from all relevant sectors and agencies to oversee the commissioning arrangements of the entire pathway, and feeds into the Health and Wellbeing Board.**
75. **The Joint Strategic Needs Assessments (JSNAs), which drive the development of Joint Health and Wellbeing Strategies (JHWSs), could be used to greater effect both to highlight what service provision is required and to determine what the priorities should be for local commissioning plans.** The current provision of mental health related information within JSNAs is inadequate and does not enable local authorities, local NHS and other partners to understand the size, impact and costs of unmet mental health needs to inform strategic development and commissioning. This is in part due to a lack of accessible public mental health intelligence. Recent reviews of JSNAs have found that many areas are not prioritising children and young people's mental health.^{45 46} Some members of this Task and Finish Group have suggested that the inclusion of data on children and young people's mental health and wellbeing be made mandatory within the JSNA. The JSNA should set out the needs of all children and young people, including those from vulnerable groups (see the Vulnerable Children Task and Finish Group report), and the shared outcomes for children and young people's health, including physical and mental health and wellbeing, with all parts of the system working to meet these. Examples of outcomes that would require health, social care and education to work together include reducing self-harm presentations at A&E, and reducing the number of exclusions from education. The Data and Standards Task and Finish Group consider the development of shared outcomes in their report.
76. **Commissioners should also use the levers already available to them to improve quality improvement and innovation.** For example, health commissioners can use the payment incentive Commissioning for Quality and Innovation Framework (CQUIN), which makes full payment of the contract conditional on meeting quality and innovation improvements - for example, more staff using outcome measures in their practice to improve children and young people's participation in their own treatment. For instance, Leeds are working to improve the pathway for deliberate self-harm. Their CQUIN is to improve the self-harm pathway for young people coming through A&E to ensure a quick response from CAMHS. Members of the Group have suggested that there should be more CQUIN indicators related to children and young people's mental health, as these mostly focus on adults or physical health.

⁴⁵ Children and Young People's Mental Health Coalition (2013) Overlooked and Forgotten.

http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

⁴⁶ Scrutton, J. (2013) A place for parity. London: Centre for Mental Health.

http://www.centreformentalhealth.org.uk/pdfs/a_place_for_parity.pdf

77. NHS England has produced:

- A non-mandatory 'Model specification for Child and Adolescent Mental Health Services'⁴⁷, to help support the commissioning of targeted and specialist services (Tiers 2 and 3). It can be adapted to cover just targeted (Tier 2) or just specialist (Tier 3) services. Whilst the specification has been developed with young people, parents/carers, providers and commissioners using an NHS template, its content can be used by other commissioners.
- A non-mandatory 'Model Specification for Transition services'⁴⁸ and a 'Model Transfer of and Discharge from Care Protocol'⁴⁹ which can be adapted by local commissioners to develop either dedicated services or in the case of the protocol, for insertion into 'sending' adolescent services and the 'receiving' services, whether adult mental health services or other services, to support delivery of a seamless transition.

78. Furthermore, there are existing structures to scrutinise the quality of services. For instance Overview and Scrutiny Committees have powers to scrutinise health and social care services. There was a recent case where the portfolio holder for children and young people in Cornwall County Council, following concerns about the quality of provision, called on the Health and Social Care Scrutiny Committee to undertake a local select committee review of child and adolescent mental health services in the county.⁵⁰ Inpatient commissioners already visit services regularly and work closely with providers on making improvements along with the CQC.

79. Many local authorities already have a Mental Health Champion, which is part of an initiative set-up by the Centre for Mental Health and other voluntary sector organisations. The Champion can be a cabinet member or Health and Wellbeing Board member, and their role is to undertake tasks such as raising awareness about mental health issues within the local council in the development of council policies and strategies.⁵¹ These individuals can potentially be very influential and help prioritise children and young people's mental health locally.

80. The Public Health Grant, which is currently ring-fenced, could be used to develop public mental health services and public health services for 5-19 year olds.⁵²

⁴⁷ NHS England (2015) Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3). <http://www.england.nhs.uk/resources/resources-for-ccgs/#camhs>

⁴⁸ NHS England (2015) Model Specification for Transitions from Child and Adolescent Mental Health Services. <http://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf>

⁴⁹ NHS England (2015) 2014/15 NHS Standard Contract: model transfer of and discharge from care protocol for young people with mental health problems in transition from child and adolescent mental health services. <http://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-transt-prot.pdf>

⁵⁰ Cornwall Council (2014) Health and Social Care Scrutiny Committee: Select Committee Review of Child and Adolescent Mental Health Services - <http://www.healthwatchcornwall.co.uk/wp-content/uploads/2013/08/Final-Report-of-the-Select-Committee-Panel-Review-of-Child-and-Adolescent-Mental-Health-Appendix-1.pdf>

⁵¹ The Mental Health Challenge - [The Challenge // The Local Authority Mental Health Challenge](#)

⁵² Department of Health (2014) Public health ring-fenced grant conditions: 2015-16. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

81. Local safeguarding boards can be a lever for bringing about change. They already encourage a joined up approach, and there are often overlaps between safeguarding and mental health and wellbeing. Some local safeguarding boards are already prioritising child and adolescent mental health. However, others may need further support to understand the complexity involved.
82. Ofsted's schools inspection framework is a lever for encouraging schools to promote mental health and wellbeing. The new Ofsted Inspection framework, which is currently in development, includes a judgement on personal development, behaviour and welfare, which includes elements that are relevant to mental health and wellbeing.⁵³ There are other educational levers: the Department of Education have recently announced that they will be developing a blueprint for schools to use when delivering counselling services, and will be working with the PSHE Association to help schools know how to teach pupils about mental health.⁵⁴

Funding and Longer Term Investment to Improve Sustainability

"The strength of the mental health of our future adult population is the responsibility of all departments of society – health, education, policing etc. If the funding for mental health support was taken from all the budgets then they would have to share the responsibility. Children and young people with mental health difficulties cost all of these departments more money - it is in everyone's best interest to invest in the children and young people of today."

