North Yorkshire County Council

NHS
North Yorkshire
Clinical Commissioning Group

North Yorkshire Children and Young People's Mental Health System Scoping and Review

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Scope

This report was commissioned by North Yorkshire CCG in collaboration with North Yorkshire County Council. It set itself nine key areas to consider in order to offer options as to how the Children and Young people's social, emotional and mental health and well-being can be developed. NWD consultants have completed this report following extensive engagement with key stakeholders. The nine areas are outlined below:

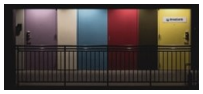
- Work with system leaders to develop a collectively owned scoping exercise that provides options and solutions to support transformation of CYP MH service pathways
- Understanding what is working well at present and where the areas are for development
- Benchmarking and learning from national best practice
- Identify proposed governance arrangements required, whilst aligning with wider system governance
- Work with system partners to ensure that feedback from front line staff as well as children and families is used to feed into the report. This could include new engagement work or draw on existing engagement infrastructure/mechanisms
- Explore the options for linking the Children's services and early help offer
- Look at current usage of the Thrive framework and how it is understood / perceived by professionals across the system
- Map existing pathways, referral mechanisms and services which make up current arrangements to understand the challenges and opportunities including snapshots of waitlists & KPIs from service providers and commissioners
- Work with providers to understand workforce requirements
    - Including identifying areas for workforce development

The aim of this report is to confirm the common held views across the integrated care system in North Yorkshire, as well as proposing recommendations and options as to how the system might develop together.

Outcomes

On completion of the scoping work senior leaders will be presented with different options and recommendations for future action that can address access to pathways which will include

- Mapping out current investment and commissioning arrangements with an options appraisal for future resourcing including:
    - Identifying other ICPs who may wish to partner and share best practice
    - Discussions with NHSE about funding available to support new pathway work
- Perceived advantages and disadvantages of each proposed approach
- Potential system savings and efficiencies of each approach
- Anticipated costs
- Anticipated timelines
- A potential data and evaluation framework which incorporates the requirements of system stakeholders
- Suggested digital solutions that build on the existing work on the Go-To website and associated infrastructure which will:
- Offer new ideas/innovations for early intervention and prevention
- Support the NHS ambition for digital first offers (where appropriate)



Approach

- Request and review documentation including strategic and system data documents
- Semi structured interviews with key stakeholders across partners including strategic, operational and referrers. Using a structure covering strategy, structure & system, shared values, staff skills and style & culture.
- Online survey for broader staff across the system
- Collate and review responses and compare against national and local direction of travel and recommendations

National and Local Contexts

There are several relevant national and policies and drivers which set the context for this work and give levers for change. These are summarised in Appendix 1

Executive Summary

42 interviews were undertaken across all levels of the system
188 professionals who work across statutory and non- statutory sectors supporting CYP MH services across North Yorkshire completed an online survey.
See Appendix 2 for links to survey results

Strengths

- A commitment across strategies to children and young people's mental health
- CAMHS SPA – a no rejection policy and emerging partnership onward referral pathways.
- Early Help multi professional assessment with consultant support
- Some good collaboration between services, especially VCSE
- Passionate staff working hard to provide effective services

Proposals are broken down into 5 key sections and based on our findings and best practice. A more detailed breakdown of these proposals is in the next section

1 Strategy

System change needs system connect and clearly communicated direction from strategic leads reflecting family and children and young people's views in line with key national policies.

- Development of system wide overarching mental health, digital and workforce strategies with experienced capacity to deliver change

2 Structure & System

The structure and work on the ground needs to reflect the strategy, local need and developments in new types of support. Families and services want a simple system where access to services and support are through a simple point(s) of access where informed professionals guide them effectively to the correct service, from universal self-help through to specialist services. For North Yorkshire, with its rural spread and complex boundaries, it is recommended to use national models of local delivery as this is developed into an integrated approach across the county. A shift to the use of standardised outputs and outcomes will give a more informed view of the system and the impact.

