SUPPORTING DOCUMENTS

HEALTH AND WELLBEING BOARD

Tuesday, 13 March 2018

Appendix B to the main report.

Agenda Item 7. Children and Young People's Mental Health Transformation Plan - Refresh 2017 (Pages 31 - 136)
Appendices to the main report.

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Report of the
Health and Adult Services Select Committee:
Oral health in early years: Scrutiny Review 2017/18

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Lead Member’s Foreword

The Health and Adults Services Select Committee (HASSC) is a scrutiny committee of the London Borough of Barking and Dagenham. The Committee scrutinises health and social care outcomes for the borough's residents to improve outcomes. We do this by working with partners to improve services and hold decision makers to account.

In 2017/18, as the Chair of the Committee, I oversaw a small-scale scrutiny review into oral health in early years. Local authorities have a responsibility for improving health, including the oral health of their populations. One of the recommendations from the Oral Health Strategy of January 2017 was to focus on the oral health of children as it is inextricably linked with the general health of the child and with health inequalities.

We therefore chose to review oral health in early years, because it would offer the opportunity to look at how we can address dental disease early in the child’s life, where the greatest difference can be made, but also enables us to focus on the most deprived communities. This enables us to target resources where they are most needed.

We know that tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013/14 and that despite some improvement in the figures, surveys undertaken in the last two years reveal the continued poor state of children’s dental health in the Borough, compared to the national picture. From 2016 figures we know that 1,200 children in Barking and Dagenham experienced dental disease; this can affect a child’s ability to eat, speak, socialise and learn normally, as well as causing distress and pain.

During the course of the review, the Committee had the opportunity to go out into the community and see and hear for themselves the experience of parents and to also meet staff in the field who were responsible for children’s oral health promotion. The committee heard about and witnessed the good work that professionals are doing on a daily basis to promote good oral health, but also learnt about the challenges parents face in regard to caring for their children’s teeth. The views of an expert were also sought, and it was useful for the Committee to meet with the Chair of the Local Dental Committee and discuss the salient issues and challenges.

We want Barking and Dagenham to become a place where a healthy lifestyle, including good dental health is normal from the start, and where people who want to make healthier lifestyle choices, are supported to do so. This report sets out the local picture for young children’s oral health and makes recommendations that involve multi-agency action to support parents and families and that seek to embed effective oral health promotion at the most important stages of children’s growth and development.

Councillor Peter Chand
Lead Member, Health & Adult Services Select Committee 2016/17 – 2017/18
Members of the HASSC 2017/18

The HASSC members who carried out this Review were:

**Councillor P Chand**  
(Lead Member)

**Councillor A Oluwole**  
(Deputy Lead Member)

**Councillor S Alasia**

**Councillor J Jones**

**Councillor E Keller**

**Councillor H S Rai**

**Councillor L Reason**

**Councillor C Rice**

**Councillor J White**
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List of Recommendations arising from this Review

For ease of reference, the recommendations arising from this Review are provided below.

The Health and Adults Services Select Committee (HASSC) recommends that:

1. The Health and Wellbeing Board (HWB) takes action to support an integrated approach to oral health promotion across all children’s services and that contract specifications for all early years’ services include a requirement to promote oral health;

2. The Committee urges NHS England to actively support the teaming up of dentists with children’s centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist;

3. The HWB is asked to monitor and report back on the progress of the oral health strategy, including the results of the ‘Teeth for Life’ (tooth-brushing) project;

4. The HWB supports action around food outlets, cafes and restaurants as part of the drive to decrease sugar consumption and improve oral health; for example, the ‘Sugar Smart’ campaign;

5. The Committee urges NHS England to implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.

6. The Committee urges NHS England to actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service;

7. The HWB, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include communication through images to help address the need for information in languages other than English

8. The Integrated Care Board look at the impact of dental emergencies on paediatric A & E attendance and challenge the system (Clinical Commissioning Groups) as to what is being done to address this.
1. Background to the Review

Why did the Health and Adult Services Select Committee (HASSC) choose to undertake a mini review on Oral Health in Early Years?

1.1 The Council’s scrutiny committees decide what topic to undertake a ‘mini’ review on based on the ‘PAPER’ criteria. The section below explains why according to these criteria, ‘Oral Health in Early Years’ was a good topic to review.

PUBLIC INTEREST

Although results of a national oral health survey of 3-year-old children in 2013 showed that oral health had improved compared to the 2010 survey, Barking and Dagenham still has worse oral health than the London and England averages. There is evidence to show that oral health in early years can negatively impact on oral health in later life, and therefore members agreed that this was an area of public interest.

ABILITY TO CHANGE

Members felt that oral health in early years was an area where the Committee could potentially add value by reviewing the reasons for poor oral health in early years, considering the quality of services available to residents to improve and treat oral health, and considering what further could be done to get the right messages out to parents and children about looking after children’s oral health.

PERFORMANCE

The 2013 survey showed that:

- 18% of Barking and Dagenham children had experienced dental disease (estimated to affect between 540 and 940 of 3-year-olds), compared with figures of 13.6% for London and 11.7% for England;
- Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013/14
- In 2014/15 hospital trusts spent £35 million on extraction of multiple teeth for under 18s.

Based on the above data, members agreed that oral health in early years was an area where performance needed to be significantly improved.

EXTENT OF THE ISSUE

A national dental survey in 2015 found that almost one-third (31.4%) of five-year-olds had tooth decay in Barking and Dagenham

Based on 2016 mid-year population estimates, this equates to around **1,200 five-year-olds** in Barking and Dagenham having dental decay, if the proportion had remained constant since the survey.

REPLICATION

The HASSC members noted that there is an Oral Health Strategy, but that this review would seek to supplement that and not duplicate it, and also to ask the Health and Wellbeing Board to report back on the Strategy’s impact and progress.
2. **Scoping & Methodology**

2.1 This Section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

**Terms of Reference**

2.2 Having received a scoping report at its meeting on 20 September 2017, the HASSC agreed that the Terms of Reference for this Review should be:

i. What are the reasons for young children in Barking and Dagenham having poor oral health?

ii. What is the quality of services that are available to residents and what do they deliver to improve oral health?

iii. What are the best ways of getting the right messages out to parents about looking after their children’s oral health?

**Overview of Methodology**

2.3 The Review gathered evidence during the Committee’s meetings held between 20 September 2017 and 16 November 2017. Details of stakeholders and their contributions to this Review are outlined below.

**Presentation by Public Health on ‘Oral Health and Young People’**

2.4 On 20 September 2017, the Council’s Public Health team delivered a presentation which considered:

- 2010 oral health survey (Barking and Dagenham): three to four-year olds;
- 2013 oral health survey (national): three-year olds and five-year olds;
- Percentage of 5-year olds with experience of decay in North East London;
- Percentage of 3 and 5-year olds with experience of decay (local, London and England);
- Dental services and dental access;
- Percentage of children accessing dental services (by age and ward);
- Hospital admissions for dental extractions;
- Preventing dental decay in young children;
- Return on investment; and
- What is Barking and Dagenham doing?

**Meeting with Parents of young children and staff at Gascoigne Children’s Centre**

2.5 Members of the HASSC had a lively meeting with parents of young children and staff at Gascoigne Children’s Centre on 6 October 2017 to talk to them about their awareness of the importance of oral health in early years and their experience of accessing and using local dental services.
Meeting with pre-school staff at the Westbury Day Nursery

2.6 Members of the HASSC met with pre-school staff at the Westbury Day Nursery on 6 November 2017 and discussed with staff their perception of the support available to parents of young children to help them promote their child’s oral health.

Meeting with the Chair of the Local Dental Committee

2.7 On 16 November 2017 members met with the Chair of the Local Dental Committee to talk about the quality of dental health services for young children in the borough and what more local organisations could do to raise awareness of the importance of oral health in early years.

Research

2.9 During the Review, Council Officers considered the following pieces of research and evidence:

Improving Oral Health in Barking and Dagenham: **Oral Health Promotion Strategy 2016-2020**


Paediatric Dentistry Orthodontics

http://www.pediatricdentistryorthodontics.com

Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. **The Oral Health of Three- Four-Year Old Children in outer North East London 2008 - 2010**

3. Introduction – Oral Health in Early Years

What do we mean by Oral Health in Early Years and Why is it Important?

3.1 Oral health refers to the physical condition and hygiene of an individual’s teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. The World Health Organisation defines good oral health as being free from diseases and disorders that affect the oral cavity.¹

3.2 Good oral health is important for general health and wellbeing and development. In contrast, poor oral health can affect an individual’s’ ability to eat, speak, smile and socialise normally, due to embarrassment about the appearance of one’s teeth, and can restrict food choices. Poor oral health can aggravate existing health conditions. It can also be an indicator of neglect or difficult social circumstances. Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

3.3 There is a strong association between oral health and deprivation. According to the Faculty of Dental Surgeons report of 2015, the variation of tooth decay prevalence is particularly alarming among three-year-olds, with approximately 34 per cent affected in Leicester, compared with just 2 per cent in south Gloucestershire.

3.4 Oral diseases can have a considerable impact on a child’s general health and wellbeing. Poor oral health is associated with being underweight and a failure to thrive. It also affects a child’s ability to sleep, speak, play and socialise with other children. Children with dental problems may not be able to gain the full benefit of their education due to increased school absenteeism and hospital appointments, leading to decreased academic performance.

Figure 1 – anatomy of a tooth

¹ Public Health England 2014 Local authorities improving oral health: commissioning better oral health – An evidence-informed toolkit for local authorities
What can potentially happen as a result of poor Oral Health in Early Years?

3.5 Our mouths are full of bacteria; hundreds of different types live on our teeth, gums, tongue and other places in our mouths. Some bacteria are helpful. But some can be harmful such as those that play a role in the tooth decay process. Tooth decay is the result of an infection due to certain types of bacteria that use sugars in food to make acids.

When a tooth is exposed to acid frequently, for example, if you eat or drink often, especially foods or drinks containing sugar and starches, the repeated cycles of acid attacks cause the enamel to continue to lose minerals. Tooth decay can be stopped or reversed at this point. Enamel can repair itself by using minerals from saliva, and fluoride from toothpaste or other sources. But if the tooth decay process continues, more minerals are lost. Over time, the enamel is weakened and destroyed, forming a cavity. A cavity is permanent damage that a dentist then must repair with a filling.

Figures 2 and 3 show comparison between healthy teeth and tooth decay.

**Figure 2 – Normal teeth, gum and bone**

![Normal teeth, gum and bone](image)

**Figure 3 – showing tooth decay**

![Cavity and Abscess](image)

3.6 Children’s primary (baby) teeth are more susceptible to decay than permanent (adult) teeth owing to differences in their chemical composition and physical properties. Primary teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria.
Infants and toddlers’ primary teeth can be affected by an aggressive form of decay called early childhood caries. The disease is associated with the frequent consumption of sugary drinks in baby bottles or sipping cups as it occurs in the upper front teeth and can spread rapidly to other teeth.² (See Figure 4).

Dental caries in baby teeth often means dental caries in permanent teeth; this is because abscesses and infection in baby teeth can spread to the permanent teeth that are developing inside the gums. Also, during the course of tooth development, children will usually have permanent teeth sitting alongside baby teeth, so again, this increases the spread of decay from the baby teeth to the permanent ones. Where baby teeth have to be extracted because of decay, these children are more likely to develop orthodontic problems as the premature loss of primary teeth can affect the alignment of permanent teeth. Tooth misalignment makes it harder to adequately clean the teeth because food debris gets more easily trapped, thereby increasing the risk of tooth decay. Prolonged dummy or thumb sucking over a period of time can also cause misalignment of teeth.

Figure 4 – Baby bottle tooth decay

What should parents be doing to ensure good Oral Health in their children?

It is never too early to start looking after children’s’ teeth and adult dental problems almost always start in childhood, so the establishment of good routines in the early years are key to having healthy adult teeth. Such routines should be based around keeping sugary foods to the minimum and twice daily brushing by the parent/carer from the time that the first tooth appears, which is usually by the time the child has reached 1 year. A pea-sized amount of toothpaste should be used, and the child should be taught to spit out the excess toothpaste rather than rinse, so that the fluoride from the toothpaste stays in the mouth giving maximum protection for the teeth. This is also the right time to start taking a child to the dentist, so that the progress of the baby teeth can be monitored, and the dentist can keep a check for the onset of any dental decay.

² RCS Faculty of Dental Surgery 2015: The state of children’s oral health in England
All the baby teeth, which are 20 in total, will have usually erupted by the time a child is about 3 years old, but it is a process that varies greatly between children. (See Figure 5 below).

**Figure 5 – Diagram showing complete set of First Teeth**

<table>
<thead>
<tr>
<th>Baby Teeth</th>
<th>Age Tooth Comes In (months)</th>
<th>Age Tooth Is Lost (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper Teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Incisor</td>
<td>9.6</td>
<td>7.0</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>12.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Canine (Cuspid)</td>
<td>18.3</td>
<td>11.0</td>
</tr>
<tr>
<td>First Molar</td>
<td>15.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Second Molar</td>
<td>26.2</td>
<td>10.5</td>
</tr>
<tr>
<td><strong>Lower Teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Molar</td>
<td>26.0</td>
<td>11.0</td>
</tr>
<tr>
<td>First Molar</td>
<td>15.1</td>
<td>10.0</td>
</tr>
<tr>
<td>Canine (Cuspid)</td>
<td>18.2</td>
<td>9.5</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>11.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Central Incisor</td>
<td>7.8</td>
<td>6.0</td>
</tr>
</tbody>
</table>
4. **The Incidence of Dental Disease in Children in Barking & Dagenham and Access to Services**

Members received information on the extent of dental disease in children in the Borough and how it compares with the incidence of dental disease nationally and London, which is discussed in this Section.

**Oral Health Survey 2010**

4.1 An oral health survey of nearly 1000 three to four-year-old children living in Barking and Dagenham, Redbridge and Waltham Forest was undertaken by the Institute of Dentistry; Barts and The London School of Medicine and Dentistry, and Queen Mary, University of London in 2008 - 2010.

4.2 Figure 7 shows results from the survey in 2010 which found that 28% of three and four-year olds in Barking and Dagenham 2010 had dental disease.

**Figure 7**

![Proportion of three and four-year-olds with dental disease](image)

Of those children with dental disease, approximately 91% had disease that was untreated.

4.3 As well as comparisons between boroughs and genders, the survey also looked at comparisons between ethnic groups. With regard to tooth decay, the survey found that 30.49% of Asian children had experienced dental decay, compared to 24.39% of white children and 23.11 black children. In terms of sugar consumption, greater numbers of Asian children exceeded The World Health Organisation’s (WHO) daily sugar intake recommendation, compared to black or white three-four-year old
children and additionally, the parents of Asian children were more likely to report toothbrushing less than twice a day than the parents of White children or Black children.

A 2016 report on the prevalence and severity of dental decay in 5-year olds by Public Health England continued to show that nationally, Asian children at five years of age had an average of 1.5 decayed teeth in comparison to an average of 0.7 decayed teeth in White and Black children, as shown in figure 8 below.

**Figure 8**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Experience of dental decay</th>
<th>Average decayed teeth at 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>30.49%</td>
<td>1.5</td>
</tr>
<tr>
<td>White</td>
<td>24.39%</td>
<td>0.7</td>
</tr>
<tr>
<td>Black</td>
<td>23.11%</td>
<td>0.7</td>
</tr>
</tbody>
</table>


**Oral Health Survey 2013**

4.4 A survey amongst three-year old children in 2013 showed that dental health in Barking and Dagenham had improved on the 2010 figures. However, as Figure 9 shows it was still worse compared to children’s dental health in London and England. The graph shows that 18% of Barking and Dagenham children had experienced dental disease, compared with figures of 13.6% for London and 11.7% for England.
Members were informed that a national dental survey in 2015\(^3\) found that almost one-third (31.4%) of five-year-olds had tooth decay in Barking and Dagenham.

As figure 10 shows, this was significantly higher than England (24.7%), but not London (27.2%)

Based on 2016 mid-year population estimates, this would equate to around 1,200 five-year-olds in Barking and Dagenham having dental decay, if the proportion has remained constant since the survey.

9.9% of five-year-olds in Barking and Dagenham (compared with 8.2% in London and 5.6% in England) experience an aggressive form of dental decay.

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4.6 Members were informed about the rise of dental decay between the ages of 3 and 5 years.

Figure 11 shows comparison figures for dental decay in three and five-year-olds in the Borough, in comparison to London and England. **In each case it shows that decay rises quite significantly between the ages of 3 and 5 years of age.**

Figure 12 shows the incidence of decay in five-year-old in Barking and Dagenham, as compared to other areas in North East London.


Note: Figures rounded to nearest 50.
**Figure 11**

% of 3 and 5 year-olds with experience of decay

(3-year-olds surveyed in 2013; 5-year-olds surveyed in 2015)

<table>
<thead>
<tr>
<th>3-year-olds</th>
<th>5-year-olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>18%</td>
</tr>
<tr>
<td>London</td>
<td>14%</td>
</tr>
<tr>
<td>England</td>
<td>12%</td>
</tr>
</tbody>
</table>


**Figure 12**

<table>
<thead>
<tr>
<th>London Borough/London/England</th>
<th>% of 5-year-olds with experience of decay in NE London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>35.5%</td>
</tr>
<tr>
<td><strong>Barking &amp; Dagenham</strong></td>
<td>31.4%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>29.8%</td>
</tr>
<tr>
<td>Newham</td>
<td>28.3%</td>
</tr>
<tr>
<td>Hackney and City of London</td>
<td>27.0%</td>
</tr>
<tr>
<td>Redbridge</td>
<td>23.7%</td>
</tr>
<tr>
<td>Havering</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>London</strong></td>
<td>27.2%</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td>24.7%</td>
</tr>
</tbody>
</table>

Accessing Local Dental Services

4.7 Barking and Dagenham has 57 dentists per 100,000 population, more than both London and England. There are 27 dental practices including community/special care dental clinics. There are also more units of dental activity (UDA)* per 100,000 population (168,123) compared with London (142,365) and England (158,977). 45.5% of children resident in Barking and Dagenham accessed dental services in the 12 months to March 2017. This figure is similar to London (see figure 13 below).

Figure 13

Other Available Sources of Advice

The Barking and Dagenham Oral Health Promotion Strategy identified the following sources of advice that are currently available to families in the Borough:

4.8 Early Years – Children Centres and Nurseries promoting good oral health

These centre programmes target families attending children’s centres and children’s centre staff, and involve a variety of oral health initiatives that facilitate the national drive to reduce dental disease among children. The local strategic objective is to improve oral health outcomes for the more vulnerable groups in our communities by focusing on children living in communities of relative deprivation, and children with learning difficulties.

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* Improving Oral Health in Barking and Dagenham: Oral Health Promotion Strategy 2016-2020
The programme involves training staff in children’s centres and identifying a nominated lead for oral health. The oral health lead for children’s centres is responsible for identifying and nominating Oral Health Champions (OHCs) that will be assigned to individual children’s centre/cluster/managers.

OHCs are responsible for:
- Implementing the standardisation of the oral health leaflets throughout all centres;
- Responding to oral health enquiries from families attending centres;
- Sign-posting to local General Dental Practitioners (GDP)/ community dental service;
- Oral health sessions, displays/campaigns for the centre; and
- Working with clinical teams to arrange outreach check-up programmes for all red and amber families and signposting green families to GDP.

4.9 Early Years Training Programme:

The training programme facilitates the national drive to reduce early onset of dental disease among children using people who work with early years and aims to target Health Visitors, School Nursing Teams, Children Centres, Community/Nursery Nurses, Foster Care and Child Minder Leads.

Training objectives are to enable participants to:
- Recognise the factors that contribute to poor oral health;
- Understand how good oral health contributes to overall health and wellbeing;
- Understand that dental diseases are mainly preventable;
- Understand the role of fluoride in prevention;
- Realise the importance of early and regular dental attendance; and
- Apply information learnt to promote oral health within their work role.

4.10 Teeth for Life Project

This is a pilot, commissioned by Public Health, which will run for a year to help teach pre-school children the importance of tooth brushing and how to brush properly. Sixty-one pre-schools/day nurseries have agreed to take part in the programme whereby toothbrushes and toothpaste are supplied for each child. Staff at each of the participating centres have been given training so that they can implement the programme correctly.

There are about three pre-schools not taking part; reasons were to do with their capacity to take on a new project and others were concerned about how they would manage the toothbrushing as they had large numbers of children attending their setting. However, these pre-schools may engage in the project at a later stage.

Health visitors are also involved in supporting the project, but already undertake oral health promotion as part of their contact with families when children are one year old and two and a half years old; this includes the handing out of a baby toothbrush. Parents are encouraged to refer to the red child health book and
complete the pages where they can mark off that their child’s teeth have come through.
Health visitors are also responsible for families who are not registered with a GP and who are living in the area temporarily, which may include those in hostel accommodation and other places of residence that are temporary or transitory.
5. Why are Children in Barking & Dagenham more likely to have Dental Disease than Children in other London areas?

5.1 This section discusses the possible reasons behind why the rates of dental disease are higher in the borough than the London and national averages.

5.2 Members found that there are a variety of factors that are likely to be contributing to a high burden of dental disease in early years in Barking and Dagenham because of what we already know about the health demographics in the Borough; but also by what was evidenced by their visits to the Children’s Centre and the Day Nursery, and meeting with the Chair of the Local Dental Committee. Below we discuss in further detail, members’ findings from these visits.

Visit to Gascoigne Children’s Centre to meet with Parents and Staff

5.3 Members of the HASSC scrutinised the experience of children in the borough through their parents and Children Centre staff. Below we highlight some of the statements made (by staff and parents) during this session which gave members an indication of the key issues that may be contributing to poor oral health in early years in the borough.

Key messages from the Visit

There was some lack of awareness or understanding about how best to look after children’s teeth: for example,

- The importance of taking care of baby teeth, fuelled by the myth that these are going to fall out anyway, so they do not really matter; as one parent remarked -

  *‘Looking after milk teeth isn’t important as they fall out’.*

- The importance that diet plays in promoting healthy teeth and about the factors that increase the risk of tooth decay.
- The importance of providing a healthy diet, limiting sugary food and drink and especially not giving milk in bottles at night: as one member of staff commented -

  *‘One message that still does not appear to have been made clear is the negative impact of bottle feeding children milk at night whilst they are sleeping – that the sugars from the milk can cause tooth decay.’*
• The importance of taking your child to the dentist from an early age;
• That visits to dentists are free for children and for the mother during pregnancy and for a year after having a baby; some parents commented -

'Going to the dentist is expensive!'

'I think there should be an oral health week and businesses should be encouraged to attend our malls and centres to give out advice and free check-ups for parents and children.'

• The importance of brushing twice a day from a very early age and the importance of routine. As evidenced from talking to the Children’s Centre staff, a significant proportion of families lack routines with their children and this affects the care of teeth: for example children may fall asleep before the parent or carer gets round to brushing their teeth, or if the children resist teeth brushing, the parent may leave it to avoid conflict. It is one of the aims of Children Centre staff to help and encourage families to establish routines and thereby include dental care as part of that, but staff cannot reach those families who do not engage with the centres. As staff remarked -

'We find that the parents who struggle to establish a routine for their children seem least equipped to support their child’s oral health. It is very important for services to advise parents of the importance of establishing a routine for their child to provide normality and wellbeing for the child.'

