associate development solutions

NHS
East Midlands Strategic Clinical Network

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

This self assessment tool was developed by Associate Development Solutions to enable organisations to assess readiness to meet the recommendations laid out in the 'Future in mind' document published by Department of Health and NHS England in 2015.

Self Assessment Tool:

Name of Organisation: **Example Self Assessment**

Contents (by tab):

Background Info:	Lists all summary actions from the 'Future in mind' document and aligns them with their associated sections from within the document
Self-Assessment:	This is the section that organisations populate with your perceived readiness to address the recommendations of the 'Future in mind' report* **Although not all recommendations made within the report are aimed directly at the organisations using this assessment tool, they will all impact the organisation in some manner were they to be agreed or actioned. Where this is the case, it is the intention of this document for organisations to determine their ability or readiness to respond once these recommendations were to be acted upon.*
Readiness_Sort:	Sorts all recommendations and sub-recommendations by the organisations determined readiness to address
Task Rating_Sort:	Sorts all recommendations and sub-recommendations by the combined size and complexity of each task as determined by the organisation
Graphs:	Provides a high level graphical representation of the organisations current position

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Current or Future	ACTION	Associated Paragraph in 'Future in Mind'
	Resilience, prevention and early intervention for the mental wellbeing of children and young people	
Current	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.	**Current action to improve early support for parents, carers and children from birth (1 and 4)** • The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support. • The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician. • The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives. • Public Health England is publishing an update of the evidence base for the Healthy Child Programme37 (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s). • Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem. • In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.
Current	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	4.15 We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing (2). This will build on the Department for Education's current work on character building, PSHE and counselling services in schools (see box for details). The named mental health lead for schools proposed in chapter five would also make an important contribution to leading and developing whole school approaches.
Current	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.	4.19 To this end, the Taskforce proposed there could be a major national branded social marketing campaign with a mechanism for dialogue so it is a genuine two-way conversation – driven by children, young people, parents and carers (3). Options include building on the Time to Change campaign (www.time-to-change.org. uk/youngpeople) as well as looking for opportunities to address mental health and wellbeing issues with the Public Health England Rise Above44 campaign.
Future	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidencebased programmes of intervention and support.	**Current action to improve early support for parents, carers and children from birth (1 and 4)** • The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support. • The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician. • The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives. • Public Health England is publishing an update of the evidence base for the Healthy Child Programme37 (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s). • Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem. • In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.
Future	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.	4.24 We propose that the Government asks the National Information Board to work in close partnership with the Government Digital Service and young people themselves to develop a single framework for harnessing the power of digital technology and protecting young people from mental harm (5). Within this framework, we propose that Government considers incentivising the development of new apps and digital tools; and also whether there is a need for some form of kite-marking scheme based on research evidence to guide young people and their parents on quality
Current	**Improving access to effective support – chapter 5 summary**	
Current	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.	Models could and should be different in different types of locality; for example, a model which works well in rural Devon may fail to meet need if applied in inner-Manchester, and vice versa. This is why we have not dictated the local offer but been clear about the national ambition (6).
Current	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.	There is a pressing need to develop these approaches more widely (7 and 16). Common features of a single point of access system include: • One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral. • Initial risk assessment to ensure children and young people at high risk are seen as a priority. • Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services). • Young people and parents are able to self-refer into the single point of access. Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stopshop services, based in the community (7 and 16).