A family support worker who took part in the Taskforce engagement exercises

83. The Group proposes far greater pooling of budgets across health, education, social care and youth justice to support early intervention and prevention, to remove any current perverse incentives, and to improve sustainability. Some members of the Group have suggested that adult commissioners should be included as well to improve transition to services for those aged 18 and over. Many members of the Group favour the creation of a single, separate identifiable budget for children and young people's mental health and wellbeing. There are many examples to learn from (Leeds, Integrated Personal Commissioning initiative, SEND reforms, Better Care Fund). Approaches such as LEAN and the Care and Partnership Approach (CAPA) should also be recognised, to identify efficiencies within local systems and consolidate care round the young person and family.

Background

84. Children and young people's mental health services have historically been underfunded.⁵⁵ The Health Select Committee report cites that only 6% of the mental health budget is spent on children and young people, despite making up 20% of the population.⁵⁶ Worse still, there is evidence of disinvestment. Evidence submitted to the HSC Inquiry into Children's and Adolescents' Mental Health and CAMHS in 2014 states that there have been significant cuts to CAMHS budgets, leading to restructuring and

⁵³ Ofsted (2014) Better inspection for all. <https://www.gov.uk/government/consultations/better-inspection-for-all>

⁵⁴ Department for Education (2014) Fresh approach to school mental health support. <https://www.gov.uk/government/news/fresh-approach-to-school-mental-health-support>

⁵⁵ Chief Medical Officer (2013) *Op. Cit.*

⁵⁶ Select Committee (2014) *Op. Cit.*, p. 38

redundancies in health and social care staff.⁵⁷ The HSC report also highlighted the disinvestment in early intervention (Tier 2) services.⁵⁸ Data from NHS England illustrates that aggregated expenditure by PCTs on child and adolescent mental disorders has fallen in real terms by about 5% between 2008/9 – 2012/13.⁵⁹ Responses to a 2014 YoungMinds' Freedom of Information request suggested that 74 out of the 96 (77%) CCGs who submitted data have frozen or cut their CAMHS budgets between 2013-14 and 2014-15 and 59 out of 98 (60%) local authorities who submitted data have cut or frozen their CAMHS budget between 2010-11.⁶⁰ According to the NHS Benchmarking Network report 2013, 'CAMHS has also been subject to disinvestment following the ending of the area based grant'.⁶¹ These cuts come at a time when there are reported increases in numbers and complexity of referrals to specialist mental health provision.⁶²

85. Some members of this Task and Finish Group expressed the opinion that there is an expectation that current resources can meet the needs of children and young people experiencing issues which have recently become more widely understood, such as Female Genital Mutilation (FGM) and sexual exploitation. In reality, without new resources, services have to reduce access elsewhere to other children and young people in need.

86. The Health Select Committee report states that poor early intervention provision may be increasing the number of admissions to inpatient services.⁶³ This is likely to be as a result of perverse incentives in the system. The Group concurred with the argument presented by the Chief Medical Officer (CMO)⁶⁴ that commissioning incentives may not always be in the right places and there may be reluctance for agencies to invest in interventions when they do not directly benefit from any savings accrued. For instance, savings made by reducing the need for young people to access inpatient beds (such as commissioning assertive outreach) do not benefit CCGs. This can therefore impact on the priority these commissioners give to early intervention provision. Good bed management can help improve outcomes, and any efficiency savings can be reinvested into jointly commissioned services. All commissioners need to prioritise targeting investment at the most appropriate services for their population because some of the examples of young people travelling distances from home to access inpatient services are not due to lack of local historical provision, but due to other areas where there is poor investment utilising neighbouring inpatient services thus reducing local availability and displacing local young people.

⁵⁷ Health Select Committee (2014) *Op. Cit.*

⁵⁸ Health Select Committee (2014) *Op. Cit.*, p. 27

⁵⁹ Hansard (2014) Mental health services: children and young people. <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-12-16/218865/>

⁶⁰ YoungMinds (2014) Devastating cuts leading to children's mental health crisis. http://www.youngminds.org.uk/news/news/2094_devastating_cuts_leading_to_childrens_mental_health_crisis

⁶¹ NHS Benchmarking Network (2013) CAMHS Benchmarking report 2013 [http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1\(1\).pdf](http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1(1).pdf)

⁶² Chief Medical Officer (2014) Annual report of the Chief Medical Officer 2013: public mental health priorities. London: Department of Health. <https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health>

⁶³ Health Select Committee (2014) *Op. Cit.*

⁶⁴ Chief Medical Officer (2013) *Op. Cit.*

87. There are many potential advantages to aligning and pooling of budgets across the system. Joining-up funds from multiple sources can support, and is indeed intrinsic to joint commissioning, working together towards shared priorities and targets. As a first step, however, it is important to know what different parts of the system would be contributing to that pool. This is particularly important in children and young people's mental health where funds potentially come from a number of pots, including NHS funding, the Local Services Support Grant, Pupil Premium and the public health grant. Some areas have used their local council's High Needs Block of the Dedicated Schools Grant to fund work to help children and young people with mental health difficulties. This is why a Transformation Plan for Children and Young People's Mental Health and Wellbeing, which asks all relevant commissioners within local areas to declare their spend, would be such a valuable first step (see paragraph 41).

Pooling budgets and what's already happening

"When resources are so stretched, each agency, service, and team, will fight to keep costs off their budget. Pooled budgets and more generous provision leads to generosity in staff and organisational culture."