There was also strong consensus amongst the Centre staff that health visiting staff should discuss the importance of oral health with parents from the outset and give advice on when to take the baby to the dentist and how to look after his or her teeth when they emerge. Staff commented -

'Health clinics are crucial as at this stage parents are very receptive to new messages. The majority of parents want to speak to the health visitor and even the most vulnerable will attend these clinics.'
5.4 Members took from this session that that:

**Knowledge and attitude toward teeth:**
- Some parents think caring for milk teeth isn’t important as the teeth will fall out
- Some parents think that taking their children to the dentist will be expensive – when it is free
- Some parents avoid conflict by not being firm in requiring their children to brush their teeth.

**Knowledge about and attitude towards dentists:**
- For some parents, there still exists a ‘dread’ factor in going to the dentist, often borne from their own childhood experience which they then pass on to the child.

**Healthy Eating:**
- Evidence suggests that in certain sectors of the local population, such as certain Asian communities, some foods that have a significantly high sugar content are consumed as part of normal diet and there may be a lack of awareness about just how badly these can affect children’s teeth.

**Borough Demographics**
- Demographic changes in the borough, which include a transient population, has meant that there is a significant proportion of families that face a range of very challenging circumstances (housing problems or domestic violence, for example), who may not always engage with services that can help them; and
- There will be families who are being housed in hostels around the borough and who may lack the resources to care for their children’s teeth adequately. This is a continuing challenge and there is further work to be done on how we effectively engage and support those families who are the most vulnerable in the borough, particularly as we seek to realise the Borough Manifesto of ‘No-one Left Behind’.

Recommendations arising from this session are as below.

**RECOMMENDATION 1**
The Committee recommends that the Health and Wellbeing Board takes action to support an integrated approach to oral health promotion across all children’s services and that contract specifications for all early year’s services include a requirement to promote oral health; this should include very early oral health promotion by health visitors to help prevent tooth decay from sweetened dummies, prolonged use of milk in bottles and other sweet foods.
RECOMMENDATION 2
The Committee recommends that NHS England actively supports the teaming up of dentists with children’s centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist.

Visit to the Westbury Day Nursery to meet with Pre-School Staff

5.5 Members of the HASSC scrutinised children’s experience of pre-school in a meeting with pre-school staff. They met to discuss their experiences of oral health in early years and consider the advice given by the Centre.

Key messages from the Visit

- The nursery encourages oral health as part of a broader health promotion focus, for example - healthy eating, no sweets or fruit juice, and only water and milk;

- Most parents react positively to this approach but not always - sometimes children are sent with biscuits for breakfast or some are sent with bottles. Staff have to educate the parents rather than the children;

- Some parents react with cringing at the mention of dentists, so obviously some people hold personal feelings which may affect their attitudes towards dental care.

- Only 2/3 parents said they didn’t want their children taking part in the tooth brushing project.
The recommendations arising from this session are as below.

RECOMMENDATION 3
The Committee recommends that the Health and Wellbeing Board monitors and reports back on the progress of the oral health strategy, including the results of the ‘Teeth for Life’ (tooth-brushing) project.

RECOMMENDATION 4
The Committee recommends that the Health and Wellbeing Board supports action around food outlets, cafes and restaurants, as part of the drive to decrease sugar consumption and improve oral health; for example, the ‘sugar smart’ campaign.
Meeting with the Chair of the Local Dental Committee

5.6 Members of the HASSC met with the Chair of the Local Dental Committee, Mr Bhawnesh Liladhar to discuss the potential reasons for poor oral health in early years in the Borough and what more can be done to address the causes.

Key messages from the Meeting

- *Often, the first visit to the dentist is when child is in pain, so negative association with dentists is made that endures;*

- *The current dental NHS contract provides no incentive to increase activity and provide for more patients, once the stipulated contract activity is achieved;*

- *But there are dentists in the borough who have not completed their contract activity;*

- *The possible reasons for higher rate of decay in Asian children is a lack of awareness in the community of importance of good oral care habits and diet is often higher in sugar than in other communities;*

- *The new Chief Dental Officer has proposed an initiative to increase the NHS contract value by 2% allocated for seeing children at 1 year specifically;*

- *A potential way to encourage dentists who have not completed their contract activity level is to twin these practices with children’s centres so that they can provide preventative advice to parents and treat children where necessary;*

- *Borough demographics have changed a lot over past decades and English may not be the first language. This combined with fear means people don’t go or take their children to the dentist.*
5.7 Members noted that approximately 45% of the population do not visit the dentist as often as they should. Often, the child’s first visit to the dentist is when they are in pain, which is not the best time as this is when they will need treatment. The single most common reason for the hospital attendance by children aged between five and nine is tooth decay, which is indicative of how much prevention work there is to do and how much extra is being spent, which could be avoided.

5.8 The national contract, commissioned by NHS England, is set up in a way that limits the numbers of patients that can be seen each year by dentists who hold NHS contracts. The outcome of this is that if a dental service sees more that the numbers of allocated patients they will not receive payment for this. As dental surgeries are small businesses this could have knock on effects for keeping the service running and employing staff. In LBBD there are some dentists that do not achieve the amount of activity that has been set for them, so there is potential for teaming these dentists up with Children’s Centres or schools and thereby increasing their activity.

5.9 Mr Liladhar informed the Members that the new Chief Dental Officer has proposed to the Government that increasing the NHS contract value by 2% could increase dentists’ capacity and enable them to see children at the age of 1 year, as has been recommended by NICE and which is supported by dentists nationally.

5.10 In answer to why Asian children have a higher rate of tooth decay than other children (see section 4.3), Mr Liladhar commented that people from the Asian communities are much less likely to visit the dentist; only doing so, if they are in pain. The survey of 2010\(^5\) did provide some evidence of this in that the percentage of Asian children who last visited a dentist in response to a dental problem was higher than Black or White children. There may be a lack of awareness of what constitutes good oral care habits in this community, for example, many parents do not brush their teeth at night (when evidence shows that doing so is very important), and these habits are then passed on to children. Furthermore, the diet in these communities can be very high in sugar so the combination means a greater incidence of dental decay in these children.

5.11 Mr Liladhar commented that in his experience, it can be a challenge to get information across to communities for whom English is not the first language. People may not understand that they are entitled to free dental care and other benefits. This issue is further complicated if residents need a translator at a dentist, they must pay themselves. Sometimes the parent asks their child to translate, which is not ideal as the dentist cannot always have confidence that everything has been translated correctly, and that they have the required consent. There are information leaflets in some dental practices, but these are all in English.

5.12 Mr Liladhar commented oral health in early years has improved over the years but this can be attributed to the promotion of fluoride toothpaste; dentists have more of a preventative role to play, if they can get families to attend their practices.

5.13 Finally, Mr Liladhar commented that the level of poverty and deprivation in Barking and Dagenham is a key factor in the oral health of children in the borough, in terms of lack of awareness and lack of engagement with dental services.

\(^5\) Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. The Oral Health of Three- Four-Year Old Children in Outer North-East London 2008 - 2010
This session led members to recommend that:

**RECOMMENDATION 5**
The Committee recommends that NHS England implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.

**RECOMMENDATION 6**
The Committee recommends that NHS England actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service.

**RECOMMENDATION 7**
The Committee recommends that the Health and Wellbeing Board, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include the provision communication through images to help address the need for information in languages other than English.

**RECOMMENDATION 8**
The Committee recommends that the A & E Delivery Board look at the impact of dental emergencies on paediatric A & E attendance and challenge the system (CCGs) as to what is being done to address this.
6. Next Steps

6.1 This report and its recommendations will be submitted to the Health and Wellbeing Board and relevant health partners, who will decide whether to agree the recommendations. An action plan will be drawn up describing how the recommendations will be implemented. In approximately six months’ time, a monitoring report explaining the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had will be produced.
The HASSC would like to extend its thanks to the following for contributing to this Review:

- The Early Intervention Worker, Locality Manager and Senior Locality Manager at Gascoigne Children’s Centre;
- Mr B Liladhar, Chair of the Local Dental Committee; and
- The Nursery Manager and Early Years Advisory Teachers at the Westbury Day Nursery

Members also thank the following Council officers for their support during this Review:

- Mary Knower: Public Health Strategist
- Masuma Ahmed: Democratic Services Officer
DRAFT

Barking and Dagenham

Children and Young People’s Mental Health Transformation Plan – October 2016 to October 2017

Refreshed December 2017
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Acknowledgements and thanks

We would like to thank all our partners, London Borough Barking and Dagenham – Education and Inclusion (in particular for your outstanding support throughout the life of this plan); Social Care; Public Health; Children’s Commissioning – Care and Support; All Age Disability Service, BAD Youth Forum. Thanks to our wider partners – our local North East London Foundation Trust (NELFT) Barking and Dagenham team for your ongoing commitment and support.

Thanks also to our other provider partners; More Than Mentors; Xenzone (Kooth); Triple P.

To all our schools in Barking and Dagenham (B&D) your participation and support has been magnificent and the role you all play in this plan is central to its success.

And of course, you, the children and young people of Barking and Dagenham who keep us honest and humble; you are at the centre of what we do in B&D.

I hope that you can see all of your work throughout this local transformation plan and I am grateful for all your help, challenge and support over the past year.

Ronan Fox
Joint Children’s Commissioner Barking and Dagenham, December 2017.
Executive summary

This document is the 2017 update of Barking and Dagenham’s Children and Young People’s Mental Health Transformation Plan.

This local transformation plan (LTP) was first produced in December 2015, and has been refreshed annually since then. It was developed in partnership between the CCG and the London Borough of Barking and Dagenham and our local providers and stakeholders, and set out aspirations for how we would achieve whole system change for children and young people’s emotional and mental health in Barking and Dagenham. The plan provided a response to Future in Mind, the national report produced by the Children and Young People’s (CYP) Mental Health and Wellbeing Taskforce in early 2015.

During 2016/17 we have seen considerable progress in developing innovative approaches to building resilience through training in schools, a new mentoring programme, and trying out new ways of proving support online.

We have developed an innovative approach across Barking and Dagenham, Havering and Redbridge to providing an integrated crisis and home treatment response, which reduces the need for inpatient admission.

We still face a number of challenges in transforming services to deliver our new model, in an increasingly constrained environment. However we are developing a much more detailed understanding of our position and the scale of the challenge in Barking and Dagenham, and have the necessary partnerships in place to progress our plans.

We always welcome comments and discussion on our plan and would be happy to hear from you. You can contact the CCG via barkdag.bdccg2@nhs.net.
1. Introduction

1.1 Purpose of document
This document is the 2017 update of Barking and Dagenham’s Children and Young People’s Mental Health Transformation Plan.

The local transformation plan (LTP) was first produced in December 2015 (the original plan can be found [here](#)) and has been refreshed annually since then. It was developed in partnership between the CCG and the London Borough of Barking and Dagenham and our local providers and stakeholders, and set out aspirations for how to achieve whole system change for children and young people’s emotional and mental health in Barking and Dagenham. The plan provided a response to Future in Mind, the national report produced by the Children and Young People’s (CYP) Mental Health and Wellbeing Taskforce in early 2015.

The purpose of this document is to:

- Provide the annual update to the Barking and Dagenham LTP
- Remind stakeholders of our shared vision
- Provide an update on progress and challenges in 2017
- Set out our priorities for 2018/19.

1.2 Our starting point
The case for change that underpins this plan was made in the first LTP which provided our 2015/16 baseline in terms of staffing, finance and activity. An update on health expenditure on CYP Mental Health in 2016/17 is provided in table 1 below.

**Table 1**

<table>
<thead>
<tr>
<th>Spend by Category £ 000</th>
<th>B&amp;D CCG 2017/18 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Young People's Mental Health (Excluding LD)</td>
<td>3,318</td>
</tr>
<tr>
<td>Children &amp; Young People's Eating Disorders</td>
<td>156</td>
</tr>
<tr>
<td>Perinatal Mental Health (Community)</td>
<td>228</td>
</tr>
<tr>
<td>Early Intervention in Psychosis ‘EIP’ Team (14 - 65)</td>
<td>686</td>
</tr>
<tr>
<td>LBBD</td>
<td>Nil</td>
</tr>
</tbody>
</table>

There has been investment by LBBD which does complement the resilience element of the CAMHS (Child and Adolescent Mental Health Services) LTP.

**LBBD / CCG Resilience funded work streams:**

1. Thrive training cost £60,000 with a health contribution of £20,000
2. Boxall Training £2,000
3. Young Minds £15,000
4. 4 primary ARP provision and 1 secondary provision 48 places total cost £1.2m
5. 1 senior adviser and 1 senior manager plus 4 officers and 0.4 adviser cost approx. £500,000
6. CCG funded £40,000 for Mental Health Advisor for LBBD Schools and LBBD funding £10,000
7. In addition a number of conferences on Social emotional mental health (SEMH) have been planned cost of £20,000
We have used our baseline data, along with our population data, to develop a working model to plan demand through the new, quadrant-based model, described in Section 3 below. We have modelled the demand that we expect to see through each quadrant and have ascertained the additional activity that will be expected to deliver the target of 35% of children and young people with diagnosable conditions accessing evidence-based treatment by 2020/21.

**Fundamental Service Review (FSR) CAMHS**

In 2016/17, we commissioned our provider, North East London Foundation Trust (NELFT), to conduct a Fundamental Service Review (FSR) to ascertain capacity and demand in order to develop more detailed plans to implement the new model and meet new access targets. The FSR provides details of current activity and workforce (taking the period Q2 and Q3 of 2016/17 as the baseline), and a gap analysis for each of the Barking and Dagenham, Havering and Redbridge (BHR) boroughs served by NELFT. According to the FSR the gap in terms of workforce for Barking and Dagenham is relatively small (1.34 medical WTE and 0.1 WTE other clinical staff). We are currently working through ways in which local transformation plans can address this gap, in Barking and Dagenham this will require considerable productivity improvements and potentially streamlining of pathways in order to provide access to more CYP to achieve the Five Year Forward View target.

A detailed staffing breakdown is included in the appendices.

The triage team have introduced a pilot programme in schools to bridge this gap and this capacity will be extended further through the wellbeing hub development. The STAR workers (STAR stands for Support, Talk And Recovery) which has been funded through the Barking and Dagenham CAMHS Transformation Plan investment will offer more outreach work and invest in collaborative working with schools and the partner agencies to raise awareness and accessibility to services as well as offering brief interventions and lower intensity interventions.

Worker and four Wellbeing hub workers (job description is a STAR worker) that have been recruited to support the emotional wellbeing hub element of the transformation of local services.

The Emotional Wellbeing hub has been created to ensure that the service offer is as accessible as possible and available to a wider population, has the ability to provide focused engagement work to support vulnerable children and young people and their families and also to develop a system leader approach to supporting those staff who are already working with children and young people, embedding mental health skills and knowledge within a wider workforce and reducing the need for children and young people to have multiple workers. This latter aspect is again in direction reflection of feedback from partners who have requested support with strategies and supervision when working with children and also from parents and carers/service users who have expressed frustration previously at having multiple staff working with them and having to repeat their stories.

The Barking and Dagenham structure also includes the Youth Offending Services (YOS) staffing as previously mentioned which is different to the other two borough areas and reflects the more deprived area needs.

The graph below shows the access rate for Barking and Dagenham CAMHS taken from the CYP dashboard subset. It shows that Barking and Dagenham services are delivering treatment to 22% of those children and young people who have a diagnosable mental health condition in 16/17.
Access in Barking and Dagenham

The overall cost to currently deliver 22% is circa £3m. In keeping with the transformation plan, if we are moving towards achieving a target of 35% of the children and young people seen the investment in the services would need to be calculated according to the Epidemiological data and gap analysis that already exist.

Gap Analysis B&D

- Barking and Dagenham had a very well established primary mental health team which was funded by the local authority and formed a vital part in the interface between the quadrants (i-Thrive). This service was decommissioned. This has perhaps led to a decrease in the number of referrals received. The service has tried to be innovative and started offering consultations and assessments in schools. The STAR workers will further develop this aspect and invest in more outreach work with partner agencies to support access.

- There is a need in Barking and Dagenham for greater levels of support around children and families where children are presenting with challenging behaviours as the primary need. Increased provision would ideally include greater provision of support to parents and around their management of challenging behaviour as a first line intervention. The CAMHS LTP investment has been directed to these cohorts in B&D.

- Barking and Dagenham would further benefit from patient and carer involvement groups (beyond that of the monthly 5x5 service user survey) so that that patients and carers views are routinely sought and they are involved with service development.
1.3 Progress to date

Progress on implementation of the LTP is summarised below.

The Positive Parenting Programme (Triple P) – this programme aims to build resilience and support children and young people with emotional and mental health challenges, lead to increased parental confidence, skill and knowledge in supporting child and family emotional resilience and ultimately result in fewer problems being experienced, better outcomes and less need for specialist support. Building on the work completed in 2016, we are piloting the use of online parenting support to reach parents as part of our overall resilience work, and testing two models:

- Wellbeing hub – via the four Children’s Wellbeing Practitioners (CWPs) – to reach families in need but not meeting children and adolescent mental health services (CAMHS) threshold
- Schools – via Schools Mental Health Advisor – to reach families in need not accessing other support via a universal approach. Between 3-6 primary schools to be identified to pilot the TPOL (Triple P Online Offer) 0-12 offer from January 2018.

Pre and post outcome measures will be collected and form a basis for the evaluation of the pilot e.g. Strengths and Difficulties Questionnaire (SDQ).

Targeted online counselling piloted by Kooth

This pilot project is targeting four specific schools in Barking and Dagenham; Barking Abbey School, Robert Clack School, Warren School, and Jo Richardson Community School. The service is aimed at children who attend those schools and a full report of the pilot is available on request which includes details of referral sources (schools, teachers, friends, CAMHS, and internet searches), key presenting issues (anxiety /stress; family relationships; self-worth and self-harm) and details of activity and user views. There has been a significant increase during 2016/17 of new registrations, and reports that 96% of young people would recommend Kooth to a friend. Young black and minority ethnic (BME) people continue to engage with Kooth representing 45% of young people in the first part of 2016/17 (Quarter 3 or Q3).

In addition to this targeted work in Barking and Dagenham, the service is being piloted across BHR:

B&D specific highlights include:

- We have witnessed a significant increase from Q4 of 2016-17 in new registrations, from 53 to 187 in Q1 2017-18
- Q1 has seen 766 Logins from 345 in Q4
- 97 unique young people compared to 60 in Q4, with 76% returning
- Therapeutic alliance reports that 96% of young people would recommend Kooth to a friend
- Young BME people continue to engage with Kooth representing 45% of young people in Q1
- Activity has increased throughout this quarter, which would reflect the increased engagement with young people

BHR Update for Quarter 2 2017/18:

- We have witnessed a significant increase in new registrations with 252 for Q2, compared to 187 in Q1
- Q2 has seen 1,183 Logins compared to 766 in Q1
- 269 unique young people in Q2 compared to 197 in Q1, with 79% returning in Q2 compared to 76% returning in Q1
• Therapeutic alliance reports that 89% of young people would recommend Kooth to a friend.
• Young BME people continue to engage with Kooth representing 43% of young people
• Activity has stabilised and increased through this quarter, which would reflect the increased engagement with young people.

**Vanguard pilot of crisis care**
BHR were successful in establishing a crisis pilot as part of the Urgent and Emergency Care Vanguard in 2016/17. This new model of care, an extension of the home treatment team model is being tested as part of a national evaluation. The Vanguard builds on learning locally about how best to provide care for CYP integrates with the wider urgent and emergency care offer including mental health liaison. Further details are in [Section 9](#) below.

**Thrive training**
The Thrive approach is a developmental model and framework that can be used to understand and identify social and emotional wellbeing needs of children and adolescents. Thrive practitioners are trained to communicate with children and young people (CYP) therapeutically and deliver interventions to support those with identified emotional wellbeing needs. Thrive was jointly commissioned by B&D CCG and LBBD, for staff within schools to improve the wellbeing outcomes for CYP as part of delivery of the B&D Local Transformation Plan. A full report is available at Appendix B. To date there are 21 Thrive practitioners trained in B&D, with a further 2 cohorts of training planned for primary schools (14 delegates) and adolescents (8 delegates). By December 2017 there will be a total of 43 Thrive practitioners across 28 schools (see attached report for list of schools). Overall participating schools have reported that the Thrive training has raised staff awareness about children’s behaviour and as a school they feel more equipped to manage behaviour and the ability to support more vulnerable children.

**More than Mentors**
More than Mentors is a new and creative model of peer mentoring, co-designed and co-delivered as a pilot study in east London. Through the Department of Health’s ‘health and social care volunteer fund’, Community Links has delivered this programme with Jo Richardson Community School and Eastbury Community School. More than Mentors draws on the best evidence from across the field, exploring peer mentoring as a way of preventing significant mental health conditions in young people. Peer mentoring – where older adolescents support their younger peers – has been shown to prevent the development of mental health problems in research studies. However, in practice, often little attention is given to the evidence around recruitment, training and support of these volunteer mentors. Community Links, with a wider partnership team (including East London Foundation Trust and the Anna Freud Centre) are working with adolescent volunteers to further co-develop, test, evaluate and subsequently disseminate an approach which sustainably delivers an effective voluntary peer mentoring workforce across London.

A full report of the work of the More than Mentors team, who started working with the borough in March 2017, is available at Appendix C. The team have been working alongside the Barking and Dagenham CCG, LBBD Service Development and Integration Department – Education and Inclusion, and NELFT to ensure that this programme adds value to the wider preventative agenda – recognising the need for building resilience as one of the key objectives when looking to support young people earlier, and prevent the development and emergence of significant mental health needs. The evaluation of the More than Mentors is being conducted independently by the Anna Freud Centre - Evidence Based Practice Unit.

This evaluation is an iterative process, combining both quantitative and qualitative components. From our initial data we have the following findings from the 2 secondary schools we have worked with so far, as summarised in table 2 below.
Table 2: More than Mentors data

<table>
<thead>
<tr>
<th></th>
<th>Mentors</th>
<th>Mentees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>10% male, 90% female</td>
<td>40% male, 60% female</td>
</tr>
<tr>
<td>Mean age</td>
<td>16.4 years</td>
<td>13.2 years</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>27.3% White British, 18.2% Any other white background, 13.6% Black African, 9.1% Pakistani, 4.5% White and Black African, 4.5% Other</td>
<td>34.8% White British, 21.7% Any other white background, 8.7% Black African, 8.7% Other, 4.3% Pakistani, 4.3% White and Black African, 4.3% Other</td>
</tr>
<tr>
<td>FSM eligible</td>
<td>27.3%</td>
<td>52.2%</td>
</tr>
<tr>
<td>SEN support</td>
<td>0.0%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

Once completed there will be 120 mentees within the borough by the end of the Spring Term 2018, and the aspiration is to offer More than Mentors in every secondary school across the borough, by the completion of the project in March 2019, including through the delivery of a Training the Trainers package. There are two significant developments that are emerging from this work –

Supporting vulnerable students during transition – Following conversations with some of the primary schools within the borough, we have are looking to explore how these More than Mentors peer mentors could support students who are anticipated to experience a difficult transition from primary to secondary school. Being aware that problems around transition can significantly contribute to disengagement from education and learning, and subsequently lead to students being excluded and disenfranchised, this is very much a preventative approach to emotional wellbeing

Launching a student-led, schools-based mental health conference – With such a considerable number of students being trained within the borough as More than Mentors peer mentors we are keen to ensure that they support the wider student population and help articulate a voice about young people’s mental health across the borough. In the next Mental Health Awareness Week (May 2018) we will be looking to co-design and co-produce a mental health conference with young people from across the borough to raise awareness about mental health and emotional wellbeing, to challenge mental health stigma and to ensure that children and young people within the borough are at the heart of taking our services forward – Nothing About Us Without Us.