Current	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.	Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices (8 and 16). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers. ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (8 and 16). This individual would make an important contribution to leading and developing whole school approaches.
Current	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	Develop a joint training programme for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals (9).
Current	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).	Ensuring there is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND) (10). This should be matched by involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)
Current	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.	Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with. It is proposed that further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision. (11)
Current	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.	For children and young people experiencing mental health crisis, it is essential that they receive appropriate support/intervention as outlined in the Crisis Care Concordat, including an out-of-hours mental health service (12). The challenge of supporting a child or young person in a crisis includes ensuring that there is a swift and comprehensive assessment of the nature of the crisis. There are examples around the country of dedicated home treatment teams for children and young people, but these are not universally available. Some children and young people end up in A&E, where access to appropriate and timely psychiatric liaison from specialist child and adolescent mental health services is not always available. Some are placed (not always appropriately) on paediatric or general adult hospital wards. The national development of all-age liaison psychiatry services in A&E Departments with targeted investment over this and the next financial year, as set out in the joint Department of Health and NHS England publication, Achieving Better Access to Mental Health Services by 2020, should mean that appropriate mental health support in A&E is more readily available. This needs to be carefully monitored.
Current	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.	There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step down' provision. This can provide clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care (13).
Current	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.	This work (response to Bubb report) will involve people with learning disabilities and their families and include: • robust admission gateway processes for those with learning difficulties; • a challenge process to check that there is no alternative to admission; and • the agreement of a discharge plan on admission. Children and young people's mental health services must draw on this methodology and apply similar principles. (14)
Current	15. Promoting implementation of best practice in transition, including ending arbitrary cutoff dates based on a particular age.	The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care. (15)
Future	16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.	5.6 Therefore, at the heart of any good local system should be cross-sector agreement to ensure clarity in respect of how services are accessed. Many areas are already using a single point of access to targeted and specialist mental health services through a multi-agency 'triage' approach, including areas working within the CYP IAPT programme such as Liverpool. There is a pressing need to develop these approaches more widely (7 and 16). Common features of a single point of access system include: • One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral. • Initial risk assessment to ensure children and young people at high risk are seen as a priority. • Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services). • Young people and parents are able to self-refer into the single point of access. 5.7 We propose the following to improve communication and access: i. Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices (8 and 16). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers. ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (8 and 16). This individual would make an important contribution to leading and developing whole school approaches. iv. Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stopshop services, based in the community (7 and 16). They should be a key part of any universal local offer, building on the existing network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment. There may also be a case in future for developing national quality standards for a comprehensive one-stop-shop service, to support a consistent approach to improving
Future	17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.	5.8 NHS England has committed to developing access and waiting time standards in mental health. By 2020, the aim would be to provide a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. It is important that children and young people are taken fully into account as further access and waiting time standards are considered, subject to resource availability. Careful consideration will need to be given to which conditions are prioritised, working with experts, services and commissioners and building on current work to develop standards for eating disorders and the introduction of the standard for early intervention in psychosis. (17)

Future	18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.	5.13 As we established in the previous chapter, children and young people and many parents and carers are digitally literate and told us they wanted better and more use made of the web. This could be expressed in a number of ways, but must be informed by the views and preferences of children and young people to be effective. The Taskforce believes a future government should look at options enabling children, young people, parents and carers to access high quality and reliable online information and support. One such option could be a national branded web based portal established using NHS Choices, in line with the recently published National Information Board framework. (18) It could build on the successful MindEd website (www.minded.org.uk) aimed at professionals to provide national information about mental health and wellbeing in an engaging and reliable format. The NHS Choices content on adult mental health should link to the children and young people equivalent – the Youth Wellbeing Directory (youthwellbeingdirectory. com) and services are encouraged to register with the Directory.
Future	19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.	5.17 For some children and young people, their route into specialist services is more extreme and is through detention by the police, under Section 136 of the Mental Health Act. Those who exhibit such distress and risk to themselves or others that a section 136 detention becomes warranted will need further support, which may not be purely from mental health services. There is broad support for legislating to ensure that no child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.(19) It is also important to develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning. CQC should be asked to carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.
Current	**Caring for the most vulnerable – chapter 6 summary**	
Current	20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.	Not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up (this can apply to all children and young people – see also paragraph 5.10) (20). Some children, young people and families find the formal setting of a clinic offputting and are unwilling to attend. This can lead to them saying that they do not wish to be referred or not turning up – particularly for some highly vulnerable groups, such as those involved with gangs or those who have been sexually exploited. As a consequence, some services experience high rates of children, young people and families not attending appointments. It is important that services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer (see also paragraph 6.2). It may be necessary to find alternative ways to engage the child, young person or family.
Current	21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.	There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs (21). 6.17 Whilst the health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes (21).
Current	22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.	The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern (22)
Current	23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.	Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government's response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines63 (whereby every young person is asked during the mental health assessment about violence and abuse) will be introduced from 2015-1664 (23).
Current	24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.	Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral to a specialist mental health service (24).
Current	25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.	Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage (25).
Current	26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.	Children and young people in vulnerable groups are amongst the most complex seen in specialist services. Systems such as appointing a lead professional through a Common Assessment Framework (CAF), Team Around the Child or Family, or the Care Programme Approach (for those with severe mental health problems) already exist in many places. For some, the consistent application of these needs to be improved – particularly for vulnerable children and young people with complex needs who require care that is well-planned and coordinated with information shared effectively. A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way (26). This role could be allocated through a number of multi-agency processes, including the CAF or Team Around the Child or Family processes.
Future	27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.	6.7 Enhanced training for staff working with children and young people would lead to greater professional awareness of the impact of trauma, abuse or neglect on mental health (27). This should be coupled with effective treatment
Future	28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.	6.9 Applying an approach whereby specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties is already best practice in some areas, for some very specific and highly vulnerable groups. Consultation and liaison teams can be used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision (including specialist services). There would need to be an identified specialist point of reference, including a senior clinician with specific expertise within mental health services. The roll-out of such teams could be piloted and, if successful, implemented at a sub-regional level (28).