A child psychotherapist who took part in the Taskforce engagement exercises

88. CCGs and local authorities can already pool budgets under existing legislation - Section 75 of the NHS Act 2006⁶⁵, and regulation 7 of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617).⁶⁶ They may enter into a partnership arrangement in relation to any NHS and health related functions, if it is likely to lead to an improvement in the way in which those functions are exercised. The Regulations also require that the pooled funding arrangements must specify the contributions to be made by each of the partners and how these can be varied, which is important as there needs to be flexibility and reciprocity in partnership arrangements. Liverpool, for instance, has a co-commissioning agreement with partner agencies regarding the pooled budget and whilst some partners have had to reduce their contribution, they are still working in partnership.

89. Local agencies can also align their budgets. This is where agencies work together to jointly consider their budgets and work to shared aims and outcomes. Unlike pooled arrangements, agencies that align their budgets retain complete accountability and responsibility for their own resources. Aligned budgets can be more flexible and include partners from private and third sectors, and can be used when there are no legal powers to pool.⁶⁷

90. It may not be appropriate or realistic for individual schools to enter into partnership arrangements and pooled budgets with local agencies. However, consideration must be given locally as to how schools can be involved in co-commissioning arrangements. School based services are considered vital by children, young people, and families, and are of considerable value to schools in supporting improvements in behaviour, attendance and achievement. One such lever may be greater use of schools forums,

⁶⁵ NHS Act 2006 section 75. <http://www.legislation.gov.uk/ukpga/2006/41/contents>

⁶⁶ NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. <http://www.legislation.gov.uk/uksi/2000/617/introduction/made>

⁶⁷ Department for Communities and Local Government (2010) Guidance to local areas in England on pooling and aligning budgets. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/8313/1508565.pdf

which are existing local structures that are representative of schools and the wider community in a given area. There is some evidence to suggest that they can have a strong influence on funding decisions regarding schools.⁶⁸ So schools forums, rather than individual schools, could potentially be a useful member of any local co-commissioning arrangements. For this to be successful, the lead commissioner would need to develop a good relationship with the schools forums. This may take time as these relationships may not currently exist. This would help to address potential issues such as differences in timelines for budget planning.

91. Some areas are already working with school forums to pool their budgets. Leeds have encouraged CCGs (and previously PCTs), LA and School Forum to pool monies by contributing to a joint Initiative Fund. This fund was used to develop their successful Targeted Mental Health Support in Schools (TAMHS) pilot and they have now established a service based on this model in every school cluster across the city. This has formed the early intervention element of the emotional and mental health service offer in Leeds. School clusters could bid for these funds, but would be required to provide match funding. The project has produced some good outcomes which benefit all agencies, including: measurable improvements in mental health and emotional literacy; high positive user feedback; improvements in school attendance; swifter access to support and advice; improved onward referrals; and full re-commissioning of services by clusters.
92. Emotional health and wellbeing is a key priority for Middlesbrough Achievement Partnership, and their Director of Public Health has allocated over £1m to the partnership to undertake a series of projects to develop early intervention and provide support for classroom staff in identifying when a child has a mental health issue and knowing how to best access the support they need. Schools have also made a contribution to the funding of this work.
93. Another example to draw from is the Better Care Fund which was set-up to create a local single pooled budget to incentivise the NHS and local government to work more closely together. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund. The amended NHS Act 2006 gives NHS England powers to attach conditions to the payment of the Better Care Fund.⁶⁹ Under the NHS Mandate for 2015/16, NHS England is required to ring-fence £3.46 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.8 billion fund will be made up of the £134 million Social Care Capital Grant and the £220 million Disabled Facilities Grant, both of which are paid directly from the Government to local authorities. A condition of accessing the money in the Better Care Fund in 2014/15 is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.⁷⁰ A condition of the fund is to improve adult social care in each local

⁶⁸ Featherstone, G. et al. A best practice review of the role of schools forums (LGA Research Report). Slough: NFER. <https://www.nfer.ac.uk/nfer/publications/LGSF01/LGSF01.pdf>

⁶⁹ Department of Health and Department for Communities and Local Government (2014) Better Care Fund: how will it work in 2015 to 2016. <https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2015-to-2016>

⁷⁰ NHS England (2013) Developing Plans for the Better Care Fund <http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-plann-guid.pdf>

council, which also has health benefits, but there is some flexibility beyond this broad condition. A few areas are also planning to use these pooled funds to support children and young people's mental health. **Consideration should be given to including children and young people's mental health in a future version of the Better Care fund, or developing a similar fund that encourages new models of commissioning such as alliance contracting. Any new fund should consider how it would include all relevant agencies.**

94. Some members of the Group were concerned that voluntary initiatives such as the Better Care Fund may not be sufficient to encourage local areas to pool budgets. Personal Health Budgets aim to give people choice and control over the care they receive. Learning can be taken from programmes such as Integrated Personal Commissioning, which is aimed at individuals with high levels of need, and where personal health and social care budgets are a key element.⁷¹ Whilst it is largely aimed at adults, it does include children and young people with complex needs, including those eligible for education, health and care plans. **Consideration should be given centrally as to how to give access to personal budgets to the families of children and young people with longer term conditions or disorders, in order to give them control over how the child or young person accesses services.**

Other levers for driving efficiency and sustainability in the system

"There is over-whelming evidence that mental health problems managed early and effectively will reduce burden on adult mental health but also in the longer run adult physical health. It makes economic sense to do that. Unfortunately when people are given budgets on a year-on-year basis, commissioners may worry less about who will save what money in 20 years' time. So a decision like this needs to come from further/ higher up. Longer term planning is required in health care service delivery."