CAMHS School Links – The Mental Health Adviser (MHA) commissioned by the B&D CCG in cooperation with LBBD Service, Development and Integration works with all schools within the borough and alongside B&D CAMHS to improve mental health outcomes for our children and young people (CYP). This programme is a ground-breaking initiative to help CCGs and Local Authorities work together with schools and colleges to provide timely mental health support to children and young people. It works to empower staff by brokering contact, sharing expertise and developing a joint vision for CYP mental health and wellbeing in each locality. In B&D it will lead to a school based MH Conference outlined above. Our ambition is for up to 60 schools to be involved in the programme in B&D.

Developing a Wellbeing Hub – recruitment of 3 additional clinical staff in Barking and Dagenham

Provision of additional 1 WTE MH Advisor post to work on provision of Social, Emotional and Mental Health
A further 1.0 WTE new **Mental Health Social Worker** post has been created within NELFT to provide dedicated Senior Triage and Social Work support to Looked After Children from Barking and Dagenham with mental health needs as part of the single point of access/wellbeing hub development.

### B&D’s Circle of Resilience

The Circle of Resilience is to represent the future upstream work as part of the B&D CAMHS LTP

1. **Technology**
   - Triple P Online (TPOL) pilot targeted at 0-12 age range
   - Kooth – four targeted secondary schools; Pupil Referral Units (PRU’s); Virtual School and Children and Young People (CYP) in the Justice System
   - Big White Wall (BWW) – 16+ commissioned by Public Health
   - Chat Health – universal service for all B&D secondary schools; also commissioned by Public Health
   - My Health London and NHS GO in partnership with Healthy London Partnership and NHS

Thus we can see that our technology and innovation offer covers all age ranges in B&D
2. The development of a SEMH guidance as part of the LTP and close working with LBBD Education and Inclusion Team setting out key principles; a graduated and inclusive approach

3. CAMHS Schools Links work with Anna Freud National Centre for Children and families – Expression of Interest submitted for 2 workshops and a CYP led MH conference in May 2018

4. More than Mentors – aspiration to be in all secondary schools by May 2019

5. Mini Mentors and Transition schemes in B&D

6. Thrive Training in schools – 28 schools on programme, with 43 practitioners in total on training

7. LAC Mental Health Social Worker employed through B&D LTP and linking in with LBBD Social care and NELFT

8. CYP Health and Justice – BHR one team (LD/SLT/Psychotherapist) to be developed with a range of targeted training – Trauma; Schools based work; sports and lifestyle activities

9. The development of the Wellbeing Hub

10. The Children Wellbeing Practitioners (CWP’s in B&D) funded secured separately through NELFT and linking in with our Mental Health Advisor

11. The Mental Health Advisor - a key link between B&D Schools and NELFT CAMHS in B&D

1.4 Expenditure plans

Total planned health expenditure on CYP Mental health is summarised in table 2 below:

**Table 2: Planned CCG spend in 2017/18**

<table>
<thead>
<tr>
<th>Spend by Category</th>
<th>£ 000</th>
<th>B&amp;D CCG 2017/18 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Young People’s Mental Health (Excluding LD)</td>
<td>3,318</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Young People's Eating Disorders</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>Perinatal Mental Health (Community)</td>
<td>228</td>
<td></td>
</tr>
<tr>
<td>Early Intervention in Psychosis ‘EIP’ Team (14 - 65)</td>
<td>686</td>
<td></td>
</tr>
</tbody>
</table>

Summary expenditure plans for the delivery of the Local Transformation Plans in 2017/18 are summarised in table 3 below:

**Table 4: Local Transformation Plans expenditure 2017/18**

<table>
<thead>
<tr>
<th>LTP priority area</th>
<th>Planned spend £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS training</td>
<td>9</td>
</tr>
<tr>
<td>Wellbeing hub</td>
<td>145</td>
</tr>
<tr>
<td>Crisis response</td>
<td>104</td>
</tr>
<tr>
<td>LAC post</td>
<td>58</td>
</tr>
<tr>
<td>Behaviour support</td>
<td>40</td>
</tr>
<tr>
<td>Digital support</td>
<td>39</td>
</tr>
<tr>
<td>Schools training</td>
<td>21</td>
</tr>
<tr>
<td>Engagement</td>
<td>2</td>
</tr>
<tr>
<td>Commissioning support</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total CAMHS</strong></td>
<td><strong>422</strong></td>
</tr>
<tr>
<td>Health and Justice</td>
<td>53</td>
</tr>
</tbody>
</table>
NOTE: The financial plan for 18/19 will be similar 17/18, we can only make assumptions up to 2020/21

1.5 Engagement

As part of B&D’s approach to our LTP we worked closely with our Public Health team to complete a CAMHS Integrated MH Needs Assessment to:

- Understand the mental health needs of the child and young person’s living in Barking and Dagenham
- Understand the services that respond to these needs currently
- Understand the gaps in current provision
- Build a model of response to the identified needs based on robust evidence


This MHNA informed our implementation of our LTP it suggested the following areas of development and options for the future including: a blended model of the Thrive Model, incorporating resilience-building, has been recommended as the operating model for Barking and Dagenham; Resilience Building; Age 5-12 and school years; adolescents; GPs; Specialist Services; Transition; Partnership Working; Participation and Active Involvement; Workforce Development and Capacity Building; Cultural Competence.

We continue to engage widely with all our stakeholders on refining and implementing our transformation plans. The Barking and Dagenham CCG Patient Engagement Forum has been involved throughout the transformation plan development, and we have held a series of specific LTP engagement events across BHR since 2015.

The Barking and Dagenham Youth Forum has also been engaged with the transformation work around children and young people’s emotional wellbeing and mental health and were inspired to make their own short film – Breaking the Stigma – to encourage more young people to speak out about mental health and break down some of the negative perceptions that they found about the issue. You can see the film on Youtube. Also B&D YF have developed our KOOTH offer and arte part of the annual evaluation of the service.

Barking and Dagenham led one of the first Thrive London community conversations in July 2017 about how to improve the mental health and wellbeing of Londoners – the need to maximise the potential of children and young people was one of the major themes discussed. See the full report in Appendix D for further details.

These activities have led to the development of the Circle of Resilience in section 1.2

The Mental Health Sub-Group of the Barking and Dagenham Health and Wellbeing Board met in October 2017 to discuss the CYP MH Transformation Plans, their comments, and an initial response from our joint Children’s Commissioner, are summarised below.

<table>
<thead>
<tr>
<th>Section</th>
<th>Sub-group comments</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>The concept of family appears to be missing.</td>
<td>LTP focuses on CYP accessing services but in B&amp;D we have</td>
</tr>
<tr>
<td>Consider roles of trusted adults &amp; need for specialist support. Standard model for counselling and pastoral services in schools? Is there a risk of varying offers to pupils depending on if an academy or Lead school?</td>
<td>engaged Triple P to provide support to parents as well as CYP</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Population needs</td>
<td>PH and B&amp;D CCG produced a MH JSNA which underpins the B&amp;D LTP. Prevalence statistics for CYP are from 2004 (New data due in 2018).</td>
<td></td>
</tr>
<tr>
<td>Strategic Alignment</td>
<td>CQUIN on Transition included in this plan. B&amp;D CAMHS have gone through a systemic i-Thrive transformation and schools are implementing the Thrive programme local in B&amp;D schools (report included in this plan)</td>
<td></td>
</tr>
<tr>
<td>Engagement</td>
<td>CSE (Children Sexually Exploited) plans; are included and are part of a wider piece of work across the BHR CCG’s and other NE partners</td>
<td></td>
</tr>
<tr>
<td>Achievements and Challenges 2016/17</td>
<td>KOOTTH online service in B&amp;D and Big White wall (commissioned by PH); plans for CYP MH day in B&amp;D with Community Links in place; CAMHS School Links initiative starting in B&amp;D; ThriveLDN have held a workshop in B&amp;D (report attached) and will be involved in CAMHS School Links work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B&amp;D Carers are part of our More Than Mentors programme (see attached report)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS 111 new pilot with Local Pharmacies to be piloted in November 2017; this will be reviewed in January 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crisis vanguard – waiting on submission of business case but investment part of the overall plan</td>
<td></td>
</tr>
</tbody>
</table>
### Priorities for 2017/18

- Family intervention
- Social prescribing
- Peer Support
- Work with boys/young men
- Education, employment & training.
- Integrated pathways Inc. Community

B&D have a range of resilience programmes with B&D Schools outlined in the plan; parenting programmes and pilots with Triple P and a wide range of CYP Youth engagement as part of our structured work with Community Links.

### Implementation

Look at criteria for Personal, Social, Health and Economic (PHSE), we need to know children are having continuous time on these subjects and perhaps Parents/Guardians need training on these skills.

A recent Government response to CYP MH on the role of education stated: - All young people should have access to a curriculum that ensures they are prepared for adult life in modern Britain. PSHE, Relationships Education, and Relationships and Sex Education (RSE) help to provide pupils with the key knowledge and skills to ensure that they can keep themselves safe, develop healthy and positive relationships, maintain good mental health, build resilience and successfully navigate the changing world in which they are growing up.

### COMMENT:

**Director of Commissioning Children Care and Support (Barking and Dagenham (B&D))** “In addition, we have had specific feedback from services users, telling us that counselling is not always provided by a female worker where a young woman or girl has been subjected to CSE or rape, or the young person should be given a choice prior to counselling on the gender of the worker. Is a basic facts revew undertaken prior to the allocation of a CAMHS worker?”

**RESPONSE:** This point will to be picked up with NELFT directly as an operational issue rather and will be raised in the MH Service Improvement Group (Commissioner/Provider contract monitoring meeting across BHR – Children’ Commissioners sit on the group)

**COMMENT:** Director of Commissioning B&D “… due to the high levels of domestic abuse within the borough there needs to be a strong focus on ‘healthy relationships’ within PHSE offering at schools, especially around gender equality, due to the disparity within the PHSE delivery at schools, we would like to see a central point of review and sharing of best practice.”

**RESPONSE:** This will be part of next year’s work with Public Health colleagues.

**COMMENT:** Dr Nick Barnes - Specialty Doctor in Child and Adolescent Psychiatry: “Thanks so much for sending this through - it is great to read about all the fantastic work that is going on, despite all the restraints that we need to face on a daily basis. I think your report really captures many of the strengths that have been evident to the More than Mentors team, when working within Barking and Dagenham. It is wonderful to see More than Mentors so embraced by the borough and the CCG, and to have this embedded within the LTP is exactly where the Department of Health would want to see this type of intervention.”
COMMENT: Jason Turner – Programme Manager Community Links: “Thank you for sharing this on Friday, it was some really exciting news to finish the week with and this has really excited the delivery team as well as the SLT hear at Community Links. It is really pleasing to know that the More than Mentors programme is seen as a valued intervention and to have this placed into the LTP is fantastic.”

COMMENT: Public Health Team B&D: “There is a lot of useful information in there. From my quick look a couple of comments:
- A 2-3 page summary would be helpful.
- Prevention via addressing wider determinants e.g. debt advice, welfare support, housing support
- Links with exercise/smoking/alcohol consumption – maybe this is there and I missed it.
- No mention of childhood obesity, bullying in school – actions
- Workforce – support healthy workplace charter for these staff/institutions and mental health of the workforce as well as the clients”

RESPONSE: There will be an Easy Read Version as part of this refresh. Also your comments are consistent with the Prevention Concordant for Better Mental Health, and the issues that have been highlighted. This will be part of next year’s work with Public Health colleagues

1.6 Governance and partnership working

Across BHR we have a Mental Health Delivery Board that provides strategic oversight of the BHR CCG mental health transformation programme including the CYP MH Programme. The Board is chaired by the BHR CCGs Executive Lead for mental health and has representation from the three local authorities, NHS England specialised commissioning and NELFT. Reporting to this Board there is the BHR CCG wide CAMHS Transformation Group which oversees the delivery of the CYP MH Transformation Plan.

The BHR Integrated Care Partnership provides us with a mechanism to work collaboratively across health and social care in the BHR footprint, for example on the proposal around Health and Justice, referred to below. We also work with partners across the East London Health and Care Partnership through those emerging governance processes.

The CCG provide updates on children’s mental health via the Health and Wellbeing Board. Barking and Dagenham also has a Mental Health Partnership Board which brings together children and adult services and provides oversight on the overall mental health agenda across Barking and Dagenham. The CCG/LBBD joint children’s commissioner and the CCG mental health clinical lead are both members of this board.

As part of the local engagement in Barking and Dagenham around the resilience programme we have instigated a number of Task and Finish Groups on the following areas: More than Mentors, Kooth Online Counselling, Triple P, CAMHS School Links, Children and Young People (CYP) Health in Justice. These groups drive forward the implementation of the CAMHS LTP with the purpose to:

- Establish and implement CAMHS LTP on a local level in B&D
- Involve key partners in B&D
- Ensure programmes has an operational fit with existing policies, procedures and governance
- On-going review of pilots and programmes
• Review and report back to relevant local and BHR governance structures.

These groups support engagement and communication across the whole system and provide a way of accounting across the partners for delivery of the LTP.

This plan has been developed by the CCG in partnership with London Borough of Barking and Dagenham, informed by discussions with the Mental Health Sub-Group of the Health and Wellbeing Board, and by information made available by NELFT. We will be discussing this plan with the BHR CAMHS Transformation Group on 30 October to achieve alignment across the area, and will be taking the plan to the Barking and Dagenham Health and Wellbeing Board.

**Governance**
2. Understanding local need

2.1 Barking and Dagenham’s population needs

The Children and Young People’s Joint Strategic Needs Assessment¹ was used to inform the 2015 CYP MH Transformation Plan. This section covers both children of primary school age and adolescents, and provides an update on our understanding of population need from a public health/epidemiological perspective.

Promoting mental wellbeing and resilience and addressing mental disorders at any age is important. Understanding the mental health needs of children and young people may also allow for early intervention and management; mental health disorders usually appear for the first time in childhood and adolescence, with one study finding that half of those who had a psychiatric disorder at age 26 had had a diagnosis of a mental illness when tested at age 15 and around three-quarters by age 18.² It may also help to mitigate against the disadvantage children may face if they cannot fully participate in the educational and social opportunities of school.

Our data:
- Modelled data suggest that 10.3% of Barking and Dagenham children aged 5–16 may have a mental health disorder.³
- This is higher than London and England (9.3% and 9.2%), which is likely to be due to the model accounting for the distribution of socio-economic classifications within areas. In general, children in a household whose family reference person⁴ is of lower socio-economic status have a higher prevalence of mental health disorders, while there is also a relationship with household income.⁵ As Barking and Dagenham is a deprived area, we would expect more children to be affected.
- No trend data is available as this is based on prevalence rates from the last national survey, which was carried out in 2004. A new national survey is being undertaken in 2017, which will cover ages 2–19.
- Table 2 presents the modelled prevalence estimates and approximate number of children thought to be affected by a mental health disorder by age and sex:

¹ [https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/]
³ PHE, Children and Young People’s Mental Health and Wellbeing [https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh/]
⁴ The person who owns the home or is responsible for rent; if multiple people do this, the highest earner is chosen. If two people earn the same income, the oldest is chosen [http://webarchive.nationalarchives.gov.uk/20160106042025/http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec-rebased-on-soc2010-user-manual/index.html].
Table 5: Modelled prevalence of mental health disorders in 5–16-year olds in Barking and Dagenham

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>5–10</td>
<td>11.4%</td>
<td>1,300</td>
<td>5.7%</td>
</tr>
<tr>
<td>11–16</td>
<td>14.0%</td>
<td>1,200</td>
<td>11.2%</td>
</tr>
<tr>
<td>5–16</td>
<td>12.5%</td>
<td>2,500</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Source: Calculated using methodology outlined in Children and Young People’s Mental Health and Wellbeing, Fingertips profile, from: Mental health survey 2004, ONS mid-year population estimates 2016; Census 2011

- The most common disorders experienced are emotional disorders (encompassing anxiety and depression disorders) and conduct disorders.
- There are large differences by sex nationally, especially in younger children. In 5–10s, this is largely due to higher rates of conduct disorders in boys (6.9% of males versus 2.8% of females), although boys also have higher rates of hyperkinetic disorders (also known as attention-deficit hyperactivity disorder or ADHD) and less common disorders. Girls, conversely, have higher rates of emotional disorders, although at ages 5–10, this difference is not large. At ages 11–16, the conditions noted above are still more common in boys, but the gaps are diminished, whereas the gap between boys and girls suffering from emotional disorders increases.
- From January to March 2017, an average of 790 young people (0–18) from Barking and Dagenham were in contact with mental health services at the end of each month, of whom an average of 575 were in contact with children and young people’s mental health services.
- From January to March 2017, an average of 490 individuals each month attended at least one contact, with an average of 1320 total contacts per month.

Further work needs to be done to align the findings of this review with the outcome of the FSR.

2.2 B&D Public Health Schools Survey 2017

LBBD commissioned and worked closely with the Schools Health Education Unit (SHEU) to design & deliver a new survey on the health of young people in Barking & Dagenham. The borough has undergone rapid change over recent years and this is the first secondary school health survey since 1995.

The key health priorities we wanted to address through the survey were:

- Diet & Exercise
- Sexual Health
- Smoking, alcohol and drugs
- Emotional Health & Wellbeing

Under Emotional Health and Wellbeing

- The emotional wellbeing of many students noted in the report as being ‘poor’ and every indicator of emotional well-being showing females worse-off. This reflects a national trend which is also born out in other recent national and London (comparator boroughs) survey’s conducted by SHEU
- The focus group conducted as part of the survey highlighted ‘reservation about the provision of counselling services in schools, around availability during the week,

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7 Mental Health Services Monthly Statistics, NHS Digital; Barking and Dagenham refers to GP-registered population; those for whom NHS Barking and Dagenham CCG is responsible.
suspicions about lack of confidentiality, unfamiliarity, being identified with authority, and low expectations about outcomes:

- It is also worth noting that during the course of the survey a high number of students (13) reported active suicidal thoughts in the freetext box related to emotional wellbeing.
- Nationally 1 in 5 young adults have a diagnosable mental health disorder however only a quarter of these get access to the support that they need.
- 29% of pupils had a low / med-low score on the Warwick-Edinburgh Mental Wellbeing Scale & 27% of pupils had a low measure of resilience (extrapolated that’s almost 3000 of our 14-18 year olds)
- Only 37% said they talk to someone about a problem that worries them or when they are feeling stressed (the equivalent figure in 2016 in the Y8/Y10 aggregate SHEU data set = 61%) & 9% of students responded that there are no adults they can really trust.
- 30% said they have been feeling optimistic about the future ‘rarely’ or ‘none of the time’.

Our response:
This report will enable us to better focus and target current services and develop better collaborative approaches, particularly in the areas of nutrition & exercise and mental health:

- Informing the development of good emotional wellbeing support and finding better ways of listening to young people and connecting with the most vulnerable. This is most acute and cuts across the whole range of services and school approaches, encompassing physical health, cultural inclusion, achievement, connection and personal identity & ambition. See section 1.2 and 1.3 and B&D’s Circle of Resilience
- As a springboard for schools to establish clear health policies and information exchange processes in collaboration with Public Health/B&D CCG and other colleagues to ensure that teachers across all disciplines are kept informed on health issues, trends and best practice. Also note the joint working on the MH Needs Assessment; the Thrive LDN event; the appointment of the Mental Health Advisor for schools as part of the LTP.
- As an opportunity for support providers such as the School Nursing Service, CAMHS and Healthy Lifestyles Services to actively engage with schools around the health messages in the report.
- As the start of a conversation with parents, young people & wider organisations in the borough.

2.3 Health inequalities

This plan is intended to help mitigate against the impact of health inequalities by building resilience to deal with the risk factors that are experienced by our local population, by promoting protective factors, by facilitating better access to help when needed through the Thrive model and by improving pathways for the most vulnerable children.

The Kings Fund (December 2017) reported that health inequalities are currently estimated to cost the NHS a total of at least £20 billion each year so it is imperative to harness the influence of each CCG/LA to challenge where health inequalities can be reduced and greater equality established.

Thus through the LTP each CCG/LA must have regard to the need to

1. Reduce inequalities between vulnerable cohorts of CYP with respect to their ability to access mental health services, and
2. Reduce inequalities between vulnerable cohorts of CYP with respect to the outcomes achieved for them by the provision of mental health services.
Please see section 1.2 for how practical support has been put in place to deal with health inequalities; but this will require a whole system approach and increase co-operation with our key partners i.e. social care; education; public health; providers for example.

3. Vision and Ambition

Our vision and ambition for children and young people in Barking and Dagenham for 2020 remains constant since 2015. It remains that our vision is for all children and young people to enjoy good emotional wellbeing and mental health.

3.1 Barking and Dagenham vision

Our vision is that children and young people in Barking and Dagenham are empowered to be resilient and able to cope with the challenges of everyday life. We envisage mental health being seen as ‘everyone’s business’ and that people within a child’s sphere of influence understand their role in promoting good mental health.

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

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

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

Barking and Dagenham Children and Young People’s Mental Health Transformation Plan 2015

The NHS Five Year Forward View (Forward View) set out a shared vision and view on new models of care (NMOC) and how services should be delivered. Some of the key points were on prevention; increased collaboration with Public Health; barriers broken down and great patient i.e. CYP involvement in how their care is provided.

The key underlying thread in the Forward View (FV) is that one size fits all does not apply anymore; the diverse nature of the population and the complexity of needs means that different approaches need to be taken. The FV emphasises ‘diverse solutions and local leadership’ in how services are thought of and delivered. Please see FV principles and B&D’s response
### Forward View Principles

<table>
<thead>
<tr>
<th>Co-production with people with lived experience of services, their families and carers;</th>
<th>See section 1 – Starting point; progress to date in particular work with Youth Forum; engagement and future plans – MH schools conference; MH Advisor in schools; Thrive Training etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;</td>
<td>See section 1.2 and 1.5 on work to date and future plans; MH Needs Assessment; PH Schools Survey</td>
</tr>
<tr>
<td>Identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;</td>
<td>See MH Needs Assessment and PH Schools Survey; circle of resilience; use of technology; online counselling; apps Chat Health; Big White Wall</td>
</tr>
<tr>
<td>Designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and,</td>
<td>See section 1 – on peer mentoring; Triple P; KOOTH all CYP focused</td>
</tr>
<tr>
<td>Underpinning the commitments through outcome-focused, intelligent and data-driven commissioning</td>
<td>Note Full Service Review (FSR); CORC report; access data</td>
</tr>
</tbody>
</table>

### 3.2 Barking and Dagenham ambition 2017-2020

The Transformation Plan published in 2015 set out our aspirations to develop a sustainable whole system approach to building resilience and better emotional wellbeing and mental health in children and young people. This approach aspires to draw on and enhance the assets found in our local community and services, in particular in health services, the council, schools, the third sector and youth justice. We are currently evolving from the traditional tiered approach to a seamless pathway into and out of four quadrants of service delivery, based on the Thrive model. Our ambition is to achieve the target of 35% of children and young people with diagnosable conditions accessing evidence-based treatment by 2020/21; to ensure that all children and young people with diagnosable conditions are encompassed within this approach and; to build resilience and promote prevention universally.