Future	29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.	6.10 Young people who are amongst the most excluded from society, such as those involved in gangs, those who are homeless and/or looked-after children, need support from people they trust. This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel **(29)**. The embedded worker can develop a relationship with the young people through youth-led activities so that they are then able to respond as a familiar, trusted adult as the need arises, working with more specialist or intensive services as required. They can also impart basic mental health skills to frontline staff. This approach has been successfully developed by MAC-UK's INTEGRATE model (see www.mac-uk.org) which also incorporates the necessary governance structures essential for success. INTEGRATE requires a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.
Current	**To be accountable and transparent – chapter 7 summary**	
Current	30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.	7.6 There was strong support from many members of the Taskforce to make it a requirement at the local level for there to be a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care (30). Many members of the Taskforce also favour the creation of a single, separately identifiable budget for children's mental health services. These proposals build on the learning from those areas which are already jointly commissioning children's mental health services between Clinical Commissioning Groups and local authorities, in some cases with pooled budgets. We envisage in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements 7.8 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/ carers (30). The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health. Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing. As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.
Current	31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.	7.9 Key drivers for the quality of any local offer should be the local Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The JSNA should address children and young people's health and wellbeing, including mental health (31). Health and Wellbeing Boards, supported by the local government-led health and wellbeing system improvement programme and Public Health England, should ensure that both the JSNA and the Joint Health and Wellbeing Strategy address children and young people's mental health needs effectively and comprehensively.
Current	32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.	7.12 There is a particular need to coordinate the commissioning of community health and inpatient services (32). Within the current statutory system, the former is the responsibility of local commissioners and the latter the responsibility of the national commissioner, NHS England. If we are serious about moving away from a tiered model, then this commissioning needs to be joined up. This need for co-commissioning has been recognised by NHS England. At the same time, however, we want to avoid the mistakes of the past where we ended up with a patchwork quilt of intensive community crisis support and inpatient services.
Current	33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions	7.13 The National Institute for Health and Care Excellence has a crucial role to play in framing a national ambition through the development of Quality Standards as well as guidance for health and social care, which are commissioned by the Secretaries of State for Health and Education (33). The quality standards will need to describe cost-effective evidence-based practice. They should provide clear descriptions of high priority areas for quality improvement. They will help organisations by supporting comparison of current performance, using measures of best practice to identify priorities for improvement. Though not mandatory, they are an important driver for change in the new arrangements for commissioning and service delivery in health and social care. It would be helpful if their recommendations could include further advice regarding implementation across the whole care pathway.
Current	34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.	7.14 In supporting implementation and delivery of high quality care, we consider that CQC and Ofsted – with their distinct roles and responsibilities in health and education – should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (34).
Current	35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.	7.15 [part] Measurement is crucial to support continuous improvement. Support and services should be based on high quality, accurate data, but there are significant gaps in relation to children's mental health. The last children and young people's mental health prevalence survey was done over a decade ago, although the Department of Health has just started the process of commissioning the next one (35). 7.17 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidencebased interventions to support evaluation of the effectiveness of the care commissioned (35). To build on this work, it is important that routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.
Current	36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.	7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (36 and 37).
Current	37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.	7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (36 and 37).
Current	38. Making the investment of those who commission children and young people's mental health services fully transparent.	7.16 At the same time, levels of investment in mental health services for children and young people should be transparent. Accurate information on current levels of spend on children's mental health across agencies is a key gap. NHS England is working to improve the quality of data on adult mental health spend from April 2015 so that it will be able to identify the overall spend in primary and community care as well as mental health services and specialist commissioning. This has been built into the NHS planning process at CCG level. We propose that, in the future, this activity is extended to cover children's mental health spend by the NHS. It is also proposed that further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment (38).