A child and adolescent psychiatrist who took part in the Taskforce engagement exercises

95. Alongside consideration of pooled budgets it is important to consider alternative mechanisms for driving greater efficiency and sustainability of funding within the system. One such lever may be **the development of currencies and payment systems for children and young people's mental health**. A new payment system is being developed for children and young people's mental health services, aligned to the Children and Young People's Improving Access to Psychological Therapy (CYP IAPT) programme, which groups children and young people according to their needs. The model focuses on the needs of the child rather than current service provision. Outcome measurement will be a key component to encourage improvements in the quality of care. Some 20 sites are piloting data collection to inform the development of the needs-based groupings known as clusters. For historical reasons, the development of these payment systems is behind the acute sector and adult mental health. The CAMHS currency project needs to continue in 2015-16 to develop currencies and a tariff that can be used from 2016-17 in shadow form.
96. **Another way to drive efficiency through the system is through increased use of approaches such as LEAN and the Care and Partnership Approach (CAPA).**⁷² ⁷³ Both of

⁷¹ NHS England (2014) Integrated Personal Commissioning: prospectus for partnership programme. <https://www.england.nhs.uk/commissioning/ipc/>

⁷² CAPA - <http://www.capa.co.uk/index.htm>

these are widely used in the NHS, to help identify efficiencies within the local system and could be used more specifically throughout children and young people's mental health. However, they will only achieve the desired improvements if they are properly implemented. Such tools should not only consider the system and processes within the health field, but across the whole care pathway of children and young people's mental health and wellbeing.

97. A specific area where savings can potentially be made is in the referral process. Data presented in the CAMHS Benchmarking report indicates that on average, only 76% of referrals are accepted by specialised NHS CAMHS in 2014,⁷⁴ which suggests that about 25% are not accepted. This figure is likely to be higher still as 82% of YIACs reported an increase in referrals from local services, including CAMHS, during 2013 – largely due to changes to CAMHS acceptance criteria and thresholds.⁷⁵ Any referral that is declined or made incorrectly will create an administrative burden on the system. Opportunities to increase appropriate referrals could potentially reduce these inefficiencies and release savings which would enable greater sustainability within the system. However, there is concern from some members of the Task and Finish Group that exercises that deal with supply and demand simply move the problem around. Whilst it is important that services work efficiently, they also need to be properly funded and resourced.

98. The annual CCG commissioning cycle was of significant concern to the Group, not just because of the administrative burden. Under this cycle, money has to be spent by the provider in year or is 'lost', leading to perverse incentives and a lack of medium and long term planning. Commissioners have highlighted that in order to make strategic, long term planning decisions, they should be able to reinvest any underspend or savings from one year in the next year. The HSC also considered this issue, and were presented with evidence that the short length of contracts and lack of secured funding has a detrimental effect on implementing effective, long term services and relationships between agencies. The consequences for children and young people when services are withdrawn with poor or inadequate notice should also be considered. Short term contracts absorb commissioner time and energy and make it difficult to evaluate the impact of services over time. **The Group proposes the use of longer-term contracts of between 3-5 years. Fixed-term funding agreements should be made available to children and young people's mental health and wellbeing for the life of a Parliament, which makes allowance for flexible alternatives to contracts (eg grant funding) for VCS providers.**

Better Information, on Need, Cost and Spend to Inform Payment Systems to Create Better Commissioning and Investment Decisions

"Greater recognition of the health economics of CAMHS services would help to demonstrate the importance of interventions in reducing impact on other systems such as health, education and social services. However, the lack of collaboration and joint working funding streams means that health, education and social care do not have a financial investment in the role that CAMHS can play in a young person's life."

A paediatric psychologist who took part in the Taskforce engagement exercises

⁷³ Lean - <http://www.capa.co.uk/Demandandcapacity/lean-thinking.htm>

⁷⁴ NHS Benchmarking Network (2014) CAMHS Benchmarking report. Not publicly available.

⁷⁵ Kendrick, J. (2013) Picking up the pieces. London: Youth Access.

http://www.youthaccess.org.uk/uploads/documents/Picking_Up_The_Pieces_FINAL.pdf

99. The Group proposes that local areas take responsibility for building the evidence locally that is needed to rationalise decisions and the economic case for investment. This should include sharing data about budgets and spend, and good information about local needs and assets. Collection of data locally is crucial to making the case for investment and hence sustainability. A new co-ordinated system needs to be transparent, clearly defined, and with measurable outcomes to build the case for investment based on real improvement in long term health and wellbeing and hence social and economic benefit.

Background

100. There continues to be significant concern about the lack of high quality, reliable, centrally flowing data for children and young people's mental health, from prevalence data for mental health conditions to baseline data on cost and spend in services. Although local commissioners should be able to map local spend and activity in existing contracts, the detailed breakdown of budgets versus actual spend can be hidden in 'block' contracts which do not separate out investment in core services. Prevalence data from 2004 is still being relied upon, and although work is underway to commission a new survey, the findings of this will not be available in the short term. These issues are considered in greater detail in the report of the Data and Standards Task and Finish Group.

What's already happening and levers for change

101. There are opportunities to improve the national picture of data and information on children's mental health. Local Transformation Plans for Children and Young People's Mental Health and Wellbeing would create a baseline, building towards a national picture of spend and provision. Local areas could also commit to contribute to the NHS CAMHS Benchmarking collaborative, which currently receives contributions from approximately 2 thirds of NHS Tiers 2, 3 and 4 providers and includes 2 independent sector providers.⁷⁶ When available, commissioners will be able to make use of the Child and Maternity Dataset which is being combined with the dataset for the CYP IAPT programme and will provide a robust and comprehensive information set. However, there is concern that this data mainly covers the NHS and misses other relevant sectors. There is a need for local and national datasets that speak to all sectors and agencies which can be used to make the case for change across all commissioning bodies.