To ensure that the targets are met we have carried out a:

1. MH Needs Assessment in B&D
2. PH School Survey in B&D
3. A Full Service Review of our CAMHS Services across BHR
4. Implemented the Thrive Approach across BHR
5. Commissioned CORC to outline key outcomes and service priorities

The model is described briefly below and in diagrammatic form in Figure 1.
**Figure 1: Thrive/Quadrant approach**

**Quadrant 1**: Building resilience; preventing ill health and promoting wellbeing by working with parents, children and young people, schools, early help provision and other universal services to support emotional needs, provide early help and practical support.

**Quadrant 2**: Helping children, young people and families to cope; to practically build resilience, highlighting risk and protective factors and providing access to digital support, parental learning, online counselling and direct and timely access for routine assessment and treatment if needed.

**Quadrant 3**: More intensive support and specialist treatment; readily available from a single point of access for all needs, with integrated pathways into and out of specialist services including eating disorders, and with specific pathways in place for vulnerable children including looked after children and those in contact with the justice system.

**Quadrant 4**: Support and intensive interventions in a crisis; available when needed, fully integrated into other pathways, working towards a 24/7 offer and seeking to outreach and reduce need for higher levels of intervention.

As part of the implementation of the CAMHS LTP some systemic changes have taken place across BHR:

1. The setting up of a Children’s Clinical Oversight Group (CCOG) which meets bi-monthly and have GP; Clinicians, commissioners and provider representation to deal with key CYP health issues on a themed approach
2. The BHR (Barking & Dagenham; Havering & Redbridge) Children and Maternity Steering Group which has GP Lead for CYP as a member.
3. A BHR CAMHS Strategic Partnership Board
3.3 Barking and Dagenham Primary Care Transformation

The Five Year Forward View sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability

In response to this, the General Practice Forward View offers funding opportunities and practical steps to stabilise and transform general practice through addressing workforce, workload, infrastructure and care design issues.

Barking and Dagenham, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget.

The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing young population in one of the most deprived areas in England where an increasing number of people are living with one or more long-term conditions in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards for care
- Close the budget gap.

The CCG’s vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a ‘place’, and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

General Practice has a key role in the identification, treatment and management of long-term conditions and mental health. These trends impact on the demand on GPs and the primary care team.

**Sustainability of services**

The BHR CCGs have agreed an annual recurrent investment of £434,673 for the 24/7 children and Young People “Out of Hours” Referral Assessment Hub

Coupled with this the current financial environment means that planning medium term can prove difficult there are opportunities that can be identified:
1. The strategic movement to Accountable Care Organisation (ACO) and the development of the East London Health Partnership; the Joint Commissioning Board across BHR, Integrated 0-19 services in B&D means that there is a shared awareness of health and social integration across key partners.

2. The deficit; while debilitating for services; can drive opportunities for change in how services are commissioned and delivered i.e. in B&D – Mental Health Advisor; MH Social Worker for LAC; school based resilience etc.

3. The development of the STP and the opportunity to ensure that CYP has a voice.

4. Ensuring that non-cost services are accessed i.e. community pharmacists; focused use of A&E

5. Ensuring that Investing to Save approaches are made to key boards and partners.

4. Workforce

Developing our workforce remains the single most important enabler, and biggest challenge to the delivery of CYP mental health transformation. A significant amount of work has been completed in 2016/17 to gain a full picture of our current workforce and to compare this with the workforce that we will need to deliver the full transformation that is expected. An overview of the work done to date and next steps follows. (Please see section 1.3 – Progress to Date)

4.1 Thrive in BHR

The THRIVE framework, jointly developed by the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust, has provided a systematic and population focused approach to improving outcomes for children, young people and their families. The i-THRIVE Partnership has been committed to putting the principles of the THRIVE framework into practice and is working with a range of sites across the country, including with NELFT in BHR. The programme of work in BHR includes a workforce review including surveys, capacity building and quality improvement. The first phase of work, including a survey of the ‘THRIVE-like’ working practices (shared decision making, use of the THRIVE quadrants, when to stop treatment, enabling self-management, skills for assessment and signposting and enabling self-care and management), is now complete and is informing the quality improvement programme, and training and development provided by the i-THRIVE academy – linking in with the developments required in CYP IAPT. The second phase is underway and focuses on building capacity and competency to work in and deliver a THRIVE like system. The final evaluation report is due in September 2018.

NELFT also has a Community of Practice (CoP) for Children and Young People Services and includes a sub group focused to CAMHS provision. The CYP CoP has a primary focus around sharing of good practice, developing consistent policies and standard operating procedures for service delivery and leading quality improvement approaches. The CYP CoP reports to the Clinical Executive within the NELFT governance framework and is led both clinically and managerially. The work of Thrive is also embedded within this group.

4.2 Demand and capacity planning

Further to demand and capacity planning undertaken by the CCG in 2016 to map need against the service model, NELFT have now completed a Fundamental Service Review (FSR) which provides detailed baseline information on workforce, caseload, activity and waiting times and is being used to inform the development of demand and capacity models to be incorporated into the contract for the wellbeing hub and crisis services across BHR.
4.3 Workforce planning across East London Health and Care Partnership

Initial discussions have taken place about the possibility of developing North East London wide workforce plans, further discussion about the benefits of this approach need to be taken forward at STP level.

As part of the Mental Health Five Year Forward View a workforce strategy sets out plans to create 21,000 new posts across all major specialties sector, including:

- 2,000 additional nurse, consultant and therapist posts in child and adolescent mental health services;
- 2,900 additional therapists and other allied health professionals in adult talking therapies;
- 4,800 additional posts for nurses and therapists working in crisis care settings, with 4,600 of these being nursing positions; and
- Perinatal mental health support, liaison and diversion teams and early intervention teams working with people at risk of psychosis should also see significant increases.

4.4 Next steps on workforce

While the details of the HEE (Health Education England) workforce strategy consultation has just been published, based on our clear picture of local challenges and workforce profile, and in terms of capacity to deliver the Thrive approach, the three key next steps are:

- To agree the capacity and cost of the services provided by NELFT, as part of the contracting process.
- Continue to work across the whole system to develop and embed the Thrive approach will continue with the support of the BHR CAMHS partnership.
- Develop a multi-agency workforce plan in line with the findings of the JSNA.

5. Collaborative and place-based commissioning

5.1 Strategic alignment

Barking and Dagenham, Havering and Redbridge (BHR) have a single Chief Officer and shared management structure. A common vision for the Barking and Dagenham, Barking and Dagenham and Redbridge (BHR) footprint was shared in the previous plans, though with local variation to meet the different specific needs and priorities in each borough. BHR CCGs also work closely with Waltham Forest CCG to commission specialist services, including for example community eating disorders and early intervention in psychosis services, across a wider geographic footprint, allowing for greater economies of scale as well as consistency of offer.

The 2016 transformation plan ensured alignment with the north east London sustainability and transformation plan (STP). There are four service areas where collaborative and place-based commissioning has been taken forward in 2016/17 in north east London; specialist inpatient services/integrated pathway, Child Sexual Abuse (CSA) hub, Health and Justice, specialist Forensic CAMHS (FCAMHS) and perinatal mental health. An overview of the current status of this work is provided below, with further details on the Health and Justice work available in Section 12 below.
5.2 Integrated pathways across community, inpatient and crisis care

Following the temporary closure, repurposing and reopening of the Brookside CAMHS inpatient unit in 2016, NHS England, working closely with BHR CCGs, have commissioned a CYP Home Treatment Team (CYPHTT). This is the first of its nature for children and young people and is subject to ongoing evaluation. The CYPHTT maintains very close working relationships with the respective locality CAMHS teams in terms of shared care and step down planning back to the locality CAMHS provision once CYPHTT intervention is no longer required. There is also the well-established Interact team that provides crisis intervention and outreach (including A&E assessments) which has been extended in 2016/17 as part of the Vanguard programme. These developments are aimed at providing a local integrated pathway for children and young people that includes admission avoidance, and appropriate and safe discharge, and that joins up with health and justice commissioners where relevant to ensure appropriate transitions between secure settings and liaison and diversion.

The integrated pathway is found in Section 9 below.

5.3 Forensic community services

A new specialist child and adolescent mental health service for high risk young people with complex needs will be commissioned for London (forensic community CAMHS). This is a national initiative and forms part of the national Health in Justice and Specialised Commissioning workstream and Children and Young People’s Mental Health Transformation Programme. Funding and the service specification is being led nationally, but the service will be commissioned and managed locally by Specialised Commissioning in partnership with Health in Justice.

The service is intended to supplement existing local and other cross-agency provision. It will provide consultation and advice, and in some cases, specialist assessment and help to work out the best way to support individuals. Any agency can make a referral, including CAMHS teams, children’s social services, and youth offending teams. The service will also play an important strategic role by forming strong links with local services, providing teaching and training, and identifying gaps in local provision. BHR have engaged with the NHSE specialist commissioning project team and intend to continue with this engagement, ensuring that local issues, such as the development of pathways into the new service and the needs of CYP with substance use issues are also considered.

5.4 Child Sexual Abuse Transformation

The London Child Sexual Abuse (CSA) Transformation Team and the NEL STP CCG Commissioning Executive have supported, subject to evidence of benefit, provision of an emotional support pathway following community paediatric examination for CSA. The CCGs aim, in line with the partnership model with the third sector piloted elsewhere in London, to work in partnership with providers in North East London to secure the hub model in NEL. This model has been approved by the NEL Clinical Senate, 7 CCG Commissioning Executive, and SCBs. It proposes moving to an NEL approach by local community paediatricians working together within existing resources. Consideration of options for commissioning emotional support pathway are due at the CSA Steering Group on 1 November.

The key features of the proposed hub are:

- Weekly clinics in inner London (52 per year) and fortnightly clinics in outer London to provide capacity for 76 new referrals and from 114 to 152 follow ups
• One NE London CSA team, made up of existing specialist paediatricians, to work across the whole area (with chaperone infrastructure for paediatricians)
• One NE London caseload
• Collective ownership regardless of geography
• Doctors travel to clinics
• Clinic appointments as close as possible to families’ homes
• A ‘PLAN DO SEE ACT’ approach to implementation
• Interfaces with emotional support pathway led by CAMHS
• Functioning colposcopies at two sites in NEL.

5.5 Perinatal mental health

NEL STP commissioners and providers have worked together, supported by the perinatal clinical network, to develop proposals to enhance specialist community perinatal mental health services across the area, based on developing an understanding of the projected population needs, current service models and workforce and capacity gaps. This work has informed the development of an STP application for transformation funds.

6. CYP Improving Access to Psychological Therapies (IAPT)

We are seeking to be fully IAPT compliant by 2018 and to ensure full membership and participation in CYP IAPT and its principles including routine outcome monitoring and improvement. An update from NEFLT on progress to date follows:

NELFT continued engagement:
We continue to support the use of the outcome measures and are exploring how we can make this process more streamlined i.e. the use of digitalised questionnaire at the point of IA to support the adoption of the principles of IAPT and the use of outcome measures. We are certainly planning to remain engaged in ensuring that we have CYP IAPT trained professionals within the services. There are three members of staff who are planning to begin training the beginning of 2018, one for Cognitive Behavioural Therapy (CBT), one for Learning Disability and Autistic Spectrum Disorder (ASD), and one for CBT supervision.

2016/17 update on staff currently released CYP-IAPT training:
Barking and Dagenham: One member of staff currently on CYP training. This is a CAMHS nurse and they are being trained in the CYP IAPT CBT intervention for children with anxiety and depression.

Trust plans to mitigate withdrawal of salary support funding rates from CYP-IAPT central funding budgets:
NELFT is currently exploring options within the NELFT wide training budgets. A lack of backfill, at a time of transformation and expected increased activity poses considerable operational difficulties.

A B&D Annual Stocktake Report on CYP-IAPT is attached in the appendices (Appendix G)
1. Eating disorders

Barking and Dagenham CCG partners with Barking and Dagenham, Redbridge and Waltham Forest CCGs to commission the community eating disorders service from NELFT which covers this four neighbouring boroughs. BHR and Waltham Forest CCGs invested their additional recurring allocation in child and adolescent community eating disorders services in 2015/16. This enabled the service to increase their capacity significantly by 6.6 WTE clinical staff (and 1 WTE non-clinical) equating to an additional 158 cases per annum, and to extend the range of interventions required by the new access and waiting time standards for community eating disorders services.

NELFT and the CCG has been monitoring performance against the access and waiting times standards since 2016. Requirements to comply with data reporting and national quality improvement were delivered through the 2016/17 Service Development and Improvement Plan as part of the contract between commissioner and provider.

Performance in 2017/18 to date against the 95% target (this is the national target by 2020) is summarised in table 6 below – note, the numbers of people using this service are low, the 0% performance relates to 1 referral being referred that during the reporting period seen after 1 week.

<table>
<thead>
<tr>
<th>CYP Eating disorder - Urgent cases - 1 week wait 95% (National target by 2020)</th>
<th>Barking &amp; Dagenham</th>
<th>0.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP Eating disorder - Routine cases - 4 week wait-95% (National target by 2020)</td>
<td>Barking &amp; Dagenham</td>
<td>66.67%</td>
</tr>
</tbody>
</table>
2. Data

A key enabler in the delivery of our LTP is availability of data that allows us to understand current and project demand for services, progress on Five Year Forward View targets, and monitoring of progress towards delivering outcomes.

8.1 Development of CAMHS dashboard

BHR CCGs have including in contractual requirements with NELFT the submission of full, accurate data returns for all routine collections in the Mental Health Service Data Set (MHSDS) and IAPT data set, and have extended the number of data items that the provider is required to report to enable commissioners and providers to have a shared understanding of the capacity, performance and development needs of the service. We now have a shared CAMHS dashboard (see Fig 2 below) which enables commissioners and providers to jointly review the following indicators:

- Operating Plan target to increase access (increase number of new CYP aged 0-18 with diagnosable mental health condition receiving treatment from NHS funded community services in the reporting period)
- CAMHS waiting times (routine, urgent and LAC referrals)
- Eating disorders waiting times performance (routine and urgent)
- Early Intervention Psychosis access and waiting times standards.

This dashboard is also available for discussion across the BHR CAMHS partnership.

Figure 2 – screenshot of BHR CCG CAMHS Dashboard (for illustration only)
8.2 Fundamental Service Review

As noted in Section 1 above, NELFT completed a Fundamental Service Review to ascertain capacity and demand in order to develop more detailed plans to implement the new model and meet new access targets. The FSR provides details of current activity and workforce, and a gap analysis for each of the three BHR CAMHS teams. The FSR provides the basis for further discussion about investment in CAMHS by the CCGs, and the implementation plans that support the delivery of the LTPs.

8.3 Outcomes Framework

Work to develop and embed an outcomes framework is described in Section 13 below.

8.4 Key Performance Indicators

Please see appendices for updated reporting requirements and KPI’s.

3. Urgent and Emergency (Crisis) Mental Health Care for CYP

BHR were successful in establishing a crisis pilot as part of the Urgent and Emergency Care Vanguard in 2016/17. This new model of care, an extension of the home treatment team model is being tested as part of a national evaluation. The Vanguard builds on learning locally about how best to provide care for CYP integrates with the wider urgent and emergency care offer including mental health liaison services.

Interact was introduced by NELFT Child and Adolescent Mental Health Service in 2008, at the time it provided a new type of Outreach Service that focused on the needs of teenagers and their family, and A&E liaison for three general hospitals, Paediatric Ward liaison, Crisis prevention and resolution. Interact now also facilitates the gatekeeping function for the Adolescent Inpatient beds and the CYPHTT as well as offering a range of post-discharge support including higher intensity visits to maintain stability in the period immediately after discharge from the ward environment.

For the development of the CYPHTT, there was recognition that the optimal place to treat children and young people was in their home environment. The CYPHTT has a good multi-disciplinary team mix which consists of Nurses, Occupational Therapists, Psychologists and Consultant Psychiatrists. This provides intensive support in the community and this prevents admissions to hospital and speeds the process of recovery in the community. There is also the opportunity to prevent a cycle of admission after admission and the potential move from becoming adolescents with frequent admissions to adult with continued admissions, as it normalises treatment and support in the home environment.

As a part of the Vanguard pilot (NHSE Crisis support programme), the Interact Team extended their age range from 12-18 years to 0-18 years and developed an emergency duty system. Interact works in partnership rather than care co-ordinating patient care and works in collaboration with various departments and teams. Examples of these partners are Brookside Adolescent Unit, Young Persons Home Treatment Team, Child and Family Consultation Services, Social Care departments and Early Intervention Services.

Stephen Mylchreest, Team Leader, Interact, has recently published a blog on this work - Spotlight on INTERACT – a children & young people prevention/resolution team

The pathway for referrals and discharge can be seen in Figure 3 below. For the Quadrant 4 (i-THRIVE model) from spending time in the services and looking closely at the interface between Quadrant 3 and Quadrant 4, this process works very efficiently and there is very
good communication and a very good partnership working between the Quadrant providers. This has been found to be extremely helpful by patients and both the Teams (Interact and CYPHTT) have received positive feedback about the same. Any young person discharged from Interact who later requires outreach services, within a three month period of discharge, can have their case reopened without being subject to the normal referrals process and assessment.
**Figure 3: Interact Pathway**

**Referral/Treatment Pathway**

- EIP
- A&E/Paediatric Unit
- GP’s
- Social Services
- Schools
- Community CAMHS

**Eating Disorder Service (EDS)**

**OOH assessments**

**INTERACT** (CYP Crisis prevention/resolution team)

- CYP assessed for Inpatient/YPHTT or community support (for age 0-11 inpatient facility accessed by CFCS)
  - Has needs best supported by Brookside/YPHTT
  - Has needs best supported in Community

- Inpatient/YPHTT at Brookside
  - Possible co-working with INTERACT for interim care

- INTERACT Co-working with CFCS, EIP and EDS
  - INTERACT plan a staged withdrawal of support

- Following discharge INTERACT may provide post discharge support

- INTERACT withdraw support and the young person is cared for by CFCS/EIP/EDS

**CFCS/CAMHS**

**EIP**

**EDS**

**Universal Services**
4. Integration

10.1 Transitions

A CQUIN* is in place with NELFT, the provider of child and adolescent and adult mental health service, to improve transition planning and experience of young people from Children’s and Young Peoples Mental Health services to adult mental health services. Providers have mapped the current state of transition planning, the main findings of this mapping were:

- NELFT’s transition standard and pathway for young people transferring into adult mental health services is known to all localities and there is evidence that most elements of the standard are adhered to. Transition joint planning is clear at 17.5 years, however, there needs to be greater focus to earlier planning and discussion with young people at 16 years as per standard across the three localities.
- Transition is articulated into the care plan at 17.5 years, however, there needs to be greater emphasis of early discussions within the care plan regarding transition.
- Information from RIO (the electronic health care record system) in respect of numbers of young people who transition is not currently reliable. We are currently working with our informatics team to review the data quality and develop a robust reporting of RIO data for transition.
- There are a number of different clinical meetings that operate within each Borough where transition cases are discussed. These operate under various structures and the plan is to move to a consistent approach within clinical services across the boroughs to support stronger governance.
- Young people’s contribution and voice within transition is variable across the three localities. Barking and Dagenham’s participation group has ceased currently and needs to be re-implemented as a priority.
- A scoping of 3rd and voluntary sector services for young people to be sign posted to needs to be completed and a service directory within each locality developed.

An implementation plan to address these identified needs, and to achieve greater consistency, has been developed.

* Commissioning for Quality and Innovation (CQUIN) national goals. The system was introduced in 2009 to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care

As part of the practicable application of this across BHR we have actively developed a Transitions from Children’s to Adults Services Policy across BHR. The policy has as Overarching Principles:

1. co-producing transition policies and strategies with them
2. planning, co-producing and piloting materials and tools
3. asking them if the services helped them achieve agreed outcomes
4. feeding back to CYP about the effect their involvement has had.

Ensure transition support is developmentally appropriate, taking into account the person’s:

- maturity
- cognitive abilities
- psychological status
- needs in respect of long-term conditions
• social and personal circumstances
• caring responsibilities
• communication needs

Ensure transition support:
• is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options
• identifies the support available to the young person, which includes but is not limited to their family or carers.

Use person-centred approaches to ensure that transition support:
• treats the young person as an equal partner in the process and takes full account of their views and needs
• involves the young person and their family or carers, primary care practitioners and colleagues in education, as appropriate
• supports the young person to make decisions and builds their confidence to direct their own care and support over time
• fully involves the young person in terms of the way it is planned, implemented and reviewed

and addresses all relevant outcomes, including those related to:
• education and employment
• community inclusion
• health and wellbeing, including emotional health
• independent living and housing options
• involves agreeing goals with the young person
• includes a review of the transition plan with the young person at least annually or more often if their needs change.

Health and social care service managers in children’s and adults’ services should work together in an integrated way to ensure a smooth and gradual transition for young people. This work could involve, for example, developing:

• a joint mission statement or vision for transition
• jointly agreed and shared transition protocols, information-sharing protocols and approaches to practice.

Service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs.

Every service involved in supporting a young person should take responsibility for sharing safeguarding information with other organisations, in line with local information-sharing and confidentiality policies, and check that the young person is registered with a GP and/or ensure the young person has a named GP.
10.2 Extended provision

As part of the resilience elements of the LTP extensive work has taken place with schools CCG, Inclusion, Social Care and Education Department within respective local authority areas to ensure that this programme adds value to the wider preventative agenda of the Local Transformation Plan (LTP) while recognising the need for building resilience as one of the key objectives when looking to support young people earlier, and prevent the development and emergence of significant mental health needs.

The LTP also aims to examine the pathways for vulnerable children and young people to mitigate the effect of any barriers to achieving good access and positive outcomes from services. Vulnerable cohorts identified are victims of Child Sexual Abuse (CSA); neglect and abuse, Looked After Children (LAC), children with learning difficulties/ASC; SEND and those in contact with the criminal justice system.

10.3 Transforming Care Partnership (TCP)

As part of our work to develop services and support children and young people with learning disability, autism or both, we have undertaken benchmarking of transforming care. This showed that we are making good progress with:

- Development of ‘At Risk of Admission Registers’ across agencies, and monthly joint meetings with CCG/LA TCP leads to discuss all children at risk of being admitted or those requiring a community care and treatment review (CTR)
- Identified Children’s Leads within the local authority and CCG who feed into the TCP Board
- Methods to ensure that local areas have mechanisms for tracking CTRs and following up the people who have them, to put robust quality measures in place.
- Provision of an Autism/LD multi-sensory room on paediatric ward at Queen’s Hospital.

We have further work to do on

- Links to Education within the TCP board
- Continued workforce training to multi agency staff on CTR and SEND reforms
- Continued development of the At Risk Register, including children in 52/38 week placements and 0-5yrs, with a view of early intervention.

10.4 Liaison psychiatry

Mental health liaison for CYP is carried out in BHR by Interact, please see section 9 above for more details.