Future	39. Committing to a prevalence survey being repeated every five years.	We propose the commissioning of a regular prevalence survey of child and adolescent mental health every 5 years, giving particular consideration to including under-5s and ages over 15 (39).
Current	**Developing the workforce – chapter 8 summary**	
Current	40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments	8.3 Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions (40). Professionals need to be trained to be able to: • Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience. • Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing. • Identify mental health problems early in children and young people. • Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings. • Refer appropriately to more targeted and specialist support. • Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions. • Work in a digital environment with young people who are using online channels to access help and support.
Current	41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.	For schools, the Carter Review of Initial Teacher Training (ITT) reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development (41)
Current	42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.	8.17 Traditionally, especially in the NHS, investment in training has focused on the provision of services. There is, however, no recognised standard training programme for commissioners of children's services or mental health services for children and young people. The recent mental health commissioning and leadership programme developed by NHS England and Academic Health Science Networks is organised around the principles of: data for commissioning, the use of the evidence base and leadership. All programmes include a module on child and adolescent mental health provision, and attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services (42)
Future	43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.	8.10 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum. All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability. This was considered in detail by the Vulnerable Groups and Inequalities Task and Finish Group. In addition, there are skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE. The CYP IAPT programme was commissioned with a modest budget to deliver training for a limited range of therapies to a prescribed group as a part of its transformation role. There are gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings. Counsellors working in schools and the community have asked for further training to improve evidence-based care (43).
Future	44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.	The CYP IAPT programme currently works with partnerships covering 68% of the 0-19 population. The Service Transformation programme includes training for existing service leaders, supervisors and therapists in the NHS, social care and voluntary sector in a range of evidence-based programmes, with a Mandate commitment for both Health Education England and NHS England to plan further roll-out (44).
Future	45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.	8.16 It is proposed that the Department of Health and Department for Education should work together with HEE, the Chief Social Worker for children and others, to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sectors and independent sector as the first stage in determining a comprehensive cross-sector workforce and training strategy (45).
	Making Change Happen – chapter 9 summary	
Current	46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.	9.8 This will require local leadership and ownership. We therefore propose the development and agreement of Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer (46). These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.
Current	47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.	9.14 The transformation of our national and local approach to children and young people's mental health and wellbeing will take time, at least the period of the next Parliament, aligning with the timescales of the Five Year Forward View. Change at the national level will need co-ordination across policy, investment, commissioning, regulation, training and inspection. Local areas will need ongoing support and guidance. It represents a complex and difficult journey and it will need strong political will combined with senior level leadership to see it through and be successful. Our closing proposal is therefore that there should be some clear governance at the national level to oversee the transformation of children's mental health with clear accountability for progress to the relevant Accounting Officers and Ministers (47).
Current	48. Enabling more areas to accelerate service transformation.	9.12 At the same time, NHS England and the Department of Health have recently invited proposals from CCGs to lead and accelerate co-commissioning arrangements for children and young people's mental health. The national response to this invitation was hugely encouraging and indicative of the potential to be harnessed by this report. Although only a limited number of areas could be chosen, as these projects develop, they will provide good examples of what can be achieved, alongside other relevant initiatives such as the Social Care Innovation Fund and the Department for Education's Voluntary and Community Sector Fund (48).
Future	49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.	9.3 If we are continuously to improve the mental health care and wellbeing of children and young people, we need data and evidence with which to do so (49). Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services. In some areas, evidence is weak or entirely lacking as to the best interventions. Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers' money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation.

	Example Self Assessment	Readiness Rating:	Complexity:	Size:	Rat
	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.				0
	1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.				0
	1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.				0
	1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.				0
	1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents				0
	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.				0
	2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.				0
	2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.				0
	2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.				0
	2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.				0
	2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.				0
	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.				0
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.				0
	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.				0
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.				0
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.				0
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.				0
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.				0
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.				0
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.				0
	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).				0
	7.4 Young people and parents are able to self-refer into the single point of access.				0

Example Self Assessment

Resilience, prevention and early intervention for the mental wellbeing of children and young people

Our aim is to act early to prevent harm, by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.