102. There are also opportunities to build up better information and datasets at local levels. These can then be used to rationalise decisions and build an economic case for investment. This should include sharing data about budgets and spend, and good information about local needs and assets. **Commissioners should make best use of data that is already collected locally across the system**, including:

- Data from NHS benchmarking collaborative⁷⁷
- Data from Quality Networks for CAMHS such as QNIC, and QNCC⁷⁸
- Public Health Profiles for Children and Young People's Mental Health and Wellbeing⁷⁹

⁷⁶ Email conversation with Stephen Watkins from NHS Benchmarking.

⁷⁷ NHS Benchmarking Network. <http://www.nhsbenchmarking.nhs.uk/projects/network-projects.php#10>

⁷⁸ <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/childandadolescent.aspx>

- Children and Young People’s Health Benchmarking Tool⁸⁰
- Outcome data collected by members of CORC
- CYP IAPT datasets and outcome measures
- CAMHS currency data
- Outcome data from counselling services, for example, commissioned by schools and through other funders
- JSNA and JHWS data
- Public Health Outcome Framework Data⁸¹
- Data from Strengths and Difficulties Questionnaires (SDQ) completed by looked after children, collected by local authorities
- CAMHS Tier 4 database being further developed

103. Commissioners do not only need better access to information, they need to know how best to interpret and use it. Commissioning support units, academic science networks and Strategic Clinical Networks have an essential role in mentoring new commissioners and in delivering learning sets, as well as supporting all commissioners (not just those in health) to analyse local data, share best practice and pool knowledge and skills. Commissioning Support Units have commissioning tools and performance management, benchmarking, analytical tools that have already been developed. They also have systems that integrate health and social care data such as the Hampshire Health Record.⁸² ChiMat for instance, have a network of health intelligence and service improvement professionals based in each geographical region of England to help support practitioners locally. They can help increase capacity to use information and evidence effectively to improve outcomes for children and young people using local services.

104. NHS England is also developing a new system dynamic modelling tool which will assist local areas to consider the impact of change in one part of the pathway on other elements of the pathway. For example, what would be the impact of introducing resources in schools on the overall level of need in the community – would it lead to more or fewer referrals to specialist services? Could introducing crisis or home treatment teams decrease length of stay or prevent admission, and to what extent?

Medium to Long Term

A Different Conceptual Framework, Based on Needs of Children and Young People

“We should be making much of “a system without tiers” and “a system without tears”... enough tears have after all been shed, don’t you think?”

Office of the Children’s Commissioner, as part of the Taskforce engagement exercises

⁷⁹ Children and Young People’s Mental Health and Wellbeing Profiling tool. <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>

⁸⁰ Children and Young People’s Health Benchmarking tool. <http://fingertips.phe.org.uk/profile/cyphof>

⁸¹ Public Health Outcomes Framework data - . <http://www.phoutcomes.info/>

⁸² Hampshire Health Record - http://www.hantshealthrecord.nhs.uk/index.php?option=com_content&view=featured&Itemid=101

105. The Group proposes whole system transformation, over a planned period of time, moving away from the rigidity of the service designed tier structure to a more flexible needs-centred approach that focuses on the roles and skills of the whole workforce, and has the child and young person at its core. There are various emerging models, some in practice, some theoretical, but the important feature will be a local, cross-organisational, seamless, integrated pathway delivery of care, which has co-production with children, young people and families built in as standard. This system needs to embrace the whole life span and cover babies, children, and young people, include early intervention and ensure that there is a seamless transition to adult services. Within the new model there needs to be a single point of access for referrals, advice or consultation for universal services and self-referral.

Background

106. Whilst the tiered model was considered useful when first conceived in 1995, there are now widespread concerns about it. This model is often considered to be unhelpful, rigid and restrictive, as well as complicated and confusing.

“Tiers were meant to be helpful but have become yet another barrier to integrated working.” “It creates barriers to access, and tends to produce a medical, reactive and referral driven service”.

Task and Finish Group member

107. The language of the system is also often criticised by children, young people, families and many of those working in the system. One of the major criticisms of the system as it stands is that it is structured and defined by the services it provides, rather than the needs of the child or young person.
108. The consequence of defining a system of care by describing the services provided means that children and young people have to fit the service, rather than the services fitting the changing needs of the child. It often results in people falling through gaps between tiers and experiencing poor transitions between different services. At its worst, it can even lead to commissioners and providers of different tiers of service effectively passing the buck to one another. In short, it is a linear model in a complex world.

What’s already happening?