5. Early Intervention in Psychosis (EIP)

BHR CCGs, with Waltham Forest CCG, commission an EIP service from NELFT that covers these four neighbouring boroughs. BHR CCGs made significant additional investment into the service in 2015/16 to meet expected prevalence and waiting time standards for EIP. The service works with people of all ages experiencing a first episode of psychosis from age 14, offering all referrals NICE –recommended treatment. The service is contracted to meet the waiting time target to ensure that 50% of people referred start a NICE-recommended care package within 2 weeks of referral and are on a trajectory to achieving the 2020/21 target. Performance is reported regularly to commissioners, and a review process is in place for each breach of the target to understand reasons for the breach and to address these.
There is a CYP pathway in place, people aged between 14 and 18 years remain under the care of a CAMHS consultant psychiatrist but are care managed by the EIP service.

Performance against the 2 week target in Barking and Dagenham for the first 4 months of 2017/18 has been above target, as summarised in table 7 below:

**Table 7: EIP access and waiting time standards performance for Barking and Dagenham**

<table>
<thead>
<tr>
<th>2017/18</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention in Psychosis (EIP)-50% seen within 2 weeks</td>
<td>0.00%</td>
<td>83.33%</td>
<td>100.00%</td>
<td>83.33%</td>
</tr>
</tbody>
</table>

Mechanisms are in place to review all breaches of the 2 week target.

BHR CCGs have also developed a primary care psychosis pathway which has been disseminated to GPs to facilitate rapid recognition of first episode psychosis and rapid access to EIP.
NELFT Psychosis Pathway For under 18 year olds

REFERRAL
Referral received from GP/School/Counsellor/ABLE (Interact)/YOT/Substance Misuse team

CAMHS TRIAGE
Information gathering process

Suspected psychosis
Refer to EIP – Email & telephone referral accepted
Core Assessment and Risk Assessment on RIO to be completed

Joint assessment with EIP & CAMHS within a week
See Guidance for assessment

CAMHS – Initial assessment and MDT discussion

Suspected Psychosis

CRISIS requiring urgent/emergency assessment
CAMHS to refer to Interact for crisis intervention
EIP referral to be made by CAMHS/Interact

Tier 4
(Brookside/Interact)
EIP to offer joint assessment within a week

NO CLEAR EVIDENCE OF PSYCHOSIS
Referral NOT accepted by EIP
On-going intervention by CAMHS as per clinical need

COMORBID PRESENTATION
SUBSTANCE MISUSE/YOT/LD/anxiety/depression
Referral to appropriate service for further assessment and management of comorbidities

FIRST EPISODE PSYCHOSIS (Cluster 10)
Referral ACCEPTED by EIP
Allocated Care-Coordinator and under CPA for further assessment (up to a period of 6 months if this is indicated) and treatment interventions up to 3 years

Over 18 and requires ongoing CARE COORDINATION after up to 3 years of EIP intervention

STABLE/RECOVERY PHASE – EIP INTERVENTION COMPLETE

UNDER 18 YRS OLD – CAMHS to continue intervention as per clinical need

OVER 18 YEARS OLD – Discharge to Primary Care

Refer to CRT
6. Health and Justice

12.1 Developing additional capacity

The 3 BHR CCGs have developed a joint approach to commissioning additional capacity to the existing Youth Offending Services across the area, utilising the additional Health and Justice funding made available to CCGs. This approach builds on the existing Youth Justice services across BHR which are part of the Local Authority statutory duties under the Crime and Disorder Act 1998, requiring the co-operation of the named statutory partners (local authorities, police, probation service and NHS). An additional three clinicians will work with the existing YOS (Youth Offending Services) across BHR: one additional Speech and Language professional and one additional Learning Disability Mental Health professional and one Psychotherapist (focused on Trauma). The proposal has been presented to the CAMHS Strategic Partnership Board and the Youth Offending Service Chief Operating Group (YOS-COG) B&D.

12.2 Recording of data from youth justice services

The YOS Management receives and approves quarterly performance reports against three National Indicators, for submission to the Youth Justice Board. These are

1. Reducing the number of young people entering the Youth Justice System as First Time Entrants (FTE)
2. Reducing re-offending
3. Reducing the use of Custody for young people

The key tasks of the service are:
- Assessing and delivering interventions to the out-of-court-disposal cohort
- Management and delivery of community sentences
- Management and delivery of secure estate sentences and resettlement
- Servicing the Youth Court and Crown Courts (in terms of provision of a court team, bail and health assessments, provision of pre-sentence reports and stand down reports)
- Victim services
- Parenting services and management of Parenting Orders

There are clear processes in place across the BHR YOS teams to identify those young people of most concern at the very early stages of contact with the YOS and give more targeted support to reduce the potential for these young people to move further into the criminal justice system. The YOS completes a more extensive report on those young people entering the youth justice system within the last year and identified that there were potentially opportunities at an earlier stage with these young people where a positive intervention would have been useful. B&D for example are currently working to develop a youth ‘at risk’ matrix that will begin to put together data from a range of sources that will identify those young people that are at greatest risk of becoming engaged in criminal activity and most likely to come in to the system. This work will be shared across BHR. There will be a concerted focus on those young people in years 6 and 7 at school that will cross both primary and secondary schools – as these cohorts have been identified for targeted work through our Health in Justice workstream.

Baselines rates are set by the YOS teams across BHR. As part of the development of the MHSDS there will be data collected i.e. Number of mental health and emotional wellbeing assessments conducted (based on a broad and agreed definition); number of new
intervention plans set up (or existing ones that are reviewed); number of children and young people who successfully engage with their intervention plan (based on a broad and agreed definition e.g. three or more sessions attended) for example. There are high level plans in place to that those identified at risk of becoming engaged in criminal activity are targeted for assessment and support.

Teams are co-located from CAMHS into our YOS teams across BHR; in Redbridge, recruitment is currently taking place for a member of staff to be co-located at the YOS three days a week.

Involving CYP in service development is part of BHR’s high level plan through our service mapping which will include the journey of the CYP in the justice system which has been commissioned with Community Links across BHR.

12.3 Developing Pathways for CYP in the Justice System

We are currently mapping the current offer for addressing the Mental Health Needs and Support for Children, Young People and their Families across the Boroughs of Barking & Dagenham, Havering and Redbridge.

This will involve Individualising how processes of screening, assessment and delivery of integrated services are implemented within the following systems:

- The Youth Justice Liaison and Diversion (YJLD) pathway assessing the CYP needs when accessing the justice system.
- The YJLD pathway working in collaboration with the CCGS - intended as - forming part of a comprehensive health and vulnerability services-offer for young people accessing the justice system and explicitly set out in LTP’s.

Assessing the implementation of an integrated pathway embedded within the comprehensive health and vulnerability services-offer for CYP who are:

- In Secure Children’s Homes on either justice or welfare grounds to assist them with their resettlement
- In YOIs in order to assist them within the resettlement pathway
- Subjects to community supervision within youth offending services
- Looked After (‘LAC’s’) – due to the often higher representation of LACs within the YJS and well known vulnerabilities of this group

Analyses of specific data and plans in local areas in order to inform the mapping process as following:

- Arrest rates for CYP in the borough
- Conviction rates for CYP in the borough and type of offence
- Number of CYP in YOIs and SCH’s from the home borough
- PHE Child Health Profiles and CYP Health Benchmarking Tool
- Local Youth Justice Plan
- Local JSNA’s
- CAMHS Transformation Plans
Key issues to be reported on during mapping exercise:

Exploring the YP’s access to mental health services, including CAMHS (Thrive Quadrants), at various stages of Youth Justice Pathways, we have chosen to think about this in separate sections:

1. **Prevention and Early help** – Exploring the risks for involvement in the Youth Justice system, such as schools exclusion, or gang involvement, and what support is currently available for children, young people and parents, when seeking to address mental health need at an earlier stage

2. **At the Point of Arrest** – Thinking particularly about Liaison and Diversion work, involvement of the police in managing mental health needs (such as Section 136 experiences), screening and assessment in the custody suites and contact through the Youth Courts

3. **Community Provision (post sentencing)** – Reviewing the support available for children, young people and parents who have been placed on community based supervision orders.

4. **Liaison with the Secure estate** – Looking at contact points for young people going into secure estate, accessing support and assessments within, and then receiving care plans and support at the point of discharge. Attention will be particularly drawn to transitions in care.

This unique mapping exercise will provide a comprehensive BHR Health in Justice support for the recruitment of our BHR One Team:

- Psychotherapist focused on Trauma
- Learning Disability Specialist
- Speech and Language Specialist

7. **Impact and Outcomes**

BHR CCGs and NELFT have worked closely together since the production of the first LTPs in 2015 to consider how to best develop an outcomes-based approach to the delivery of transformation of children and young people’s mental health.

A short update on the work done to date, and plans for next steps, follows.

13.1 **A wellbeing hub development framework**

As part of the development work undertaken to design, commission and operationalise a wellbeing hub approach to children and young people’s emotional health and wellbeing, which will enable the shift away from the ‘tiered model’ of CAMHS provision to the Thrive model, a development framework was produced to set out the deliverables for the hub, and an outline of ways to measure progress against these deliverables. The measures developed including process and input measures, in lieu of a set of agreed outcome measures. This framework was incorporated into the 2016/17 contract with NELFT as part of the Service Development and Improvement Plan.
13.2 Whole systems outcome framework

During 2017, work to scope and develop a whole systems outcome framework was completed by CORC (Child Outcomes Research Consortium). The overall aim of this work was to find a way of identifying and tracking the outcomes of the Local Transformation Plans across BHR, to develop an outcomes framework that could be embedded across the whole system.

The proposed framework has three levels:

1. **Outcome measures** – these will focus on the overarching outcomes that the LTPs seek to achieve namely: that children and young people with mental health difficulties are supported in the community; parents, carers and professionals are confident in responding to needs; children, young people, their families and carers are resilient, equipped to handle life's up and downs; vulnerable children and young people are prioritised, and their care supports their specific needs; children and young people are able to access support in a timely manner; and that children, young people, their families and carers have a positive experience of support.

2. **Output measures** – the progress of interventions or activity that contribute to achievement of the outcome: underpinned by a theory about the way they impact on the outcome, and with what populations.

3. **Process measures** – measures of whether ways of working are in place that enable THRIVE-like delivery: these are intended to move BHR towards achievement of its vision, but may not be directly tied to activity.

The full report from CORC is available at Appendix E.

A suite of outcome measures has been identified, and work is underway, through the CAMHS Transformation Partnership Group, to implement and embed these measures, including work to consider and potentially align these measures with public health population outcome measures, schools surveys and other mechanisms for measuring and monitoring impact. BH CCGs will work with NELFT during the contract round for 2018/19 to embed this framework, where possible, in the provider contract, updating and refreshing the wellbeing hub development framework referred to above.
14. **Implementation**

We are still travelling along the CAMHS Transformation Roadmap, produced in 2016, see Fig 4 below:

**Figure 4: CAMHS Transformation Road Map**

Detailed implementation plans are now in place at BHR level (developed by the CCG and shared at the CAMHS transformation partnership group), provider level (developed by NELFT as required in the contract) and each borough/CCG at their local implementation groups. We have identified the following priorities for 2018/19 in terms of implementation.
14.1 BHR priorities for implementation 2018/19

- Full implementation of the Wellbeing hub in each borough incorporating additional staff including crisis response
- Building on the outcome of the FSR to develop robust workforce plans
- Developing integrated pathways across NEL and further collaborative commissioning arrangements
- Developing and embedding an outcomes-based approach to our main contract

14.2 Barking and Dagenham priorities for 2018/19

Within B&D, the priorities for the coming year are:

- Continuing to build on partnership links with B&D Local Authority in particular Education and Inclusion; Public Health; Social Care; LAC/Children in Care Teams; All Age Disability Service on key service areas
- Develop and build on links with NELFT
- Improve our co-production with B&D CYP (Children and Young People)
- Continuing to take forward Thrive training
- Continued engagement of Youth Forum
- Evaluating Kooth online counselling
- Rolling out More than Mentors
- Triple P parenting pilots
- Health in Justice Workstream
- Continued development of the resilience work in schools

14.3 Expenditure plans

Our LTP expenditure plans for 2018/19 will be based on the full year effect of our expenditure in 2017/18, as set out in Section 1.4 above.
## 14.3 Risks

The main risks to delivery of the LTP, and mitigating actions, are summarised below.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| **Securing resources for CYP MH Transformation** | • LTP Plans jointly developed with key partners  
• Robust business cases for investment agreed between commissioners and providers  
• Partnership working with local authorities to mitigate against impact of resource constraints |
| **Workforce**                                  | • Ensuring that workforce planning tools are used to meet future demand  
• Ensure that investment is upstream with schools and LTP is focused on resilience up skilling of key early intervention staff  
• Focus on the universal offer and ensure that adequate training is provided  
• Increase CYP-IAPT programme and ensure that trained staff remain in the service |
| **Commissioning of MH services**               | • Engage key partners in programme delivery  
• Establish clear governance structures for all programmes to existing health/social care pathways  
• Ensure Task & Finish Groups have correct representation i.e. NELFT; Education; Inclusion; SC; CCG; VCS; PH  
• Develop clear outcomes for the service i.e. CORC has been commissioned across BHR  
• New Models of Delivery include School Links; I-Thrive; Online Counselling; Mentoring – ensure that resilience is strengthened upstream |
| **Data**                                       | • Ensure MH Service data Set is updated and reviewed  
• Ensure that local programme providers can update data on MHSDS  
• Ensure data on prevalence is treated appropriately (dates back to Millennium Core Set from 2004)  
• Close working with PH colleagues i.e. MH JSNA in B&D |
| **Stakeholder engagement**                     | • CAMHS Strategic Partnership Board is in place across BHR  
• Engagement in LTP refresh |
| **CAMHS Complexity – highly complex service** | • Ensure outcomes cover variety of conditions  
• Mature commissioning arrangements in place  
• Key links between Community CAMHS and Specialised CAMHS |
15. List of Appendices

Appendix A: list of commonly used abbreviations in this report

Appendix B: Thrive Evaluation and Impact Report

Appendix C: More than Mentors progress report

Appendix D: Thrive LDN Barking and Dagenham Community Conversation Report

Appendix E: CORC report: Developing a Children and Young People’s Mental Health and Wellbeing Outcomes Framework for BHR CCGs

Appendix F: BD CAMHS Staffing Matrix

Appendix G: BD CYP-IAPT Annual Stocktake Report

Appendix H: CAMHS Information Requirements
Appendix A: list of commonly used abbreviations in this report

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>Barking and Dagenham</td>
</tr>
<tr>
<td>BHR</td>
<td>Barking and Dagenham, Havering and Redbridge</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for quality and innovation.</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
</tr>
<tr>
<td>CTR</td>
<td>Care and Treatment Review</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>ED</td>
<td>Eating Disorders</td>
</tr>
<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
</tr>
<tr>
<td>FSR</td>
<td>Fundamental Service Review</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LAC</td>
<td>Looked After Child</td>
</tr>
<tr>
<td>LBBD</td>
<td>London Borough Barking and Dagenham</td>
</tr>
<tr>
<td>LBR</td>
<td>London Borough Redbridge</td>
</tr>
<tr>
<td>LBH</td>
<td>London Borough Havering</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>LTP</td>
<td>Local Transformation Plan</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>NEL</td>
<td>North East London</td>
</tr>
<tr>
<td>NELFT</td>
<td>North East London Foundation Trust</td>
</tr>
<tr>
<td>SEND</td>
<td>Special Educational Needs and Disability</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
</tr>
<tr>
<td>TCP</td>
<td>Transforming Care Partnership</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
</tr>
</tbody>
</table>
This page is intentionally left blank
The Thrive approach is a developmental model and framework that can be used to understand and identify social and emotional wellbeing needs of children and adolescents. The training consists of 10 sessions whereby if delegates demonstrate a commitment and understanding, go onto become Thrive practitioners. Thrive practitioners are trained to communicate with children and young people (CYP) therapeutically and deliver interventions to support those with identified emotional wellbeing needs. Thrive was commissioned for staff within schools to improve the wellbeing outcomes for CYP.

To date there are 21 Thrive practitioners trained from the first cohort of 25 delegates. There were two further cohorts of training, one for primary (14 delegates) and one for adolescents (8 delegates). Training for the two cohorts is due to be completed by the 4th of December. Therefore, in December 2017 there will be a total of 43 Thrive practitioners across 28 schools (See appendix 1 for list of schools).

Due to Thrive being in an initial stage of implementation in schools, two case studies are presented to demonstrate the impact, challenges and the next steps in embedding Thrive into a whole school approach.

**Case Study 1. Hunters Hall Primary School**

Hunters Hall Primary school currently have 683 children on roll. There are 2 Thrive practitioners (a learning mentor and a teaching assistant) trained in Hunters Hall were employed solely to deliver Thrive interventions.

Hunters Hall currently use a targeted approach with their Thrive interventions, delivering 5 interventions a week in a group setting of 5 children per group. This is delivered for Year 4, 5 and 6, for a period of 6 weeks. Therefore, totalling 75 children participating in Thrive interventions on a weekly basis.

The Groups covers a range of topics, initially the first group of students taking the opportunity to co-produce the group’s rules and covering other areas such as ‘heroes’ and ‘what makes you special?’ A baseline of the child’s needs was recorded before the intervention and post intervention. In addition, the group was evaluated and measured as an outcome. In the data received from Hunters Hall’s interventions from 2016-2017 outcomes included:

- Whole group: boosted self-esteem and enabled them to manage friendships more easily.
- Whole group: Increased self-confidence enabling children to work well within a group, to speak in front of an audience and be active listeners.
- Whole group: Fewer occurrences of red and yellow behaviours logged. Children able to self-reflect on behaviour.

In addition, the individuals were assessed pre- and post-interventions to measure the impact of the intervention. Please note that initials represent the child’s name.
Table 1.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Class</th>
<th>Baseline: Motivation for developing skills</th>
<th>End: Motivation for developing ideas</th>
<th>Difference: Motivation for developing ideas</th>
<th>Baseline: Morals and values</th>
<th>End: Morals and values</th>
<th>Difference: Morals and values</th>
<th>Baseline: Understanding need for rules</th>
<th>End: Understanding need for rules</th>
<th>Difference: Understanding need for rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>EB</td>
<td>3N</td>
<td>42</td>
<td>62</td>
<td>20 (32%)</td>
<td>37</td>
<td>54</td>
<td>17 (31%)</td>
<td>41</td>
<td>64</td>
<td>23 (35%)</td>
</tr>
<tr>
<td>EG</td>
<td>3M</td>
<td>61</td>
<td>83</td>
<td>22 (26%)</td>
<td>50</td>
<td>71</td>
<td>21 (29%)</td>
<td>35</td>
<td>71</td>
<td>36 (50%)</td>
</tr>
<tr>
<td>CJ</td>
<td>3N</td>
<td>70</td>
<td>89</td>
<td>19 (21%)</td>
<td>44</td>
<td>68</td>
<td>24 (35%)</td>
<td>43</td>
<td>61</td>
<td>18 (29%)</td>
</tr>
<tr>
<td>AN</td>
<td>3S</td>
<td>67</td>
<td>86</td>
<td>19 (22%)</td>
<td>54</td>
<td>76</td>
<td>22 (28%)</td>
<td>38</td>
<td>71</td>
<td>33 (46%)</td>
</tr>
<tr>
<td>CE</td>
<td>3S</td>
<td>72</td>
<td>89</td>
<td>17 (19%)</td>
<td>45</td>
<td>77</td>
<td>32 (41%)</td>
<td>46</td>
<td>74</td>
<td>28 (37%)</td>
</tr>
</tbody>
</table>

Percentage is calculated from the difference between “baseline” and “End”. See Figure 1.

Figure 1
Impact on whole school approach

- Hunters Hall have reported that the Thrive training has raised staff awareness about children’s behaviour and as a school they feel more equipped to manage behaviour and the ability to support more vulnerable children.
- Children are aware of their support contacts and are visible across the school.
- Hunters Hall had no fixed term or permanent exclusions for the period of 2015-2016 and 2016-2017.
- Hunters Hall have developed a Thrive area that includes a sensory area where interventions are delivered.
- Since using the Thrive approach, Hunters Hall report that they feel more equipped with working with CYP’s emotional and wellbeing needs.

Feedback and next steps

- The Thrive approach takes time to fully embed as staff need to be made available to deliver interventions.
• To increase parental engagement with the Thrive approach
• For Thrive to deliver a whole school awareness session for all staff.

Case Study 2. Warren Junior School

There are two Thrive practitioners at Warren Junior school. They have also cascaded their skills to three teaching assistants who use the Thrive interventions at the school. Trish Taylor, a teacher at the Warren school teaches in the mornings and delivers Thrive interventions every afternoon for those who have been identified as having lower abilities in Math and English. Trish reported that the school had an existing framework that supported the implementation of the Thrive approach. Trish reported that in the initial phase of embedding Thrive practice into their school, they delivered 12 psycho-educational assemblies to the school children which included aspects of Thrive such as peer support and informing children how to identify other children who may need support. Trish reported that one of the challenges of implementing Thrive across the school is that in the initial phase staff were resistant to the approach as it challenged existing ideas of behaviour management. However, Trish reports that staff have now witnessed the improvements and impact of the Thrive work which has resulted in a change of attitude.

Other actions that the Warren school have implemented because of using the Thrive approach includes:

• Delivered 3 inset sessions for all staff (including kitchen staff/caretaker, etc.)
• Provided additional voluntary continued professional development for staff about the Thrive approach
• Have started a lunchtime club providing targeted support to encourage social skills for those who are struggling at playtime.
• Have used the action plans with parents
• Developed a peer mentoring support system
• Have developed a ‘Chill and Chat’ room whereby students can drop in to speak with a member of staff
• Every quarter, the Warren school assess the whole school and each class will have a Thrive target.
• Thrive practitioners offer advice and guidance to staff

Mid-course summary of delegate feedback

Below is anonymised data received about the impact of the training.

“Great day- made me think. I am already planning next term.”

“Enjoyed today’s session about dealing with the approach to teenagers’ behaviour.”

“Thought provoking, emotionally charged session which was handled thoughtfully for participants.”

“The day was emotional but very insightful.”

“Really enjoyed sharing our action plans and deciding which strategy to use in developing areas of need.”

“Very informative session.”
**Next Steps as stated by previous impact report (October 2016)**

1. **Finalise and agree the Thrive action plan**
   The Mental Health Adviser for LA and Thrive Trainer Sharon Gray to meet in January to develop a robust Thrive implementation plan to assist schools in embedding approach.

2. **Explore benefits between the Thrive approach to holding and physical interventions such as Team Teach.**
   Team Teach is a de-escalation strategy used when CYP are in a state of emotional and mental health crisis whereas the Thrive approach is a whole school system and approach at working with all CYP’s wellbeing needs.

3. **Further Overall impact to be gathered**
   Ongoing, accurate data is required from all schools so that information can be analysed to provide a clear understanding of needs for both school and young people.

4. **Support Schools to sustain Thrive**
   This can be supported by the LA and Thrive implementation plan for schools to be guided with this process.

5. **Consider further Thrive Continuing Professional Development/training.**
   A Thrive network meeting has been set up and was held on the 26th of September 2017 and recommended that this meeting be held on a regular basis. This serves the purpose to celebrate achievement and identify possible issues together, through creative thinking we can facilitate discussion, peer support and possible solutions.