	Readiness Rating:	Complexity:	Size:
1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.			
1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.	2. Partially Implemented	3. Medium	3. Medium
1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.	2. Partially Implemented	3. Medium	3. Medium
1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.	2. Partially Implemented	2. Simple	3. Medium
1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents	2. Partially Implemented	3. Medium	3. Medium
2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	2. Partially Implemented	4. Complex	3. Medium
2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.			
2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.			
2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.			
2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.			
2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.			

	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.			
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.			
	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	3. Medium
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.			
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.	4. Not Ready/ Anticipate Some Barriers to Change	4. Complex	4. Large

Supporting Information:	**Theme Readiness Rating:**
	#N/A

Improving access to effective support – chapter 5 summary

Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time.

		Readiness Rating:	**Complexity:**	**Size:**
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.	2. Partially Implemented	3. Medium	4. Large
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.	3. Changes Agreed but Not Started	4. Complex	5. Very Large
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.	3. Changes Agreed but Not Started	4. Complex	5. Very Large
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.			
	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).			
	7.4 Young people and parents are able to self-refer into the single point of access.			
	7.5 Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop shop services, based in the community .			
	8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.	3. Changes Agreed but Not Started		
	8.1 There is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices.	3. Changes Agreed but Not Started		
	8.2 There should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals.	3. Changes Agreed but Not Started		
	9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	3. Changes Agreed but Not Started		
	10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).			
	10.1 There is a strategic link between children's mental health services and services for children and young people with special educational needs and disabilities (SEND)			
	10.2 There should be involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)			
	11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	4. Large
	11.1 Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with	2. Partially Implemented	3. Medium	4. Large
	11.2 Further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	4. Large
	12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.	3. Changes Agreed but Not Started	3. Medium	3. Medium
	12.1 CYP experiencing mental health crisis receive appropriate support/intervention as outlined in the Crisis Care Concordat	3. Changes Agreed but Not Started	3. Medium	3. Medium
	12.2 There is an out-of-hours mental health service available for children and young people experiencing mental health crisis	3. Changes Agreed but Not Started	3. Medium	3. Medium
	12.3 Supporting a CYP in a crisis includes a swift and comprehensive assessment of the nature of the crisis.	2. Partially Implemented	3. Medium	3. Medium
	12.4 There are dedicated home treatment teams for children and young people.	2. Partially Implemented	3. Medium	3. Medium
	12.5 The national development of all-age liaison psychiatry services in A&E Departments should mean that appropriate mental health support in A&E is more readily available.	4. Not Ready/ Anticipate Some Barriers to Change	2. Simple	4. Large

	13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	4. Large
	13.1 There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	4. Large
	13.2 This are clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care	3. Changes Agreed but Not Started	3. Medium	3. Medium
	14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.	3. Changes Agreed but Not Started		
	14.1 There is a robust admission gateway processes for CYP with learning difficulties			
	14.2 There is a challenge process that checks that there is no alternative to admission for CYP with learning disabilities and/or challenging behaviour.			
	14.3 The creation of an agreed discharge plan on admission for CYP with learning disabilities and/or challenging behaviour is standard practice.			
	15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.	4. Not Ready/ Anticipate Some Barriers to Change	3. Medium	3. Medium
	15.1 There is flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.			
	16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.	2. Partially Implemented		
	17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.	2. Partially Implemented		
	18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.			
	19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.			
	19.1 No child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.			
	19.2 Develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning.			
	19.3 CQC should carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

Caring for the most vulnerable – chapter 6 summary

Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.

		Readiness Rating:	**Complexity:**	**Size:**
	20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.			
	20.1 Not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up			
	20.2 Services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer			
	20.3 It may be necessary to find alternative ways to engage the child, young person or family.			
	21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.			
	21.1 Health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes			
	22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.			
	23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.			
	24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.			
	25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.			
	26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.			
	26.1 A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way.			
	27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.			
	28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.			
	28.1 Specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties.			