Case Study: A seamless needs-based care pathway: Liverpool CAMHS

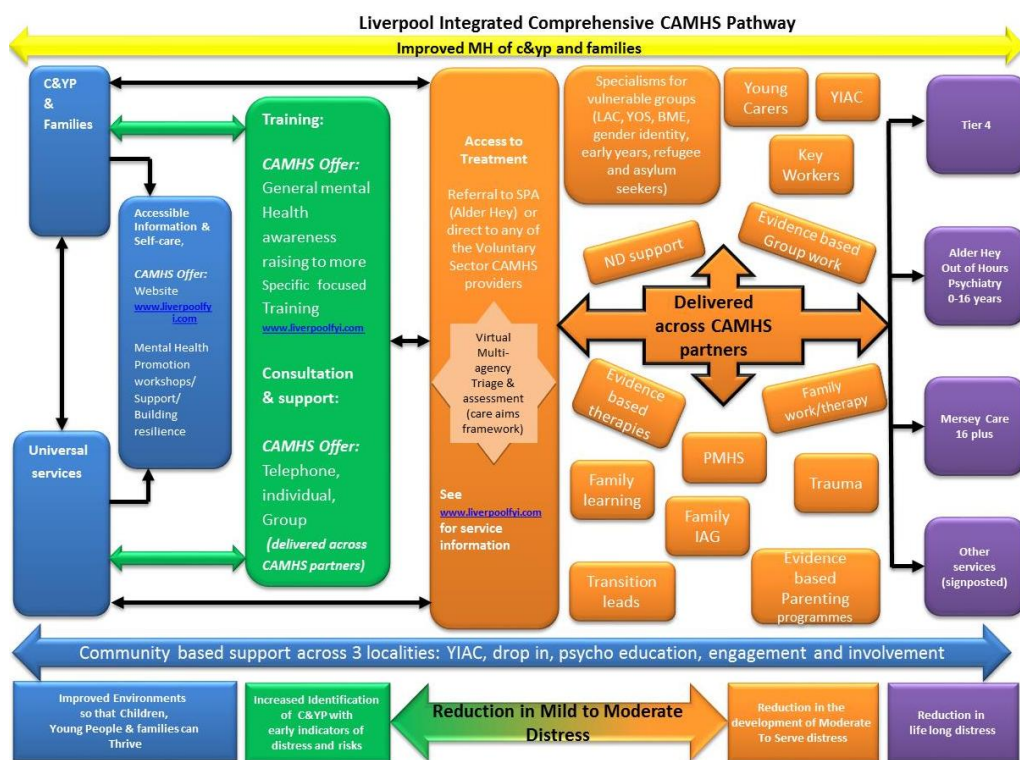
Children and young people have told us that they can’t always access the appropriate mental health support for them, and many have experienced being passed through several services before arriving at one that is right for them. Some areas have been working hard to make it easier for children and young people to access the service that best meets their needs. Liverpool has instigated an integrated, comprehensive mental health service pathway with strong multiagency working arrangements, which includes the voluntary community sector. They have developed a seamless care pathway involving a multi-agency single point of access, which enables patients to be triaged according to level of need and to be directed towards the most appropriate services – whether based in the statutory sector or the voluntary community sector.

John and his family had been in contact with statutory CAMHS for some time. John struggled with the talking therapies that CAMHS offered, as he found it extremely difficult to talk about himself and his feelings; after a while, he started refusing to attend sessions. In many areas, John would be forced to make the decision to choose between attending CAMHS or having no support at all. Fortunately, the Liverpool model enables John to attend a local voluntary

community service to receive creative expressive therapy, whilst also allowing his parents continue to see psychiatrists who work in specialist CAMHS.

109. Many areas are already working to move away from the tiered structure and are designing new local models. Liverpool for instance has been working hard to develop a seamless pathway which is needs led and outcomes focused (see diagram below, which they refer to as ‘the offer’). They are using *Care Aims*⁸³, which focus on outcomes rather than processes. Their pathway identifies the roles and responsibilities of different agencies and services, and has a focus on early intervention. They have a strong emphasis on pre-referral intervention (eg well-developed youth based provision provided by the voluntary sector, and public mental health provision). Universal services receive specialist support and training from CAMHS.

Diagram of Liverpool’s Integrated Comprehensive CAMHS Pathway



110. One of the key features of this model is the focus on building resilience, social capital, and early intervention and prevention, in order to prevent problems escalating. It is important to clarify what each agency within this model is providing, especially universal services such as schools and primary care. The development of service models and the services commissioned should be needs led and focus on children, young people and their families rather than what is easiest for services. Services do not always have to be based in a traditional clinical setting, so consideration should be given to co-locating services in universal settings such as schools, primary care and voluntary sector services. This model also promotes a single point of access into the mental health care pathway. A single point of access can enable easier access to the system for children and young people, better management of referrals, advice or consultation for universal services and self-referral. However, it is essential that there is a no wrong door approach,

⁸³ Care Aims. http://www.careaims.com/index.php?page=care_aims

that is responsive to need, and that a single point of access does not end up being a bureaucratic, gatekeeping system that controls or rations access. The report of the Prevention and Access Task and Finish Group sets out ten key principles which are critical for the successful and effective operation of any single points of access arrangement.

111. As well as Liverpool, there are many other strong examples of system redesign going on across the country and opportunities to take this further. As described earlier, a crucial first step is understanding the current baseline through a Transformational Plan for Children and Young People's Mental Health and Wellbeing. This information can then be used to develop both the National Ambition (see paragraph 118), and local models of delivery. **Emerging Models have a number of key features that should be considered by other areas intending to transform their systems: it should have a focus on early intervention and prevention, a single point of access, be needs led, drive towards shared outcomes and have a step up and step down approach to ensure that children and young people receive the appropriate level of care where, when and how they need it.**

Further examples and models to learn from

112. Consideration should also be given to the age range for the service model and care pathway, and specifically the age for transition to adult services. There is much debate on this subject with many proponents of a 0-25 service arguing that 25 is a much more suitable time for transition, as 18 is such a critical time in a young person's development which already coincides with many other life transitions. Some areas are already developing pathways for 0-25 and are seeing positive results. This is also in keeping with the SEND reforms and the Education, Health and Care plans which have been established for all SEND referrals. There are many YIACS across the country which are already offering provision for up to 25 year olds.
113. However, there is also concern that where 0-25 services are commissioned, there may be too great a focus on those conditions that persist in the top end of the age range, leaving gaps in service provision for younger age groups. It is therefore important that adult mental health commissioners work with CAMHS and/or other commissioners to improve the capacity of these services to respond across the age range and meet the needs of 16-25 year olds who would otherwise fall through the gaps. **The Group proposes that further evaluation should be carried out to consider the optimum age for transition, which takes account of the needs of the young person, as well as the impact on other service users within the system. All transitions should offer flexibility and be based on individual needs rather than absolute age.**
114. An alternative model, 'Thrive' (Timely, Helpful, Respective, Innovative, Values-based and Efficient)⁸⁴ has recently been developed by the Anna Freud Centre and Tavistock and Portman NHS Foundation Trust, and has been adopted by Camden. It creates a framework for both commissioning and providing new models of care that explicitly acknowledges the multifaceted contributions required to support children and young people's mental wellbeing. It uses four groupings of individual need which are distinct in terms of:
- Needs and/or choices of the individual within each group
 - The skill mix required to meet these needs