**Summary**

Due to limited data provided by school, conclusions were drawn from schools who provided feedback about the impact of using the Thrive approach. When schools adopt a whole school approach to meeting the emotional wellbeing of their CYP, the ethos, culture and environment fosters support and improved outcomes for CYP. However, due to Thrive being a whole school approach this has implications on policy, practice and resources. Therefore, it is important to note that it may prove challenging to draw accurate conclusions at such an early phase of the initiative.

**Recommendations**

To collect outcome data from all schools who use the Thrive approach. This will provide a broader summary of the impact across schools in LBBD. Outcomes and data collected should include, individual attainment and attendance details for children and young people who participate in Thrive interventions.

To keep an up to date list of all Thrive schools and practitioners.

To continue with the Thrive Network meetings to share expertise and knowledge.

For all schools to be made aware of Thrive and how it can be used in schools. This can be delivered within the implementation plan.

For schools that adopt the Thrive approach, to have at least two full time Thrive practitioners on site for the Thrive approach to be effective.
For school staff to be aware of the similarities and differences of using Thrive and Boxall and how they can be used collaboratively.

For Thrive, Schools and LA to develop an implementation plan to ensure that the senior leadership team (SLT) are involved in the implications and benefits of using the Thrive approach.

Appendix 1-

LBBD Schools who participated in Thrive training

1. Roding Primary School
2. Thomas Arnold Primary School
3. Riverside Bridge School
4. Godwin Primary School
5. Hunters Hall Primary School
6. Manor Longbridge Primary School
7. Marks Gate Junior School
8. George Carey Primary School
9. Henry Green Primary School
10. Eastbury Primary School
11. Richard Alibon Primary School
12. St Peters RC Primary School
13. Warren Junior School
14. Southwood Primary School
15. Parsloes Primary School
16. Marks Gate Infants School
17. Ripple Primary School
18. Grafton Primary School
19. William Ford Junior School
20. John Perry Primary School
21. Dorothy Barley Junior School
22. The Leys Primary School
23. St. Teresa RC Primary School
24. Dagenham Park C of E Secondary School
25. Eastbrook Comprehensive Secondary School
26. The Jo Richardson Community School
27. The Sydney Russell School
28. Mayesbrook Park Campus
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Introduction;

More than Mentors is a new and creative model of peer mentoring, which has been co-designed and co-delivered as a pilot study in east London. Through the Department of Health’s “health and social care volunteer fund” Community Links has been invited to take the lead in rolling this programme out in 5 boroughs across the capital – with Jo Richardson Community School and Eastbury Community School, both in London Borough of Barking and Dagenham, being the first schools where we have successfully delivered this intervention.

More than Mentors draws on the best evidence from across the field, exploring peer mentoring as a way of preventing significant mental health conditions in young people. Peer mentoring – where older adolescents support their younger peers – has been shown to prevent the development of mental health problems in research studies. However, frequently in practice, little attention is given to the evidence around recruitment, training and support of these volunteer mentors. Community Links, with a wider partnership team (including East London Foundation Trust and the Anna Freud Centre) are working with adolescent volunteer through to commissioners, to further co-develop, test, evaluate and subsequently disseminate an approach which sustainably delivers an effective voluntary peer mentoring workforce across London.

Working relationship between More than Mentors, Barking and Dagenham CCG and wider stakeholders;

Starting working with the borough in March 2017, the More than Mentors team have been working alongside the Barking and Dagenham CCG and the Education Department within the local authority to ensure that this programme adds value to the wider preventative agenda of the Local Transformation Plan (LTP) – recognising the need for building resilience as one of the key objectives when looking to support young people earlier, and prevent the development and emergence of significant mental health needs.

As the project has developed and evolved, we have been able to liaise with the wider Children and Young People’s workforce within the borough, and have met with the local CAMHS service to ensure there is robust and transparent governance and safeguarding procedures between the project delivery team and the wider networks responsible for Children and Young People’s Mental Health and safeguarding.
Outcomes and Evaluation of More than Mentors between March - July 2017;

The evaluation of the More than Mentors is being conducted independently by the Anna Freud Centre - Evidence Based Practice Unit. This evaluation is an iterative process, combining both quantitative and qualitative components. From our initial data we have the following findings from the 2 secondary schools we have worked with so far;

Total participants in the programme: N = 40 (20 mentors and 20 mentees, 75% female)

<table>
<thead>
<tr>
<th></th>
<th>Mentors</th>
<th>Mentees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>10% male, 90% female</td>
<td>40% male, 60% female</td>
</tr>
<tr>
<td>Mean age</td>
<td>16.4 years</td>
<td>13.2 years</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>27.3% White British</td>
<td>34.8% White British</td>
</tr>
<tr>
<td></td>
<td>18.2% Any other white background</td>
<td>21.7% Any other white background</td>
</tr>
<tr>
<td></td>
<td>13.6% Black African</td>
<td>8.7% Black African</td>
</tr>
<tr>
<td></td>
<td>13.6% Bangladeshi</td>
<td>8.7% Other</td>
</tr>
<tr>
<td></td>
<td>9.1% Pakistani</td>
<td>4.3% Bangladeshi</td>
</tr>
<tr>
<td></td>
<td>4.5% White and Black African</td>
<td>4.3% Any other black background</td>
</tr>
<tr>
<td></td>
<td>4.5% Other</td>
<td>4.3% Chinese</td>
</tr>
<tr>
<td>FSM eligible</td>
<td>27.3%</td>
<td>52.2%</td>
</tr>
<tr>
<td>SEN support</td>
<td>0.0%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

Quantitative Analysis –

We are awaiting analysis of the quantitative data that is being processed from this first cohort, and expect this to emerge in early November 2017. The measures that make up the child wellbeing questionnaire include the Student Resilience Survey (SRS), the Strengths and Difficulties Questionnaire (SDQ) and the short Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS). We have also been looking at students attendance and attainment at school, alongside wider demographics.

Qualitative Analysis -

Looking at the more qualitative feedback we have applied 3 approaches so far;

1. Mentor Training Feedback Questionnaires – completed by all Peer Mentors after they have completed their training
2. Independent semi-structured interviews with Mentors and Mentees at the end of mentoring process – conducted by a research assistant from the Anna Freud Centre
3. Mentoring experience questionnaires – completed by mentors and mentees at the end of the mentoring process.
Exploring this feedback further;

1. **Training feedback questionnaires** – these have provided feedback about specific domains of the training, and we have selected quotes from a variety of surveys;

   **Skill-building** - “I understand the difference between being friends with the mentees and being their mentor as they communicate in different ways, e.g. mentors suggest solutions and friends give direct answers to the problem”.

   **Confidence** - “[I feel more confident in becoming a peer mentor] due to the regular and open discussions we have, as a group, we discuss feelings the mentee may feel and how to get them to open up, in the most relaxed and informal way possible”.

   **Practice** - “It was helpful as I could visualise the human errors which could be committed during the sessions. So I understand ways from avoiding these errors” “Being a peer mentor puts you in a position where you have one-to-one contact with your mentee. The role plays were often observed and watched by all the group, not allowing us to act as ourselves”.

   **Benefits of participation** - “It is very beneficial to your knowledge regarding mental health as well as your future career path. You also help someone whilst doing this”

2. **Independent Semi-structured interviews with mentors and mentees**;

   A research assistant from Anna Freud Centre has been able to analyse 4 (2 mentees, 2 mentors) interviews (out of a total sample of 8 interviews) to explore themes and views about the mentoring process. The research questions asked in these interviews were;

   **What was helpful about More than Mentors?**

   **What was not as helpful, or what could be improved?**

   Some emerging findings include;

   (i) **For the Mentors**;

   **What was helpful about More than Mentors?**

   Mentors experienced personal development and growth - “I’ve definitely built on myself as a person. Like I’ve become more patient, definitely. And I’ve just become more tolerant as well, ’cause what feels like a really tiny thing to me is a massive thing to [my mentee]. So I’ve been able to take things into perspective a lot more. It’s probably made me a lot more well-rounded as a person, so that’s good.” – Mentor.
Mentors developed new skills - “[My mentee and I] got on really well, but I’d say it was still professional, in the sense that I was still there to help her. I wasn’t just there to be like, I’m gonna wave a magic wand and everything’s gonna be better, or I’m gonna be your friend and talk to you for an hour. It was a brilliant mix of being able to be a friend but also be able to help her out” – Mentor, Cohort 1

Mentors felt genuinely helpful to mentees, which gave them a sense of accomplishment and happiness.

What was not as helpful, or what could be improved?

Mentors had conflicting views about the length of the mentoring sessions, with one finding them too long and another not long enough.

One mentor said they would have liked to have had a recap of the training at the end of the programme.

(ii) For the mentees;

What was helpful about More than Mentors?

Mentees felt listened to by their mentor- “I: How’d you feel at the beginning of each meeting with your mentor? P: Happy. ‘Cause I know like, she’s gonna listen. And sit there and not judge me on it. ... she proper listens. Like, sometimes, no one listens. But she proper listens.” – Mentee, Cohort 1

Mentees felt they could speak to their mentor about things they couldn’t talk to friends or family about.

Mentees learned tips and tricks from their mentors about managing anger, improving friendships, and building confidence at both home and school - “I: What kinds of things have you learnt after working with your mentor? P: To be nice to people. ‘Cause like, sometimes like, if they barge me, I’ll go like, what, who you barging? And I get really rude to ‘em. And now I don’t do that no more, ‘cause I’ve learnt to control it and just walk away from it.” – Mentee, Cohort 1

One mentee wanted to become a mentor to help others like he was helped.

What was not as helpful, or what could be improved?

One mentee wanted to know more about why they were recruited, as they were uncertain why they had been chosen for the project since they hadn’t volunteered.
More than Mentors Progress Report for CYP Mental Health Local Transformation Plan, Barking and Dagenham Clinical Commissioning Group

3. Experience of mentoring’ questionnaire – key findings expressed as a Wordle

Mentees words to describe their mentors

Mentors words to describe their mentees
More than Mentors Progress Report for
CYP Mental Health Local Transformation Plan,
Barking and Dagenham Clinical Commissioning Group

Next steps

Over the few months we have been liaising with schools and youth groups across the borough to explore the opportunity of delivering the More than Mentors programme within their settings. We have also been looking to adapt the programme to ensure it works for the young people and the setting, rather than making it a “one size fits all” model.

As a result we have the following programme of activity;

<table>
<thead>
<tr>
<th>London Borough</th>
<th>School/ Community Group</th>
<th>Numbers of Mentors</th>
<th>Start date for Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>Jo Richardson Community School</td>
<td>30 mentors recruited and interviewed</td>
<td>2nd October and 4th October (2 cohorts of training)</td>
</tr>
<tr>
<td></td>
<td>All Saints School</td>
<td>15 mentors recruited</td>
<td>2nd November 2017</td>
</tr>
<tr>
<td></td>
<td>Eastbrook School</td>
<td>15 mentors recruited</td>
<td>November 2017</td>
</tr>
<tr>
<td></td>
<td>Robert Clack Community School</td>
<td>12 – 15 mentors recruited</td>
<td>November 2017</td>
</tr>
<tr>
<td></td>
<td>Eastbury Community School</td>
<td>10 mentors to finish mentoring programme – COHORT 1</td>
<td>November 2017 – looking co-develop MtM Ambassadorial role with students.</td>
</tr>
<tr>
<td></td>
<td>Dagenham Park schools</td>
<td>Up to 15 mentors</td>
<td>November 2017 / January 2018</td>
</tr>
<tr>
<td></td>
<td>Barking and Dagenham Young Carers</td>
<td>Up to 10 mentors*</td>
<td>Taster session run with Young Carers in July 2017. Looking for training to start January/February 2018</td>
</tr>
</tbody>
</table>

* - The recruitment of this group is dependent upon a request from the UCL ethics committee that we can recruit mentees aged 9 and 10 years of age – given the requests of this specific group.

If we are able to complete all the work outlined above, then we hope to have trained up a minimum of 120 peer mentors by early 2018, and would therefore hope to have supported 120 mentees within the borough by the end of the Spring Term 2018.

Our aspiration is to build on the supportive relationship we have with the Barking and Dagenham CCG and the Barking and Dagenham’s Department of Education in order to be able to offer More than Mentors in every secondary school across the borough, by the completion of the project in March 2019.

In 2018 we are also aspiring to ensure we have a Training the Trainers package in place and available to staff within Barking and Dagenham
More than Mentors Progress Report for
CYP Mental Health Local Transformation Plan,
Barking and Dagenham Clinical Commissioning Group

Reaching Out

Given the working relationships we have developed within the borough of Barking and Dagenham, we have also been able to propose further suggestions to support the mental health and emotional wellbeing of children and young people within the borough – work that is “reaching out” beyond the original remit of the More than Mentors brief, but hopefully will enable a more sustainable impact.

There are 2 significant suggestions that are emerging;

1. **Supporting vulnerable students during transition** – Following conversations with some of the primary schools within the borough, we have are looking to explore how these More than Mentors peer mentors could support students who are anticipated to experience a difficult transition from primary to secondary school. Being aware that problems around transition can significantly contribute to disengagement from education and learning, and subsequently lead to students being excluded and disenfranchised, this is very much a preventative approach to emotional wellbeing.

2. **Launching a student-led, schools-based mental health conference** – With such a considerable number of students being trained within the borough as More than Mentors peer mentors we are keen to ensure that they support the wider student population and help articulate a voice about young people’s mental health across the borough. In the next Mental Health Awareness Week (May 2018) we will be looking to co-design and co-produce a mental health conference with young people from across the borough to raise awareness about mental health and emotional wellbeing, to challenge mental health stigma and to ensure that children and young people within the borough are at the heart of taking our services forward – **Nothing About Us Without Us**.

These are exciting times for the More than Mentors project as we start to scale up the original work and begin to reach the numbers that we feel will demonstrate significant impact. But we are very aware this work would not have been possible without the support of the Barking and Dagenham CCG and the borough’s Education Department. Thank you.

If you require any further information please contact;

Dr Nick Barnes, Strategic Lead for More than Mentors  nick.barnes@community-links.org
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Thrive LDN Barking and Dagenham Community Conversation Report
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Introduction

Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners.

It is supported by the Mayor of London and led by the London Health Board, in partnership with Greater London Authority, Healthy London Partnership, NHS England (London Region), Public Health England (London Region) and London Councils.

On 4 July, Thrive LDN launched 6 aspirations for the capital. But the only way we can achieve these is by working with Londoners.
**Purpose of document**

Barking and Dagenham led one of the first Thrive LDN community workshops based around the six aspirations for London. The conversations were focussed on how to work together to achieve these aims locally.

This document summarises some of the outputs from the event as well as proposing actions which could be adopted locally.

To make real change happen, we need to work together and take ownership of some of these ideas. No single organisation or individual will achieve these alone, so we challenge everyone who attended the workshop to think about how they can contribute in their own way and how they might work with others.

**Community workshop in Barking and Dagenham**

The community workshop was run by Thrive LDN and Mental Health Foundation. Around 73 people attended the workshop, including residents, service users, carers, councillors, council officers, NHS providers and commissioners and representatives from community and voluntary sector organisations.

The event included introductions to Thrive LDN from Dan Barrett, Senior Communications and PMO Lead, a summary of the local context from Dr Matthew Cole, Director of Public Health for Barking and Dagenham and a summary of the research from Antonis Kousoulis from the Mental Health Foundation.

We then held workshop discussions on the 6 Thrive LDN aspirations to discuss how they may be achieved locally. Facilitators on each table recorded the discussions and the main points were captured.

A two page summary follows, which gives a light overview summary of the discussions.

Following the two pages you can see the full facilitator notes if you would like more detail.
Overview summary of workshop tables

1. A city where individuals and communities take the lead

Key themes and actions:

- Particular local challenges that need to bear in mind: fluid diverse community
- Actually lots of great local community organisations exist, but lack of knowledge of them, be good to map assets centrally
- Focus should not about mental health, but good mental health could be the outcome
- Skill up local young people to become peer advocates
- Faith groups potentially a catalyst to lead
- Bring activities/engagement to people in their own environment for early interventions: pub, barbers, schools, faith groups
- Let community commission their own stuff and run it but provide support too

2. A city free from mental health stigma and discrimination

Key themes and actions:

- Campaigns such as Time to change help break down stigma and discrimination, workplace pledges, This is me campaign (promotes personal stories)
- Use local media to feature positive stories on mental health, inform on clear terminology, challenge stigma online
- Train the trainer – sessions in schools for staff and young people
- Mental health awareness week and day is only once per year should be more events which are fun, and get people from different ages and backgrounds to connect
- Educating faith communities/local business owners (like barbers for men, or nightclubs for young people for e.g.)
- Educate young people in schools, peer mentoring, speakers in school

3. A city that maximises the potential of children and young people

Key themes and actions:

- Work with families to help change social and cultural stigma
- Co-produce services with young people
- Promote and support community young mental health champions, create a community youth forum, and support peer mentoring projects, diverse role models
- Develop mental health education in schools, with more activities based on well-being
- Supplement this with increased access to services such as a school counselling, interventions before point of crisis
- Provide mental health training to all teachers and support workers
- More resources to bridge the gap between children and adult services
- Parenting classes and better communication of available services
- Borough is disconnected- needs ‘togetherness projects’ such as a community garden space and community festivals where could raise awareness
- Support and collaborate with different community leaders

4. A city with a happy, healthy and productive workforce
Key themes and actions:

- transparent communication, particularly where organisational change happening is very important and employees should have opportunity to discuss and express feeling regarding change
- Where people been off sick, shouldn’t just mean return to exact same job, need flexibility option
- Insecure jobs, zero hours etc. creates stresses
- Training for staff and managers important. Difficulty that only larger organisations could afford
- Need to support small businesses both in training but also hiring those with mental health challenges
- Positive workplace environment where people get along important
- Support those working in caring roles or where deal direct with people in potentially distressing situations, e.g service industry jobs. Managers should be trained to see distress signs and check in with their staff after a particularly difficult day
- Mental health champions in the workplace
- More support to fulfil individuals’ potential and talk about goals and aspirations rather than just targets and KPIs.

5. A city with services that are there when and where needed

Key themes and actions:

- Idea of creating a wellbeing hub in the borough
- Need holistic and joined up services, including recognising cases of mental health challenges where people have multiple and long term conditions
- Access to advocacy in the borough has been restricted. More flexibility needed at work. “Mental health vocational services” work well but are stretched.
- Services stretched
- Growing population, also very diverse, different cultures may not recognise mental health traditionally
- Some good examples around of innovative service delivery and digital tools, innovating

6. A zero suicide city

Key themes and actions:

- More information needed to inform any organisations’ prevention models (e.g. an audit of methods could inform ways to prevent methods of suicide)
- treat mental health problems at an earlier point and reduce the risk of suicide
- After critical ‘999’ care, there is lack of follow up for - maybe use GPs more
- Train those in the community to discuss mental health (e.g. Mental Health First Aid training for hairdressers/barbers, bartenders, receptionists, those within public bodies or faith groups)
1) A city where individuals and communities take the lead

Challenges

- Very fluid community, transient population, changing demographic and a lack of integration
- Accessibility - language barriers, cultural barriers, social isolation
- Some funding issues, voluntary sector struggling and heavy cuts to services in the area
- Taboo of any association with mental health
- People who have accessed mental health services and become detached from community then on their return home not integrated into community
- Benefits agency should recognise participation in volunteering/community projects
- Areas such as Gascoigne being deconstructed means connectedness and community cohesion are gone – people moved to temporary accommodation
- History of crime in areas is destabilising and has isolated some people who are fearful

Local programs tackling these challenges

- Digital provision - B&D seen as leader-peer support app, gives autonomy
- Online counselling for young people, targeted roll out, no referrals or lists, signposted, access is open ended
- Studio 3 arts - community project
- Youth forum made a good film around breaking stigma
- ‘Big Local Project’- Chadwell Heath- Money to help local people act together
- Peaced Together, a therapeutic art programme developed by Heidi Singleton at Community Resources, Lifeline church in Barking [http://www.peacedtogether.co.uk/](http://www.peacedtogether.co.uk/)
- Farm – have activities around positive mental health and wellbeing
- Community health champions - volunteers are residents who talk to other residents. Volunteers build confidence, wellbeing improved when give something back. Can build on success-target places where people could have greater leverage- faith groups etc.
- Football club run inclusive events
- Clubs for older people which reduce social isolation in some of the sheltered housing. Work well where older residents run them themselves with some support. Empowers people.
- Barking College
- Example of an evening club in Hertfordshire where older people go, activities, dancing, karaoke etc- There is a charity in London- South London Cares and North London cares who do this sort of thing
- Time to Change-sharing own experience can empower others- set up a network

Ideas for more community cohesiveness

- Join up people in the borough - up to date directories of what exists, regularly monitored
• Focus on how network of sports clubs in the borough can enable broader engagement
• Skill up local young people to become peer advocates of services or activities
• Focus should not about mental health, but good mental health could be the outcome
• Faith groups potentially a catalyst to lead
• Bring activities/engagement to people in their own environment for early interventions- pub, barbers, schools, faith groups
• Let community commission their own stuff and run it but provide support too, don’t shift responsibility. Example of club set up by MH service users – collapsed as needed the support. Need to remove these barriers
• Different needs and expertise in the community- could then match make- e.g. new to the area, with someone who is settled. Needs to be facilitated and structured
• Street parties
• Activities for people in 30s-50s – get missed out of the older and younger activities
• Educate people that wellbeing is part of mental health
• Use different language in events improving mental health- self-care – a way of recognising what you find enjoyment in, understanding people’s passions, remove terminology.
• Incorporate into what’s already there- health survey ask how are you today
• In first instance people want to speak to friends and family usually just access services when get much more unwell that people generally go to services. Others are better placed to provide early interventions in the community
• Mental health can be over medicalised-focus on experts providing services. But other things people are involved in can have a knock-on effect. Experts don’t have to ‘social prescribe’
2) A city free from mental health stigma and discrimination

Local programs tackling stigma and discrimination

- **Youth forum** – promotes youth engagement. It’s a team of young people with an aspiration each year – this year they did mental health surveys in schools, and it’s now into phase 2. Talking about mental health like this whilst engaging youth to participate is a good way to tackle stigma.
- **Kooth** – online counselling. Allows young people to have access to counselling services whenever, wherever – more accessible.
- **DABD** – focuses on the elderly, to reduce isolation, offer peer support to their friend/neighbour, and foster community development. It encourages the elderly to do things they like together, and it includes helping them digitally set-up so they can keep in touch with their families who may live far away.
  - Another program focusing on the elderly is called Castle Point.
- Another program that was set up to boost positive mental health involved young men. The young men went to the gym together, built their self-confidence, energy, motivation and connected which could help them express themselves about their mental health.
  - Another program focusing on youth and physical activity is the youth leaders program.
- **Progress project**: Young people with disabilities connecting and sharing their story over scrapbooking.
- **Good neighbour guide to better the community**: Talks about events and issues in the community -> we could get mental health into this guide.
- **Time to change program to help break down stigma and discrimination**: Campaigns and champion network, workplace pledge.
- **Train the trainer**: Sessions in schools for staff and young people.
- **Peaced together** – therapeutic art program, taking broken things and repairing them -> teaches about resiliency, continuity.
- **This is me**: Speaks of personal experiences, promotes personal stories.
- **Mental health awareness week and the mental health awareness day**: Is only once per year, and it appears rushed, with a small budget. There should be more mental health events which are fun, and get people to come out and connect. It needs to be a more holistic experience with people from different ages and backgrounds coming in.
- **Programs that promote young offenders and people with learning disabilities engagement in the community**.
- **Mazebook House**: About medication: Forum for people to be heard, how it makes them feel -> work towards better living, independence, accepting life with long-term medication.
- **There is a need to promote these programs, and focus on delivery** – but there is no capacity/fund to handle more people.