	28.2 Consultation and liaison teams are used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved above and beyond the level of existing cross-agency provision (including specialist services).			
	28.3 There is an identified specialist point of reference, including a senior clinician with specific expertise within mental health services.			
	29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.			
	29.1 This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel. This model shall incorporate the necessary governance structures essential for success.			
	29.2 Develop a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

To be accountable and transparent – chapter 7 summary

Far too often, a lack of accountability and transparency defeats the best of intention and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

		Readiness Rating:	**Complexity:**	**Size:**
	30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.	2. Partially Implemented		
	30.1 There is a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care.	2. Partially Implemented		
	30.2 There is a single, separately identifiable budget for children's mental health services.	1. Fully Implemented		
	30.3 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/ carers.	2. Partially Implemented		
	30.4 The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health.			
	30.5 Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing.			
	30.6 As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.			
	31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.			
	32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.			
	33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions			
	34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.			
	34.1 CQC and Ofsted should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (34).			
	35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.			
	35.1 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence based interventions to support evaluation of the effectiveness of the care commissioned (35).			
	35.2 Routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.			
	36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.			
	36.1 The introduction of the first ever waiting time standards in respect of early intervention in psychosis.			
	36.2 Access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes.			
	37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.			
	38. Making the investment of those who commission children and young people's mental health services fully transparent.			
	38.1 NHS England will be able to identify the overall children's mental health spend by the NHS.			
	38.2 Further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment.			
	39. Committing to a prevalence survey being repeated every five years.			

Supporting Information:	**Theme Readiness Rating:**
	#N/A

Developing the workforce – chapter 8 summary

It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.

	Readiness Rating:	Complexity:	Size:
40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments	2. Partially Implemented	4. Complex	4. Large
40.1 Professionals trained to be able to: Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.	2. Partially Implemented	3. Medium	4. Large
40.2 Professionals trained to: Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.	2. Partially Implemented	3. Medium	4. Large
40.3 Professionals trained to be able to: Identify mental health problems early in children and young people.	2. Partially Implemented	3. Medium	4. Large
40.4 Professionals trained to be able to: Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.	4. Not Ready/ Anticipate Some Barriers to Change	4. Complex	4. Large
40.5 Professionals trained to be able to: Refer appropriately to more targeted and specialist support.	2. Partially Implemented	3. Medium	4. Large
40.6 Professionals trained to be able to: Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.	2. Partially Implemented	3. Medium	4. Large
40.7 Professionals trained to be able to: Work in a digital environment with young people who are using online channels to access help and support.	4. Not Ready/ Anticipate Some Barriers to Change	4. Complex	4. Large
41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.			
42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.			
42.1 Attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services			
43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.	2. Partially Implemented	4. Complex	3. Medium
43.1 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum.	1. Fully Implemented	3. Medium	3. Medium
43.2 All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability.	1. Fully Implemented	3. Medium	3. Medium
43.3 Skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE shall be addressed.	2. Partially Implemented	4. Complex	3. Medium
43.4 Skills gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings shall be addressed.	5. Not At All Ready/ Anticipate Significant Barriers to Change	5. Very Complex	4. Large
43.5 Counsellors working in schools and the community will receive further training to improve evidence-based care	2. Partially Implemented	4. Complex	3. Medium
44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.	5. Not At All Ready/ Anticipate Significant Barriers to Change		
45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.	5. Not At All Ready/ Anticipate Significant Barriers to Change	5. Very Complex	4. Large