⁸⁴ Thrive Model.

http://www.annafreud.org/data/files/CAMHS_EBPU/Publications_and_Resources/Thrive031214.pdf

- How we describe the needs (wellbeing, ill health, support)
- The resources required to meet the needs and/or choices of people in that group

115. The groups are not distinguished by severity of need or type of problem. The advantage of this model is that it has the potential to move away from a strict hierarchy of commissioning and delivery, towards a system that requires all agencies to contribute to the delivery of support that enables children and young people in each quadrant to thrive and achieve, make collaborative choices and indeed move between quadrants. It obliges providers to place expertise at the front end of delivery systems to establish with children, young people and families, the intervention most appropriate to their current need. Identifying the specific needs of a child or young person and matching these to a relevant cluster group, makes a clearer distinction between treatment and support. This removes those for whom effective treatment is not currently indicated, which frequently serves to block new referrals being accepted, and places them with a service that can meet their needs. Such a service may have specialist child and adolescent mental health practitioners within it to support other practitioners, but the emphasis would not be on 'recovery' rather on keeping the child or young person safe and supported. This also makes it potentially easier to use personal budgets and a broader set of providers on a more flexible basis. Each THRIVE quadrant represents an opportunity for shared decision making between practitioners and children, young people and parents/carers, and supported choice between alternative evidence-based treatment options.

116. The Thrive concept proposes a three year commissioning cycle with quarterly performance meetings and annual contract reviews. All those responsible for planning services (including education, young people and families and providers) would jointly agree high-level key quality indicators for improving services to each group, using a mix of process and outcome measures. The quadrants can be exemplified as follows:

- *Coping /Getting Advise* for children and young people adjusting to life circumstances, experiencing mild or temporary difficulties where best intervention is within the community, eg signposting, self-management supported by access to online support/levels of resilience demonstrated by validated measures of resilience and one off consultations. This could include the child, young person or family receiving a one or two session support from what would, under the previous tiered model, be seen as Tier 3.
- *Getting help* - for children and young people who would benefit from evidence-based treatments eg access to NICE recommended interventions/levels of recovery or reliable change demonstrated by collecting progress towards mutually agreed goals and validated symptom measures
- *Getting more help* - for children and young people who would benefit from extensive long-term treatment eg extensive treatment in community or inpatient setting, length of inpatient stay/level of functioning and demonstrated through measures regarding impact on life, symptoms and goals
- *Getting risk support* – for children and young people who have not benefitted from evidence-based treatments but still remain a significant concern and needs continuous risk management to keep them from harm eg response to A&E admissions/ risk management and planned response to crises.

Case Study: Thrive from Young person's perspective

Anne was a 14 year old girl who was referred to CAMHS Tier 2 for help with obsessional problems, anxiety and school refusal. CBT resulted in some improvement but then she

relapsed. She was given a place in a special school, which she did not like, so she stopped attending again. A further course of CBT was recommended but she refused to engage, saying that talking made things worse. She was referred to Tier 3 for long term weekly psychotherapy alongside fortnightly support sessions for her mother with another CAMHS worker. Anne became increasingly depressed and eventually required inpatient admission (Tier 4).

CAMHS in Camden have implemented the Thrive Model. Focussing on Anne's individual risk and needs, Camden CAMHS were able to assess that she was at risk of long term negative outcomes, so she was passed to the Multi Agency Support team where a support worker visited her twice a week and encouraged her to engage in activities in the community. The CAMHS worker in the team provided the support worker with monthly clinical supervision, and provided clinical oversight of the case. Education offered some home schooling, and the home tutor came to network meetings every 2-3 months, chaired by the CAMHS worker, to reflect on the case and review the care plan. 2 years later, Anne had rebuilt her confidence and took up a place in a local college

117. The models presented here can be used by local areas to inform the development of their own local system models. Indeed, there will be no one size to fit all, and areas must transform their services to meet local need.

A National Ambition which is Interpreted Locally

"Seems that mental health services are entirely dependent on where you live. I have friends with clinical depression in the North [who are] on huge waiting lists of years whereas [in London] I can be seen in a matter of weeks"

A young person who took part in the Taskforce engagement exercises

118. The Group proposes that the National Ambition be formulated, describing precisely the elements of best care, so that this can be translated at local level into a system whereby there is whole pathway accountability and shared outcomes are clear and defined.

Background

119. One of the key concerns raised by professionals who engaged with the work of the Children and Young People's Mental Health and Wellbeing Taskforce was the fundamental lack of clarity about what 'CAMHS' is, what it is for, what it offers to the children and young people who need it, and which children and young people it serves. There was a wide call by professionals for greater clarity to be provided at national level to define what the system needs to offer.

120. In recent years there has been a shift away from top down specifications, towards locally defined models. Indeed there is a consensus that the care pathway for children and young people's mental health should be determined by local need. However there are significant differences in the level and types of services that are provided locally. In order to achieve greater clarity for children, young people, providers and commissioners, and a greater opportunity for equity of provision across the country, **a Universal National Ambition should be developed to articulate what the system needs to offer and the responsibilities of everyone within the system towards shared outcomes.**

Creating a National Ambition

121. A National Ambition would require join-up centrally to ensure that the messages being communicated to the frontline are consistent and children and young people's mental health and wellbeing is given equal priority to physical health.