Community

- Asking the local people what they want/need + feedback follow-up, promote transparency so they know what is happening and that their feedback truly means something.
• Understand and share information about B&D demographics to promote more awareness amongst different cultural groups
• Awareness of the prevalence of mental health issues, and awareness of stigma
• Coffee shops – building places where people feel safe, and can connect
  • Safe space where people can talk about issues that they have, for e.g. at home
• Local champions and role models sharing their story and testimony
  • Educating faith communities/local business owners (like barbers for men, or nightclubs for young people for e.g.)
  • This facilitates conversation for people who may not be willing to talk to a professional. Makes it accessible.
  • Changing the narrative – show people with mental illnesses as capable people -> normalise mental illness
• Create mental health badges like the breast cancer ribbons to create a sense of community

Services

• Make mental health first aid training more enterprise-friendly (because as of right now it’s a little long) to encourage the workplace to train employers
• Workplace: wellbeing activities, fighting the “workplace culture” and towards building a happier one. Getting to know local companies and businesses to get engaged
  • Looking Ahead support: Inviting local businesses into the mental health services on open days
• Education – start young, encourage young people (a lot of work in B&D is done with the elderly but not much on mental health)
  • Continuous education program in schools, involving the families and parents too
  • Education VS practical support: e.g. we can learn about suicide but when it comes down to it can we deal with it?
  • Create a curriculum. Everyone has mental health, it’s a spectrum. It’s different from mental illness. Celebrate positive mental health
  • “Don’t suffer in silence” – training young people in mental health first aid
  • Peer mentoring
  • Speakers in school
• Media, social media – educate on clear terminology, post photos challenging stigma. Challenge stigma online
• Destigmatise mental health services – because people as of right now are scared to approach them and stigma acts as a barrier to access service. Focus on strengths rather than difficulties
  • Rebranding of IAPT’s was done recently – “Recovery model”
3) A city that maximises the potential of children and young people

**Culture and Language**

- Focus on changing language used around mental health, make it ‘part of everyday conversation’. This shift can happen by breaking down the stigma, but also by promoting mental health as a ‘part of everyone’.
- There needs to be supportive work done within families to help change the social and cultural stigma, as ‘without changing the home environment, young people will find it difficult to uphold changes made at school’.
- Co-produce services with young people, making them central to the change work. From working with young people, there can be a greater understanding of the range of issues they face, e.g. cyber-bullying, eating disorders.
- Promote and support community young mental health champions, create a community youth forum, and support peer mentoring projects.

**Services**

- Further develop mental health education in schools, with more activities based on well-being such as mindfulness sessions. Yet also to supplement this with increased access to services such as a school counselling.
- Provide mental health training to all teachers and support workers, providing insight into what the ‘tell-tale signs are’. This needs to include mental health first aid training.
- More resources need to be put in to ‘bridge the gap between children and adult services’.
- The concept of mental health and well-being needs to be developed from an early age.
- There must be more ‘before the point of crisis’ interventions, with the reduction of waiting times from referral to psychological services. Signpost young people to community services during this period.
- Focus on parenting workshops, to skill them in understanding mental health issues and how to notice signs of mental health difficulties.
- There needs to better communication of what services are available and how to access them.

**Community**

- The borough feels ‘very turbulent and disconnected’. There needs to be ‘togetherness projects’ such as a community garden space.
- Organise community festivals as an opportunity to ‘raise the awareness of mental health in a more personal way’.
- Raise the aspirations of young people in the area, offering opportunities not just within the borough.
- Have diverse and realistic role models, for young people, come and talk in schools and youth clubs.
- Support and collaborate with different community leaders
- Work with the local community to raise awareness of mental health in a ‘fun and creative way’ e.g. art workshops.
4) **Thrive LDN objective: Developing a healthy, happy and productive workforce**

**Culture and Language**

- Companies going through a transformational change needs to recognise the impact it has on employees, and department heads should seek methods to assure employees – such as transparent communications surrounding regarding the change and the opportunity for employees to express their feelings regarding the change to the relevant department, such as HR.
- When people apply for jobs, they often leave the box blank regarding mental health/disabilities as they do not want a reason to go through an occupational health interview.
- The culture of constantly being ‘on’ and ‘awesome’ is hard for people with more introverted personalities. Being expected to have a huge smile always is difficult – made even harder by a present mental health problem.
- Those working zero hours contracts, temp roles or so called ‘disposable’ roles like restaurant staff, builders, retail staff need protection. Not having reliable hours is distressing, as is not knowing if you will make rent next month - all that paired with the long hours can be debilitating on one’s mental health.
- There is often a pressure on resources within the office, such as finding the space for people to work quietly, which is why remote working or working from home can be exceptionally useful for people experience mental ill health.
- Contrastingly, always working remotely can have negative consequences on people’s mental health as being in constant transit can be isolating – as can working from home all the time. A balance needs to be struck, which usually comes down to giving employees the choice.
- Recovery shouldn’t mean going straight back to your exact old job - reduced hours should be an option or working from home. Alternatively, part time roles could be brought in – although this is difficult as it is near enough impossible to survive on part time wages in London.
- Managers are often promoted because they are good at their job, not good with people. This must be addressed as managers have a responsibility to look after their employees’ wellbeing, as well as ensuring they are productive at work.

**Services**

- Temporary workers or self-employed contractors are often so consumed in daily operational tasks, they forget to take a break and are more likely to risk burnout, especially they don’t feel as if they can take leave, sick days etc.
- Bereavement can trigger low places for individuals, and all workplaces should have measures in place to support employees during these difficult times – especially as individuals process bereavement differently.
- Mental Health First Aid training is only an option from big corporations who can afford to invest money and people’s time – not small businesses who already find it difficult to support those off work with mental health problems as their absence is felt harder.
- Small businesses feel less inclined to hire those who have disclosed mental health problems as they are worried about employees needing to take long
term sick leave. We need measures in place to stop this – but to support small local businesses hiring those with mental health problems, instead of punishing them for not. (This sentiment was expressed by several attendees).

Workplace Community

- We must ensure that those who work in roles looking after other people such as carers, or on the front line such as hospitality staff, receptionists or call centre operators are supported. Exchanges with others can often be difficult in these roles, with staff often exposed to verbal abuse. Managers should be trained to see distress signs and check in with their staff after a particularly difficult day.
- Getting along with the people you work with is imperative. A good talk at the water cooler, or during lunch, can do wonders for people’s wellbeing and sense of belonging – your network doesn’t end with family and friends. For those lacking in family or friends, friendly colleagues can be a huge comfort.
- Mental health champions in the workplace – those with lived experience who are happy to talk about mental health and therefore helping to reduce stigma are essential. The less clinical talk, the better – as not everyone can relate to it. We are human.
- More support to fulfil individuals’ potential and talk about goals and aspirations rather than just targets and KPIs.
- Workplaces need employee assistance programmes in place, as well as ensuring mental health is included in the equality & diversity policy and procedure and taken seriously by not just HR, but all line managers too.
5) A city with services that are there when and where needed

Challenges

- We know of local connection between LTCs and mental health problems, so let’s train people more in mental health. Isolation is a big issue as well, and migration a big factor - the IAPT services are stretched (waiting time for referrals is long)
- Service providers are trying to inform people that they are amicable. Probation officers support young people but they are not connected to all local services. Can address negative feelings earlier.
- Women with multiple and complex needs have mental health low on their focus and agenda. There is a gap there in dual treatment services, we need more holistic and joined up services that links up with community services
- Coordinators to move in the community to listen to people (who are passionate). Even high cost services support people to stay in work. Some services are discriminatory, including GPs (some don’t know how to talk to people with mental health problems). Some people are not comfortable talking to their doctor.
- Create availability for people who are at risk of experiencing symptoms. First point of contact is important. 22% increase in population – not everyone understands mental health problems causes and they are isolated. Conflict with traditional cultures.
- Younger people don’t always know how to access services and they often have to travel far for them. There are great people in the services (but stretched)
- Waiting times are long for certain problems, especially enduring ones. Community services need to work closer together.
- Access to advocacy in the borough has been restricted. More flexibility needed at work. “Mental health vocational services” work well but are stretched. Difficult to access benefits.
- When service users are out of hospital some GPs don’t accept locally new registrations. Not enough funding for people with multiple problems.
- People are pushed to full-time work but people with mental health problems struggle. A job is everyone’s right.

Examples of good practice – making the most of what’s already implemented

- People are not accessing hospitals – delays for beds; but this is getting better in B&D compared to London. Community teams manage a lot of acute incidents. Good that hospital stays are short and that there is a collaboration with community services
- Community pharmacists currently run a pilot project for people with mental health problems to be referred to them if discharged from hospital.
- Highlight the voice of people’s stories – this can be developed – “Big White mall”: online peer support for some residents: online unlimited access for local residents
- With local Transformation Plans, we have piloted many projects (e.g. PPP) -> need to have conversations about what they want to see. There are good seeds of good practice, so we can capitalise on that
- Some of it is piloted in schools, trying to reach Children and Young people – successful so far. Children’s centre and library in Thames View is often empty – we can improve that
- Idea of creating a wellbeing hub in the borough – passion to make it work. Example of other boroughs that have done this – physical places and outreach workers.
- Access to A&E was fine for self-harm but the on going referral to specialist services was delayed because of capacity. We need a tier that is in-between, perhaps more social workers out of clinical services. Attempting to do that in B&D
- Samaritans: very good service, generic counselling services
- MIND offers free counselling and they are community-based; Arts activities for people on the waiting list.
- Kooth – online counselling services for young people and signposting
- Mental health street triage works well in B&D – team of mental health professionals support the police.
- Women’s groups are available and are very good. Recovery college as well. But a lot have been cut. Such schemes could include primary and secondary care + focus on prevention. Same for young people – support prevention, e.g. The listening zone (TLZ)
- Statutory services are covered but other interventions are not accessible, like in DA services. The Bromley-By-Bow centre in another borough is a good example of social prescribing. Peer support through one scheme – need to enable people with lived experience to take the lead -> be facilitators
- Gardening scheme that was not taken up. But there are social activities for people with learning disabilities like group trips. Need for equal work and activities -> there are some for swimming and air football for service users.

Opportunities for prevention

- Next step can be disintegration and highlight community services and commitment by the council for those with enduring problems. Local Authority staff are trying to set up more resources as there aren’t many social services locally – preventative services can be further developed; upskilling local workers. No MH-specific peer-support schemes in B&D – except “Big White Mall” (see below for more details)
- The council is working towards a “hub”-type scheme, but more focus is needed in primary care and up skilling GPs. Examples of good practice in other boroughs (e.g. “Integrated project” in Haringey). More focus earlier on to help people start feeling better. Using simple tips for individuals and mentoring
- A lot of communities don’t recognise mental health -> more resources through prioritising prevention
- Support people from hospitals in the crisis services project. The crisis care service is meant to be there but it doesn’t always work. There are massive expectations and demand for services but they are not always available -> so we need to fill gaps before crisis with a focus on prevention when first symptoms appear
6) A zero suicide city

Prevention

- More information is needed to inform any organisations’ prevention models (e.g. an audit of methods could inform ways to prevent methods of suicide)
- Prevention is key in this area to treat mental health problems at an earlier point and reduce the risk of suicide and it would be better for the individuals and more cost effective if support was provided earlier.

Frontline Services

- Cuts to frontline services mean lack of appropriate and timely services when needed (often referred to inappropriate services).
- After critical ‘999’ care, there is a lack of follow up for individuals.
  - Individuals are at risks of ‘bouncing’ between services
  - Waiting lists to services mean individuals’ mental health could worsen in the meantime.
- Possible to use GPs more – but recognise with waiting times etc., this may not be practical.
- Less support available for those over 16
  - Could target groups particularly at risk e.g. young offenders.
- Possibility of creating an app in which individuals can text IAPT if they are in a crisis point.
  - Will help individuals when ‘in-person’ support has long waiting lists.

Community

- Mental health is not talked about enough.
- Greater proportion of men take their lives than women – need to build mechanisms for men to talk about health more upstream of crisis point.
  - Could normalise, for example having a mental health equivalent of ‘Movember’ or involve in sports (e.g. in schools).
- Train those in the community to discuss mental health (e.g. Mental Health First Aid training for hairdressers/barbers, bartenders, receptionists, those within public bodies or faith groups)

Local example of best practice – ‘Big White Wall’
Developing a Children and Young People’s Mental Health and Wellbeing Outcomes Framework for BHR CCGs

Craig Hamilton
12/20/2016
## Contents

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1. Introduction and Context

CORC was commissioned by Barking and Dagenham, Havering, and Redbridge CCGs (BHR) to develop, in partnership with North East London Foundation Trust (NELFT,) a mental health and well-being outcomes framework that can be adapted to cover all aspects of children’s mental health and well-being services including universal, targeted and specialised CAMHS. The framework will help to ensure all current and future services provided under the wellbeing hub are outcomes focused, holistic, and accessible and built around the needs of children, young people and their families.

The work took place between September and December 2016, and this report presents the frameworks that have been developed together with key learning and recommendations to aid implementation.

2. The Approach

In developing proposals for an outcome and measurement framework CORC initially reviewed the current approaches, frameworks and reports in use, and the strategic outcomes laid out in the CAMHS transformation plans of all 3 BHR CCGs (See Appendix 1).

The approach CORC proposed involved workshops and interviews with key stakeholders in NELFT to gather information about how data is currently being collected and used, and perspectives on what is working well and key issues to address. To effectively dovetail with implementation of THRIVE in BHR and manage the burden on NELFT staff, it was agreed that this would be achieved as part of i-THRIVE redesign workshops. Where necessary, and to engage the full range of stakeholders, we carried out additional interviews. Below is further information regarding these engagements:

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<th>Workshop / Meeting</th>
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<th>Output</th>
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<td>30th September 2016</td>
<td>• Gained knowledge and understanding of the current reporting systems in place across NELFT</td>
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<td></td>
<td>26th October 2016</td>
<td>• Established how well outcomes are already being measured.</td>
</tr>
<tr>
<td></td>
<td>7th December 2016</td>
<td>• Consulted on over-arching outcomes and suite of measures</td>
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<td>1st December 2016</td>
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<tr>
<td>i-THRIVE workshops - Barking &amp; Dagenham CAMHS</td>
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<td>9th December 2016</td>
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<td>Mapping &amp; Baselining Interviews – NELFT Performance, ICAN, and RiO teams</td>
<td>24th October 2016</td>
<td>• Gained knowledge and understanding of the current reporting systems and IT systems in place</td>
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<td>18th November 2016</td>
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Table 1: Engagement Summary
Developing an Outcomes Framework for BHR

Drawing on the CORC model of best practice, i-THRIVE Outcome Framework, and learning from previous CORC projects, we developed proposals which were discussed with the BHR CAMHS Transformation Commissioner on the 15th December 2016.

4. The Framework

The Basis for the Framework

It was agreed in developing the framework:

- That there was continued commitment to continue to work with the outcomes and objectives laid out in the transformation plans of all 3 BHR CCGs
- That BHR’s outcomes framework, and the associated indicators and measures would build on Future in Mind, the BHR transformation plans, and the i-THRIVE framework
- That this outcome framework would be embedded in performance management frameworks and contract specifications (over time as appropriate)
- That there is value in creating a forum to utilise the data collected for shared learning and quality improvement, separate to performance management settings.

BHR’s shared vision and outcomes

A common vision for the BHR CCGs was shared in the transformation plans, though with local variation to meet the different specific needs and priorities in each borough. The outcomes laid out by each CCG largely mirrored each other, and were consistent with THRIVE principles. By theming the individual outcomes (Appendix 1) we derived six over-arching outcomes for BHR, which are:

- **Outcome 1**: Children and young people with mental health difficulties are supported in the community
- **Outcome 2**: People within a child’s sphere of influence (parents, carers and professionals) are confident in responding to needs
- **Outcome 3**: Children, young people, their families and carers are resilient, equipped to handle life’s ups and downs
- **Outcome 4**: Vulnerable children and young people are prioritised, and their care supports their specific needs
- **Outcome 5**: Children and young people are able to access support in a timely manner
- **Outcome 6**: Children, young people, their families and carers have a positive experience of support

The Draft Framework

The outline framework embedded below (Appendix 2) identifies measures that BHR may wish to monitor at three levels—

- **Outcome measures** – intended to provide a gauge of whether the over-arching outcomes are being achieved, and collective efforts are resulting in movements toward the vision. In this context, this might include measures of child and young person outcomes as a result of service intervention (routine outcome measures, or ROMs) and also other measures of outcome.

- **Output measures** – these are measures of the progress of interventions or activity that are expected to contribute to achievement of the outcome, for example the number of people who have engaged in a parenting course. These can often be more cost-effectively and regularly measured. They are underpinned by a theory of change that explains the way in which they impact on the outcome, and with what populations.
Developing an Outcomes Framework for BHR

• Process measures – i-THRIVE will have an impact on the way in which services and activity are delivered. The theory of change associated with i-THRIVE posits delivering in a THRIVE-like way will help to move BHR towards achievement of its vision for child mental health. Measures associated with the process of THRIVE implementation - demonstrating whether ways of working are in place that enable THRIVE-like delivery - but not directly tied to activity are identified in the framework as process measures.

A framework for the whole system
The nature of the BHR transformation and the implementation of THRIVE relies heavily on partnership working across the whole system: CAMHS, Education, Social Care, Primary Care, and Community Voluntary Sector. So whilst CORC were only commissioned to deliver an outcomes framework for the CAMHS provider, NELFT, given the i-THRIVE transformation model being implemented we felt it appropriate to consider outcomes and measures that could be applied to the whole system. Thus, in the framework we have made an attempt to distinguish where we think an indicator would be applicable to NELFT, elements of the wider system, or both.

A suite of outcome and feedback measures
Based on CORC’s own experience, CYP IAPT, and THRIVE, we have suggested a suite of measures (Appendix 3) for use in work with children and young people. In line with THRIVE thinking there is a particular focus in the suite on tracking personalised goals alongside a standardised outcome measure, as well as capturing the young person or family’s experience of the service. The implementation of THRIVE in BHR involves the use of a measure of shared decision making, so this too has been included.

Having a suite of measures to choose from allows practitioners greater flexibility to choose a measure, which is most appropriate to the work that they and service users are engaged in. During the workshops, this idea was widely supported by CAMHS staff.

Suggested Usage
• The Goal Based Outcome tool to be used at the beginning of an intervention, then on a session by session basis, and finally at the end of the intervention.
• A measure of shared decision making to be used at the beginning of the intervention.
• A minimum of one standardised patient recorded outcome measure (PROM) to be completed by the service user at the beginning and end of an intervention (or more frequently if practitioners feel appropriate).
• A minimum of one standardised clinician rated outcome measure to be used at the beginning and end of an intervention.
• The CHI-ESQ to be completed by the service user at the end of the intervention (or earlier if deemed appropriate).
• In addition to the above, we encourage the use of symptom tracking and experience measures throughout interventions where the practitioner judges this to be clinically meaningful and as part of a responsive, person centred support.

5. Key Considerations for Implementation

The implementation of this framework will involve some further development work in NELFT. Data shared with commissioners is currently biased towards activity and experience data. During the course of this project we identified that:

• NELFT is already collecting a range of Routine Outcome Measures (ROMs), including SDQ, GBOs, RCAfs, ORS, CGAS, HoNOSCA. The most commonly used measure is the SDQ, and there is a common perception amongst staff that they must use the SDQ with each service user because it is a Key Performance Indicator (KPI). Despite this not being factually correct, it is clear that many staff use the SDQ because they think they have to rather than because they think it is clinically useful. Indeed, many staff voiced that they thought the SDQ was often not useful.

• Although all 3 CAMHS teams are now a member of the South East CYP IAPT Collaborative and numerous staff members have been CYP IAPT trained, the use of ROMs is patchy. Those staff that are CYP IAPT trained report that they use ROMs with children and young people and that they are clinically useful. However, this is not mirrored by staff who have not attended the CYP IAPT training, who report that they have limited knowledge of ROMs. This suggests that the learning from the CYP IAPT training is yet to be cascaded throughout the wider teams.

• NELFT have developed an IT system, I-CAN, to support the collection of ROMs. It is capable of collecting all outcome measures included in the CYP-IAPT suite and providing instant feedback on scores to clinicians and service users. I-CAN training has been delivered in Barking and Dagenham, and Redbridge, but not yet in Havering. Some clinicians reported entering ROMs onto I-CAN directly but it appears that most ROMs are still collected on paper and entered into I-CAN by an administrator. Those who are using I-CAN reported problems with the systems and suggestions for improvements, but relayed that poor communication links with the I-CAN team prevent these issues from being addressed.

• Outcome data does not appear to be currently used to inform provision of services at Trust or team level. Reasons cited for this include: insufficient capacity, limited knowledge of how to interpret outcome data, and limitations of IT systems (RiO and I-CAN).

• Despite the sporadic use of ROMs across NELFT currently, staff generally recognised the need to use outcome and feedback measures. When we consulted with staff about the suggested suite of measures it was seen as being preferable to being limited to using a single measure. There was a genuine willingness amongst NELFT staff to embrace the routine use of outcome measures under the proviso that they are adequately supported to do so.
6. Recommendations

Appropriate Training in Working with Outcomes Measures and Outcomes Data

It will be important to ensure that all staff that will be using outcomes measures have the appropriate training and resources to feel confident using these tools in their practice. Feedback from children and young people stresses the importance of this. If practitioners do not feel fully supported and confident in the use and utility of these tools, they will not be empowered to incorporate them into their work in a way that is meaningful to the child or young person. Consequently, the data collected from these measures will not be representative of the progress and experience of service users.

Training needs of staff should be assessed, and it should be ensured that staff understand the importance of measuring children and young people’s outcomes, are aware of and familiar with available tools (both more general tools and/or tools that are particular for their field), and are confident in their ability to collaboratively set individual goals with children, young people and their families.

Training needs extend to those who will be reviewing the data at the service and commissioning level. The complex nature of the data being collected is such that the data will not provide concrete answers about whether services are performing positively/negatively at a glance. The data serves as an indicator and provides guidance of where to interrogate and discuss data further. It must be ensured that commissioners, service leads, and data analysts understand what the data can, and more importantly, cannot say about services and how they can responsibly discuss and make choices based on this and other data.

**Recommendations:**

- Protected time for staff to attend training on how to use outcome measures
- CYP IAPT trainees to cascade outcomes measure training to the wider team
- CAMHS staff to attend appropriate CORC training (see next section)
- Staff to be trained in the use of InterGRATE and CollaboRATE by i-THRIVE

Leadership

Robust leadership is needed to support the practical implementation of the framework and also to provide the necessary motivation, vision and change mandate at all levels of the system. This requires understanding and buy-in to the model as well as clear lines of accountability around data flow and implementation timescales.

In the workshops, it was evident that staff were unaware of how outcome data was being used at an organisational and CCG level and there was anxiety about the way it might be used to manage individual performance.