Supporting Information:	Theme Readiness Rating:
	#N/A

Making Change Happen – chapter 9 summary

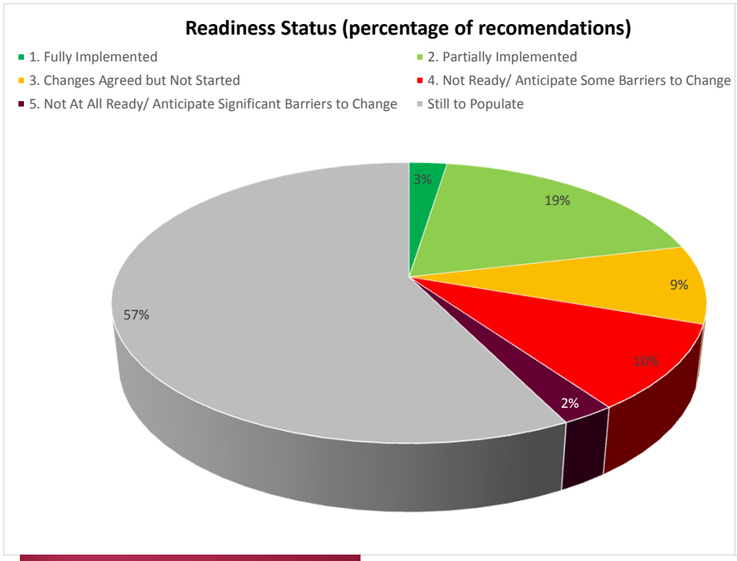
	Readiness Rating:	Complexity:	Size:
46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.	4. Not Ready/ Anticipate Some Barriers to Change	4. Complex	4. Large
46.1 Develop agreed Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer. These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.	4. Not Ready/ Anticipate Some Barriers to Change	4. Complex	4. Large
47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.			
48. Enabling more areas to accelerate service transformation.			
49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.			

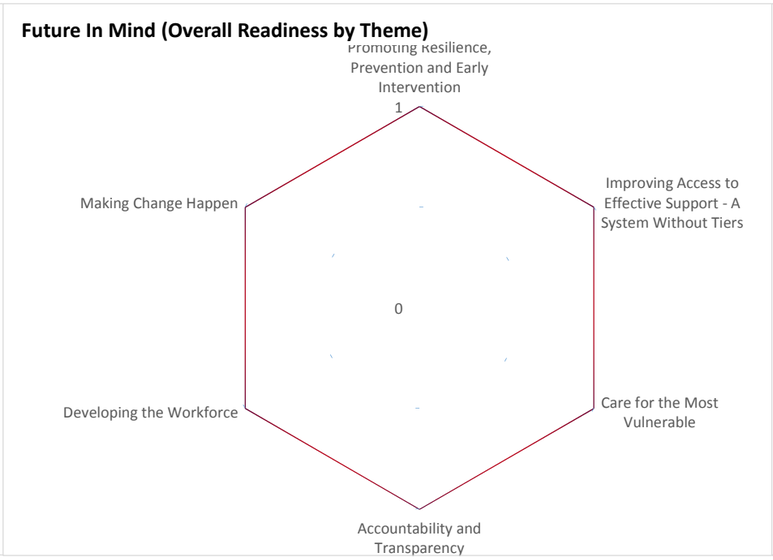
Supporting Information:	Theme Readiness Rating:
	#N/A

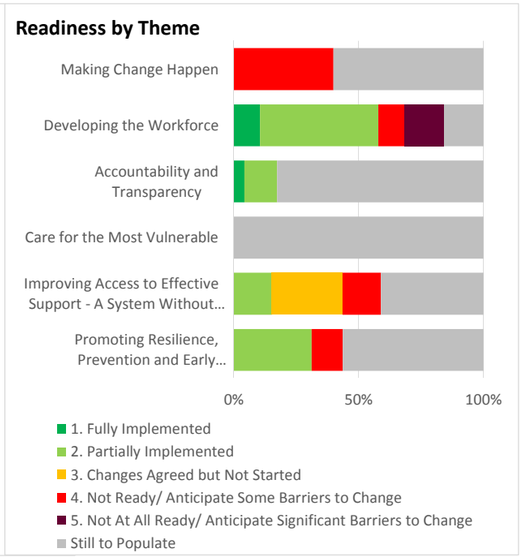
	Example Self Assessment	Complexity:	Size:	Rat
	1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.			0
	1.1 (Current Action) Reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.			0
	1.2 (Current action) Every birthing unit should have access to a specialist perinatal mental health clinician by 2017.			0
	1.3 (Current Action) The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.			0
	1.4(Current Action) Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parents			0
	2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.			0
	2.1 DfE is to produce guidance for schools in teaching about mental health safely and effectively (spring 2015). Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.			0
	2.2 DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.			0
	2.3 DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.			0
	2.4 School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels.			0
	2.5 The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.			0
	3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.			0
	4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence based programmes of intervention and support.			0
	4.1 (Potential Action) Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.			0
	4.2 (Potential) The DfE and DH are to run '0-2 year old early intervention pilots looking to prevent avoidable problems later in life. The Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.			0
	5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kite marking scheme in order to guide young people and their parents in respect of the quality of the different offers.			0
	6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.			0
	7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.			0
	7.1 One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.			0
	7.2 Initial risk assessment to ensure children and young people at high risk are seen as a priority.			0
	7.3 Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).			0
	7.4 Young people and parents are able to self-refer into the single point of access.			0