122. The development of the Ambition should be made with involvement and agreement from all relevant sectors including health, education, local government, justice and the voluntary and community sector (VCS). A Transformational Plan for Children and Young People’s Mental Health and Wellbeing would set the groundwork for this. Children, young people and their parents/carers should be actively involved in the development and review of both the national Ambition and local Offers.
123. The national Ambition would set out several components:
- What children, young people and families should be able to expect in any area in order to secure the best possible outcomes for their mental health and wellbeing.
 - The roles and responsibilities of commissioners and services working with children, young people and families
 - How local commissioners and services, working with local children, young people and families, would deliver the local offer
 - How services that contribute to the pathway work towards jointly agreed outcomes
124. Local areas would use the national Ambition as a starting point for developing their own local offers. The Joint Strategic Needs Assessment (JSNA) could be a helpful tool in this process. This should consider the mental health needs of children and young people, including the risk and protective factors associated with mental health and wellbeing. The JSNA would inform the local joint health and wellbeing strategy, and commissioning plans. In the absence of good national data, local areas will need to develop their own view on the needs of local children and young people’s mental health. Some areas, such as Nottingham, have already undertaken a deep dive on the needs of this group. They have used this data to develop a new pathway. The report of the Prevention and Access Task and Finish Group considers in greater detail how the National Ambition could be implemented locally.
125. The development of the national Ambition should also be informed by learning from the special educational needs and disability (SEND) pathfinders. Findings from the evaluation of the implementation of the local offer by pathfinders from five areas highlighted the importance of two key factors:⁸⁵
- agreement from central and local government on core principles that the local offer should be aligned around
 - involvement of children and young people and families
126. The development of the National Ambition should be informed by evaluations of similar policy developments in the UK or internationally. For instance, building on the positives of initiatives such as the National Service Framework for Children, Young People and Maternity Service. The National Service Framework for Mental Health set out national standards and goals, and included mental health promotion, and primary mental health care as well as secondary care. Some elements of this were successful, such as

⁸⁵ Spivack, R. et al. (2014) Special education needs and disability pathfinder programme evaluation. Thematic report: the local offer. London: Department for Education.

[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380110/RR429A -
_Evaluation_of_the_SEND_pathfinder_programme_local_offer.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380110/RR429A_-_Evaluation_of_the_SEND_pathfinder_programme_local_offer.pdf)

improvements to secondary care.⁸⁶ This is possibly because the Government at the time were quite explicit about expected outcomes for secondary care. However, other elements such as mental health promotion and prevention were less successful. This offers lessons for ensuring the success of a National Offer through setting out explicit expectations.

Concluding Points

- There is broad consensus that the current system of children and young people's mental health and wellbeing provision is failing many children, young people and their families and those working within it to plan, commission and provide services.
- There needs to be a seamless care pathway, which includes the full range of mental health and wellbeing provision for children and young people of all ages.
- There should be a focus on early intervention and preventing problems before they start.
- Local areas need to develop a Transformation Plan for children and young people's mental health, which improves transparency and accountability across the whole system.
- Joint commissioning, an identified lead commissioner, and pooled or aligned budgets are key to implementing the Transformation Plan.
- Good data is crucial to making the case for investment and sustainability, and should inform local commissioning plans.
- Areas should consider a whole system redesign, which moves away from the rigid tiered model. This should include a single point of access to make it easier for children and young people to get appropriate help when they need it.
- There needs to be a Universal National Ambition which encompasses precisely what the elements of best care are, so that this can be translated at local level.
- Children, young people and families should be involved at national and local level to ensure that the services commissioned and provided meet their needs.

⁸⁶ McCulloch, A. & Lawton-Smith, S. (2012) UK mental health policy development, in Phillips, P. et al. (eds) (2012) Working in Mental health. London: Routledge.

Members of the Co-ordinated System Task and Finish Group

Name	Title
Sally Burlington	Head of Programmes, LGA
Jackie Cornish	National Clinical Director for Children, Young People & Transition to Adulthood at NHSE
Kate Ward	Children and young people's mental health and wellbeing team, Department of Health
Sue Bailey	Chair of Children & Young People's Mental Health Coalition
Keith Douglas	MD, NHS South Clinical Support Unit
Peter Fonagy	National Clinical Advisor , CYP IAPT, CE Anna Freud Centre
Aaron Gain	Principal Manager, Children and Families Commissioning West Sussex
Vivienne Griffin	Director of Social Services, Wolverhampton
Paul Jenkins	CE Tavistock & Portman
John Lees	Associate Director of Commissioning, Birmingham South Central CCG
Jane Mischenko	Lead Commissioner for Children, Leeds CCG
Kath Murphy	Head of Mental Health, Specialised Services, NHS England
Alison O'Sullivan,	Vice President of the Association of Directors of Children's Services
Nick Page	CE of Solihull Metropolitan Borough Council
Kathryn Pugh	CYP & IAPT Programme Lead, NHS England
Dawn Taylor	Deputy Director, Children and Young People's mental health, DfE
Sandeep Ranote	CAMHS Psychiatrist & Lead for Specialist Clinical Networks
Jon Wilson	Norfolk Youth Service
Margaret Cudmore	VC Independent Mental Health Service Alliance

We would also like to thank the following people for their contributions to the report

Name	Title
Andy Bell	DCE Centre for Mental Health
Liz Bland	Parent representative, Parents Say
Lauren Connor	Exec Head White Horse Federation academy chain, Swindon
Caroline Dollery	GP, CCG Chair, GP mental health commissioner, chair of EE SCN for MH
Paula Lavis	Children and Young People's Mental Health Coalition
Lisa Nolan	Children's Commissioner (Liverpool CAMHS and early years), NHS Merseyside
Kate Shethwood	Policy Officer, ACDS
Sam Ramanah	Local Government