Optimally, staff should feel empowered and safe to discuss outcome data from their caseload, (rather than feeling under pressure to achieve good outcomes which may lead to gaming behaviours). At all levels, there should be clarity and transparency about how the data will be used and realistic expectations about what can be expected from the data (see CORC’s report on the CYP IAPT outcome data). Discussing outcomes in supervision, team and organisation meetings should be business as usual.

**Recommendations:**

- Regular fora for providers and commissioners to review outcome data
- Service leads and commissioners to attend appropriate CORC training (see next section)
- Service leads to access appropriate training through CYP IAPT
Each CAMHS team to review outcomes practice using CORC Best Practice framework (see next section)

Participation of Children and Young People

In the original project plan, we suggested that we consult with children and young people prior to developing an outcomes framework. The practicalities of the project have meant that we have been able to do this within agreed timeframes. It would be very useful to hear from service users about their experience of using outcome and feedback measures, and the learning from this could contribute to further development of the suggested suite of measures and the guidance about how they are used in practice.

**Recommendation:** The i-THRIVE team are planning on consulting with children and young people to inform the service redesign. As the development of the outcomes framework is in alignment with the THRIVE transformation, the burden on service users could be reduced if rather than running additional sessions, these sessions covered outcomes too.

Practical Considerations

There were numerous practical considerations that were flagged during the workshops that will be key to address in order for the framework to be implemented successfully. For successful implementation these practical elements must be addressed, and partnered with buy-in and confidence of staff on the ground in using outcomes and embedding this framework in their practice.

**Burden:** There was concern from some NELFT staff that the addition of new measurement tools will introduce undue burden on staff. Wherever possible, CORC has endeavoured to align recommendations for data in this framework to what is already being collected and flowed on the ground; however, it is recommended that this be taken into consideration for implementation. This may involve extra staff to manage the administrative burden, or extensively reviewing and updating processes to cease collection of unnecessary data in order to accommodate the new data being collected.

**Recommendation:** Redbridge CAMHS proposed that they undertake a time and motion study to ascertain how long assessments and the associated administrative tasks take to complete. This may be taken forward in conjunction with the i-THRIVE team in 2017. Learning and recommendations arising from this should be transferred to all three areas to inform the overarching BHR outcome framework.

**IT Systems:** IT infrastructure is a common challenge in implementing the collection and reporting of outcome measures, and this is true of NELFT too. I-CAN should be able to capture most of the outcome measures suggested in the framework, but this will need to be verified. Consideration will need to be given to how NELFT can capture the CollaboRATE and InterGRATE measures, which will be used as part of the implementation of THRIVE.

Various issues were described by staff who had used I-CAN and it will be important for these to be taken account of in the ongoing development of the system. It was felt that communication between the I-CAN team and CAMHS teams could be much improved and that it would be helpful if there could be more frequent face-to-face time to discuss issues.

The RiO system may need some development in order to collect some of the data mentioned in the outcome framework e.g. THRIVE groupings, advice and signposting outcomes. During the workshops it was evident that the data collected on RiO is not always representative of the data that is being collected locally. For instance, during the workshops, the service managers contested that data on referral types collected from RiO was inaccurate, and that they held more accurate data locally in spreadsheets.
In 2017, Havering and Redbridge CAMHS are being co-located with other children’s services in their borough. This involves a move toward more agile working and a move away from using paper records. Consideration will need to be given to how this could impact the use of ROMs with service users as paper currently the main way of administering them. I-CAN may provide a mechanism for direct input of ROMs, which may negate the need for paper in most instances, but the infrastructure will be needed to support this e.g. Wifi access at NELFT sites, 4g access if staff are working remotely, tablets used in sessions so services users can input ROMs. It would be useful if services users were involved in developments so they can help shape the experience of CAMHS going forward.

**Recommendations:**

- NELFT to review the measures in the framework and highlight where there may be issues with data collection on RiO and I-CAN
- Regular fora for I-CAN/RiO teams and CAMHS teams to discuss issues and future developments of these systems
- NELFT to review of infrastructure that will support the use of outcome measures in clinical practice with CAMHS staff.

**Involvement of Wider System**

Achieving the outcomes outlined in the BHR transformation plans involves contributions from a range of agencies (beyond NELFT) and therefore the outcome measurement framework should seek to capture their progress towards achieving these as well. Therefore there are some key questions to be addressed:

- What other agencies need to be engaged to achieve outcomes, shape the outcome framework, provide information for it, and meaningfully monitor it?
- What are the most appropriate existing structures for engaging partners in taking this forward?

It is likely that different fora will be appropriate for the differing purposes of monitoring the overall delivery of the Outcome Framework, THRIVE implementation, Quality Improvement and contract monitoring. In determining how to move forward BHR CCGs might consider:

- How outcome data is best integrated into oversight of Transformation Plan delivery and THRIVE implementation, including for example the frequency with which different types of data are reviewed by different fora.
- What needs to be put in place to support the reviewing of data as a routine part of strategic oversight, monitoring plan implementation, quality improvement, contract monitoring and service delivery
- The feedback loops that need to be put in place to ensure there is active dialogue - downwards to individual organisations, and outwards to service users - about how the borough is progressing towards achieving key outcomes, and to address any issues that arise from data analysis

Key to this will be the kind of culture partners are seeking to promote across the BHR region, and the means through which transparent and accountable leadership can be manifest. For example, the regularity with which key indicators are reviewed in the different organisations working in partnership to achieve local priorities.

**7. Next Steps**

CORC can support NELFT and BHR CCGs with the implementation of the outcomes framework in a number of ways:
Training
As a member of CORC, NELFT can access free places on each of the following CORC training events in London. Details on how to book are here.

- **Embedding best practice in use of outcome and feedback measures.** Suitable for clinicians, service leads – 13th March 2017
  ‘Introducing questionnaire-based outcome and feedback measures in children and young people’s mental health and wellbeing. By the end of the course participants will understand the rationale for using this kind of outcome measure and will feel informed and confident in choosing and using measures and interpreting response data.’

- **Interpreting outcome data in children and young people’s mental health.** Suitable for service leads, data analysts – 22nd February 2017
  ‘Supporting practitioners, managers and business/data managers working in children and young people’s mental health and wellbeing settings to understand what constitutes best practice in the use of outcome and feedback measures. Participants will understand how to embed this through local routines, processes and approaches and develop action plans to apply learning to their own organisational context.’

- **Ethics and data management.** Suitable for data managers – 18th July 2017
  ‘An introduction to the ethical considerations in using routinely collected person-level data for service improvement, management and research. The course will also give participants an understanding of approaches to anonymising and storing data for these purposes.’

- **Measures in a commissioning context.** Suitable for service leads, data analysts, and commissioners– 18th May 2017
  ‘Looking at how routine outcome measurement informs commissioning for children and young people’s mental health and wellbeing across different stages of the commissioning cycle. The course explores issues and approaches associated with developing outcome and measurement frameworks, setting realistic targets and making meaningful use of limited, partial or flawed data.’

**CORC Best Practice and Accreditation Framework**
CORC have developed a framework for the best practice in the use of outcome and feedback tools (See Appendix 4), which is freely available to CORC member organisations. The framework takes a whole system approach, there are 16 criteria across 4 themes: leadership and management, staff development, infrastructure and information management, and service user involvement. Completing the self-review would allow NELFT to measure where they are now in regard to their outcome practices and provide a road map of what needs to be improved in order to reach CORC accreditation standard.

**CORC Report**
As part of their annual membership, NELFT can have their outcome data analysed by CORC. A review of the data could be facilitated by CORC as part of the on-site visit below.

**On-site Visit**
CORC membership entitles NELFT to 1 day’s on-site visit. There are various ways that this day could be used:
- Delivery of training packages as mentioned above
- Bespoke training based on NELFT’s particular needs
- Facilitated review of NELFT’s annual CORC report
- Facilitated self-review of outcome and feedback measure practice using CORC Best Practice Framework
Developing an Outcomes Framework for BHR

Additional bespoke support can also be provided at a cost. Contact Sally.Marriott@annafreud.org for more information on any of the above.

Appendices

Appendix 1: Outcomes from BHR Transformation Plans

Appendix 2: Suggested BHR Outcomes Framework

Appendix 3: Suggested Suite of Outcome Measures
## Appendix 4: Overview of CORC Best Practice Framework

### LEADERSHIP AND MANAGEMENT

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<th>Summary of Self-Assessment</th>
<th>Areas of Strength</th>
<th>Areas for Development</th>
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- Organisational vision
- Organisational commitment to collection and collation
- Organisational commitment to interpretation and use
- Organisational culture supportive of use and learning

### STAFF DEVELOPMENT

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- Understanding of different data sources (including measures)
- Use of measures
- Training and Continued Professional Development (CPD)
- Review of measures and feedback in supervision

### INFRASTRUCTURE AND INFORMATION MANAGEMENT

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- Enabling use of data in direct practice with clients
- Enabling use of data at practitioner level
- Enabling use of data at team level
- Enabling use of data at service level

### SERVICE USER EXPERIENCE

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</table>

- Service user’s understanding of measures
- Communication with service users about measures
- Collaborative setting of goals and choice of measures
- Service user’s feedback on support
## B&D CAMHS Staffing Matrix

### Barking and Dagenham CAMHS Structure

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<th>Post Description</th>
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<td>Triage Worker</td>
<td>Band 6</td>
<td>2.00</td>
</tr>
<tr>
<td>Admin</td>
<td>Band 5</td>
<td>0.93</td>
</tr>
<tr>
<td>Admin</td>
<td>Band 4</td>
<td>3.50</td>
</tr>
<tr>
<td>Admin</td>
<td>Band 3</td>
<td>4.16</td>
</tr>
<tr>
<td>YOT Nurse</td>
<td>Band 7</td>
<td>1.00</td>
</tr>
<tr>
<td>YOT Psychotherapist</td>
<td>Band 8A</td>
<td>0.90</td>
</tr>
<tr>
<td><strong>CAMHS Transformation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Star Workers</td>
<td>Band 4</td>
<td>4.00</td>
</tr>
<tr>
<td>Looked after children social worker</td>
<td>Band 7</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>CAMHS Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultants</td>
<td>Consultant</td>
<td>2.00</td>
</tr>
<tr>
<td>Speciality Reg (STR) ST1 - 3</td>
<td>SPR</td>
<td>1.00</td>
</tr>
<tr>
<td>Speciality Doctor</td>
<td>Specialist Doctor</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Total WTE</strong></td>
<td></td>
<td><strong>37.44</strong></td>
</tr>
</tbody>
</table>
Annual Stocktake Report

Partnership: Barking & Dagenham
Partners: Barking & Dagenham CAMHS, North East London NHS Foundation Trust, LB Barking & Dagenham
CCGs: Barking CCGs and Dagenham CCGs

This report has been produced by the London & South East CYP IAPT Programme Team as part of the CYP IAPT Annual Stocktake cycle to enable providers and commissioners to reflect on progress implementing the principles of CYP IAPT in the context of system wide change underway through the Local Transformation Plans and Sustainability and Transformation Plans.

The report will explore the available data about the implementation of the core principles of the CYP IAPT programme essential to quality improvement and service transformation:

- Value and facilitate authentic participation of young people, parents, carers and communities at all levels of the service
- Provide evidence-based practice whilst being flexible and adaptive to changes in evidence
- Raise awareness of mental health issues in children and young people, and take an active role in decreasing stigma around mental health difficulties
- Demonstrate accountability by adopting the rigorous monitoring of the clinical outcomes of the providers and feedback from young people and families about their experiences of using the service
- Actively work to improve access to and engagement with services

These principles are co-dependent and are applied within a culture of collaboration and shared decision-making.

The data presented in this report includes:

- Self-reported quarterly monitoring data submitted by providers in the Barking and Dagenham partnership including self-rating against the Delivering With Delivering Well Values and Standards and the CYP IAPT Markers and Indicators, as well as self-reported quantitative workforce, activity and outcome data
- Take-up of training places since the partnership joined CYP IAPT as well as expressions of interest for upcoming training and current applications
- Use of outreach resources from the Learning Collaborative to support quality improvement

The objective of this Annual Stocktake is to facilitate providers and commissioners jointly setting goals and outcomes with the CYP IAPT Learning Collaborative, which the collaborative can provide support and resources to achieve during 2018.
QUARTERLY MONITORING

Quarterly monitoring data for 2016-17 has been submitted for 0 of the 4 quarters. This makes it difficult for us to comment on your progress since you joined the learning collaborative. Your latest submission was for Q3 2015-16. We suggest starting a conversation about this during the annual review meeting. For reference; partnerships that joined the learning collaborative in your wave have submitted up to 4 out of the 4 quarters.

Accountability

There are current issues with the level of compliance with paired outcome measures. There is a trust wide action plan in place to improve this compliance. This was updated in March 2016 and a fortnightly meeting put in place to review the trust compliance and individual staff compliance with paired measures with a view to improving the compliance with paired measure at a local level. Discussion of clinical outcome measures is used as part of supervision. However due to the level of compliance with paired measure it is clear this continues to require some imbedding into local practice.

We have developed a data based system ICAN that allows for the tracking of completed and paired measures: these included such indicators as the SDQ, current view and RCADs. We are promoting the use of the SDQ as a standard measure and the use of the parenting SDQ where a child is younger and the SDQ is not clinically appropriate. In this way promoting compliance with paired measure and PROMS.

Locally, an audit has been undertaken on the child centered and SMART nature of care plans. From this a presentation was formulated and provided to the whole team on the development and creation of SMART care plans. This was delivered as part of the team away day and copies made available in each office.

Initial assessments are offered within 12 weeks with an average of 8 weeks. Feedback from children and young people is that this wait is too long. Systems are in place to reduce waiting times.

There is currently an initiative within the CAMHS "Clinical Academic Learning Meeting" to provide updated training to clinical staff on formulation in assessments.

Staff undertake goals within care planning. There has been a recent audit on use of Care Plans and, as a consequence, increased in use. Care plans are now viewed within clinical supervision.

In terms of the data submitted by your CCG footprints for the reporting period April 2017.

<table>
<thead>
<tr>
<th>MHSDS Metric</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP23 - Open referrals (children’s and young people’s mental health services), end RP</td>
<td>600</td>
</tr>
<tr>
<td>CYP32 - Referrals to children and young people’s mental health services, starting in RP</td>
<td>140</td>
</tr>
<tr>
<td>MHS32b - Referrals starting in RP, aged 0-18, that were self-referrals</td>
<td>-</td>
</tr>
<tr>
<td>MHS55a - People attending at least one contact in RP, aged 0-18</td>
<td>110</td>
</tr>
</tbody>
</table>
**Accessibility**

There are clear ways and simple to use means for a young person and/or their family to provide regular feedback or to complain. Additionally, the availability of independent advocacy and support services is well signposted and young people and/or their families are supported to access the help available.

Self-referral to CAMHS is provided for 14-21-year-olds through the adolescent service. Self-referrals are not offered for children aged 13 years and under. A range of settings across the borough is provided for treatment, but could be developed further.

The adolescent service states clearly on publicity that therapists from different cultural backgrounds, sexuality and gender can be requested. When there is an increase in demand you this can impact on resources.

**Evidence Based Practice**

There are clear ways and simple to use means for a young person and/or their family to provide regular feedback or to complain. Additionally, the availability of independent advocacy and support services is well signposted and young people and/or their families are supported to access the help available.

Currently, the interventions offered by CAMHS are in line with those recommend and recognised by NICE. There is a local steering group that is working to develop a shared care plan library of NICE compliant care plans to support staff to better develop NICE compliant care.

**Governance/Leadership**

There are local meetings and trust wide meetings that support the governance of CYP IAPT. At this time these meetings are led by NELFT and look at internal barriers to reaching the 90% target for paired outcome measure. This included looking at the IT system as well as clinical pathways and operational issues.

There are staff away days 4 times a year for the children's integrated services in Barking and Dagenham. There is a CAMHS Clinical Academic Learning Meeting once per month where learning and development take place.

**Participation**

Currently there is a local listen group that is attended by a group of current and previous service users. This group has been involved in many projects including developing a film and delivering
training to the CAMHS team. However, recently, the number of attendees has reduced and a relaunch is planned for June.

The young people’s user group called "Listen!" is due to be re-launched. The Listen! group have provided training days to CAMHS staff on "Understanding the YP’s experience". There is user involvement in staff recruitment but not YP user involvement, this still needs to be developed.

**TRAINING PLACES**

Since joining the CYP IAPT Collaborative in 2013 a total of 15 staff have signed up for CYP IAPT training at KCL or UCL in various modalities/routes – 9 completed, 1 in progress of completion, 5 withdrawn. No applications and 1 expression of interest have been received for upcoming 2017/19 CYP IAPT trainings. Please see the graphics below for details of specific trainings for more details.

Modalities with 0 intake/expressions of interest: **Evidence Based Counselling Practice (EBCP)**, **Systemic Family Practice Eating Disorders SFP (ED)**, **Staff Working with 0-5s and their parents/carers (0-5s)** and **Autism Spectrum Disorders & Learning Disabilities (ASD/LD)**

**Postgraduate Certificates in CYP IAPT Management**

![Diagram of three figures with one completed in 2014 and another completed in 2015]

Two withdrawals registered for the PG Certificate in CYP IAPT Management in 2014. Pass rate - Pass

**Postgraduate Certificates in CYP IAPT Supervision**

![Diagram of two figures with one not completed in 2014, one marked PT and one marked CBT]

Two withdrawals registered for the PG Certificate in CYP IAPT Supervision.
One withdrawal registered for Postgraduate Diploma in CYP IAPT Therapy in 2017 (reason cited – change of job)

Pass rate – Pass

NEW WORKFORCE TRAINING

The new Workforce Initiative covers the Children’s Wellbeing Practitioner programme (CWP) and THE Recruit to Train programme (RTT) with the aim of increasing mental health workforce capacity by training 1700 new staff in Evidence Based treatments by 2020 offering support to 70k more children and young people.

- 4 staff from Barking and Dagenham are currently training in the CWP 1 Year Certificate that started in April 2017
- Barking and Dagenham have also submitted an expression of interest for the second cohort of CWPs, beginning in April 2018

OUTREACH

- Six supervisors took part in Enhanced Supervision Training in 2014.
- Organised an Away Day and delivered training on Outcomes in April 2014.
- iThrive team delivered a workshop in 2016
GOALS
No goals were identified in the most recent Quarterly Monitoring submission.
## APPENDIX 2.
### BREAKDOWN OF TRAINING PLACES FOR Barking & Dagenham PARTNERSHIP

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Presenting problems</th>
<th>Staff began training</th>
<th>Status (Complete unless stated otherwise) + EOIs / Applications 2017/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service leadership</strong></td>
<td></td>
<td>4</td>
<td>1 completed 2014; 2 Did not complete 2014; 1 completed 2015</td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Supervision (SFP ED)</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Supervision (CBT)</td>
<td></td>
<td>1</td>
<td>1 did not complete 2014</td>
</tr>
<tr>
<td>Supervision (SFP CDD)</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Supervision (PT)</td>
<td></td>
<td>1</td>
<td>1 did not complete 2014</td>
</tr>
<tr>
<td><strong>EOIs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Training (PT)</td>
<td>Children (3-10 years) with conduct problems and their parents/carers</td>
<td>1</td>
<td>1 completed 2014</td>
</tr>
<tr>
<td>CBT</td>
<td>Anxiety and Depression</td>
<td>5</td>
<td>4 completed 2014; 1 In Progress due to complete 2019 1 expression of interest 2018</td>
</tr>
<tr>
<td>Interpersonal Therapy (IPT-A)</td>
<td>Adolescents with depression</td>
<td>2</td>
<td>1 completed 2015; 1 Did not complete 2017</td>
</tr>
<tr>
<td>Systemic Family Practice (SFP CDD)</td>
<td>Depression, Self-Harm and Conduct Problems</td>
<td>1</td>
<td>1 completed 2015</td>
</tr>
<tr>
<td>Systemic Family Practice (SFP ED)</td>
<td>Eating Disorders</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Staff working with Autistic Spectrum Conditions and Learning Difficulties (ASLD)</td>
<td>Autistic Spectrum Conditions and Learning Difficulties</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Evidence Based Counselling Practice (EBCP)</td>
<td>Depression, Anxiety</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Working with 0-5s and their parents/carers (0-5s)</td>
<td>Mixed (Conduct problems)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Domain</td>
<td>Indicator Name</td>
<td>Threshold</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>NELFT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS DNAs</td>
<td>% DNA rate First appointment</td>
<td></td>
<td>Less than 13%</td>
</tr>
<tr>
<td>CAMHS DNAs</td>
<td>% DNA rate Follow up appointment</td>
<td></td>
<td>Less than 13%</td>
</tr>
<tr>
<td>CAMHS DNAs</td>
<td>DNA (aggregate First and Second appointments)</td>
<td></td>
<td>Less than 13%</td>
</tr>
<tr>
<td>CAMHS Survey</td>
<td>5X5 Survey report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Emergency RTT</td>
<td>% CYP requiring emergency assessment seen by the end of the following working day (Serious immediate incident of self-harm, including overdose)</td>
<td>95%</td>
<td>Monthly</td>
</tr>
<tr>
<td>CAMHS Activity</td>
<td>Number of new referrals received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity LAC</td>
<td>Number of BHR LAC referrals received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity LAC</td>
<td>% of BHR LAC referrals accepted</td>
<td></td>
<td>NELFT to provide narrative on the reasons why any LAC not accepted into the CAMHS service.</td>
</tr>
<tr>
<td>CAMHS Activity LAC</td>
<td>Reasons for not accepting referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity</td>
<td>Total CAMHS caseload (Total number of individual children and young people aged 0-18 receiving treatment in the reporting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity</td>
<td>Total number of NEW individual CYP receiving treatment in the reporting period. Treatment is defined as at least 2 contacts (including indirect contacts) within a 6 week period in relation to the same referral.</td>
<td>7% increase against Operating Plan baseline by 31st March 2018. [NB this new wording in line with Operating Plan.]</td>
<td>Quarterly</td>
</tr>
<tr>
<td>CAMHS Follow up</td>
<td>Number of CAMHS inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Follow up</td>
<td>% of CAMHS inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact</td>
<td>95%</td>
<td>Monthly</td>
</tr>
<tr>
<td>CAMHS Activity</td>
<td>Description</td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity CSE</td>
<td>Number of known cases of Child Sexual Exploitation (disclosure does not need to be physically evidenced.)</td>
<td>Monthly.</td>
<td></td>
</tr>
<tr>
<td>CAMHS Activity CSA</td>
<td>Number of known cases of Child Sexual Abuse (disclosure does not need to be physically evidenced.)</td>
<td>Monthly.</td>
<td></td>
</tr>
<tr>
<td>CAMHS Waiting times</td>
<td>Total number of CYP patients waiting for treatment at the end of the Qtr</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>CAMHS Waiting times</td>
<td>Average waiting time from the date of referral (in days)</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>CAMHS Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Eating Disorders Urgent</td>
<td>% of urgent referrals receiving a NICE concordant treatment within 1 week of first contact.</td>
<td>95% Quarterly from Q1 reported directly to Unify.</td>
<td></td>
</tr>
<tr>
<td>CAMHS Eating Disorders Emergency</td>
<td>% of emergency referrals receiving a face to face response from a qualified practitioner within 24 hours of first contact.</td>
<td>95% Quarterly from Q1</td>
<td></td>
</tr>
</tbody>
</table>