Graphs: Example Self Assessment

24/09/15







associate development solutions

Question	Current position	What is needed to achieve this	Who needs to do this	When				
11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.	Recently appointed service user particpation lead working across the tier 2 and tier 3 services. Well established workplan including development of young persons and parents peer support groups in each locailty on a weekly basis. CAMHS LD team have close working links with Family Unite Network a charity that supports parents.	To develop mentoring programme for ex service users. Further development of CAMHS website and contribution with the local offer in the local authority.						
40.Targeting the needs of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidenced based training.	CAMHS have developed training packages for local staff at the local A&E dept / paed wards. •Targeted CAMHS teams have provided specialist training to community childrens health and local authority teams. . • Staff from CAMHs have visited some local schools this year to provide training to staff and pupils on mental health awareness and hope to roll this out further • CAMHS provide a rolling training training every 6/12 to local external agencies with a variety of workshop choices on topical mental health subjects. • All staff within the service have robust supervision arrangements in place. • Every staff member wihtin the directorate has a personal development plan in place which informs the teams training needs analysis • Training requests that have been supported are based on current service need and NICE guidance. • Recent discussions with local authorities regarding joint training is underway. •Monthly IAPT operational meeting are held between tier 2 and tier 3 services •IAPT is a standing agenda item at each services business meetings •research and IAPT related articles are routinely circualted for staff that have completed training or	• To push IAPT with supervisors • To work in partnership to develop local training programmes. • To confirm training programmes for local schools • Consultation and supervision to staff working within tier 1 services • To progress with plans for joint training across the local authorities. • To implement training programme to local acute hospitals and agree frequency • To continue with CAMHs professionals training workshops	CAMHs / BBC / CBC / Acute services / Education / Community health					
43. Extending the C&YP IAPT curricula and training programmes to train staff to meet the needs of C&YP who are currently not supported by the exisiting programmes.	per professional codes • Bedfordshire tier 2 and 3 CAMHs are currently part of the Reading C&YP IAPT consortium. We have successully trained 3 staff (one in tier 2 and two in tier 3) in the train the trainer module, this training has just completed and together we are devloping a plan to roll this programme out to external partners. • CAMHS LD service do not currently use IAPT. •CHUMS have one members of staff extending their cypiatp cbt diploma to apply for the supervisor training to enable them to support other members within the service who are currently involved within the iapt training. • Bedforshire IAPT have successfully appointed a service user particpation lead to lead service user enegament across the county. THis post was established in October 2014 and additioanl funds have been secured to extend this position until October 2016. THe workplan has been highly successful and has already made huge contributions to the service including routinely engaging service user on each interview panel (following a robust training programme), weekly support groups for young people and separate meetings for families, service user art groups, IT project meetings to develop web based services, established regular service user stakeholder forums and enaging young people in the vision for services	• To work in partnership to develop local training programmes. • Recent plans to implement local IAPT leadership groups within teams to push forward the IAPT agenda • Work to be resurrected on installing the ethos of IAPT within CAMHS • CAMHS LD service do not currently use IAPT - maybe further training for CAMHS LD staff for young people with LD/ASD for applying IAPT processes.	CAMHs - tier 2 and 3 in liaison with local schools, local authorities, children's community health and acute trusts.					
44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.	•Bedfordshire CAMHS are part of the C&YP IAPT programme and are promoting the training locally although are unable to comment on how this will be delivered on a National basis.							

45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.	•Bedfordshire CAMHS are due to have a review of current services to ensure staffing and resources are fit to meet the needs of the local population. Plans are underway to develop a seamless service between tier 2 and 3 CAMHS. •CHUMS are currently identifying the skill mix within the service in line with supporting young people with mild to moderate mental health difficulties. CHUMS hope that this will enhance their curretn skill base and knowledge thus building on individual strengths and resources. Through this process we can identifiy the areas for developement within the service and apply for the appropriate range of training that is available.	Plans are underway to review services	CAMHS and tier 2 services