- Urgent work on key services with long waiting times
- Increase universal and early intervention offers
- Digital: expand the digital offer including upgrading the Go-To website and providing a range of evidence based digital mental health support offers.
- Integrated Working: Use the Thrive model to map services into a single system with a Single Point(s) of Access as the hub(s) utilising multi professional teams to make effective and empowered decisions.
- Data, Reporting and Recording: Develop common approaches to identifying and measuring needs and outcomes, using MHSDS compliant measures, linking to integrated reporting.

3 Shared Values

A joint system works most effectively with shared values and a single model. Thrive model work has begun but needs developing

- Use the Thrive model, with joint training, to bring services together into one system

4 Staff & Skills

- Develop staff skills to understand and implement the Thrive model as well as increasing universal and targeted evidenced based capacity at a local level

5 Style & Culture

- Develop a person centred and needs led system where the journey and needs of the person requesting support becomes paramount, offering a seamless and informed journey from the first point of contact to receiving the right support

Detailed Proposals

1 Strategy

There is strategic importance placed on children and young people's mental health in several North Yorkshire strategies but there was mixed understanding and sign up to the mental health strategy for North Yorkshire. The current CCG Mental Health Strategy (Oct 2021) replaces the CYPMHW transformation plan to 2020. It is a review and analysis of the current work against key NHSE&I priorities as well as giving good examples of work taking place. However, it lacks data, strategic direction and any evidence of impact.

1.1 The development of a system-wide children and young people's mental health transformation board and plan, co-produced with key stakeholder and agreed through the ICS and Safeguarding governance structures.

1.1.1 Children and young people's social, emotional and mental health is a clear strategic priority, but across various strategies. There are good arrangements in place for the dialogue, however, it is unclear how the partnership governance fits together. Under the emerging ICS/P there are two groups which cover this agenda. The LD and MH delivery group, which is mainly adult focused, and the Children and Young people's delivery groups, looking at all health issues. With social, emotional and mental health being a key strategic priority this current arrangement may not give sufficient senior officer oversight. This will need to be clarified as the ICS/P evolves. In our view, the way in which governance and decision making is organised needs developing: Develop the SEMH Strategic Group into a single, core CYPMH Board to act as the principal decision-making group for the system

- Embed/locate this Board within a wider network of stakeholders, including children, young people and their families, clinicians and professionals and wider children's services
- We think this Board should be the 'centre of gravity' for all aspects of CYPMH, with direct, senior level representation from each main partner including universal/ public health. This must include members of Bradford & Craven / Vale of York CCG to develop common models of delivery across North Yorkshire County. Strategic steer from the ICS may be required to enable common ways of working.
- Be a mixed commissioner/provider forum (adopting, where necessary, a Part A (commissioner only) - Part B (commissioners and providers) format
- Be responsible for service strategy/transformation as well as business as usual
- Have delegated authority to sign off
- Be accountable for the financial 'envelope' for CYPMH services
- Ensure the current proposed governance structure (see Appendix 3.3) provides governance and accountability from the ICS delivery groups to the Safeguarding Partnership board.

1.1.2 Develop a revised strategy that builds out from the refreshed CYP mental health services vision, and together with a detailed cross system implementation plan. Secure a clear mandate from relevant Boards/Committees to fully develop the emerging vision of more integrated children's services and co create a 5 year SEMH strategy with families, health, education, the VCS, local authority to plan the vision going forward. It should

- articulate the current situation, the vision and how to get there

- draw on and develop local data
- outline how it would overcome the geographical challenges and inequity of offer
- clearly establish the investment in children and young people's mental health across the system and where investments need to be made from which funding sources.

1.1.3 Ensure recommendations are taken through a process of co-production with families and professionals to outline the vision, the suggested developments and to create task & finish groups to keep the developments in line with their voice to enable a person & needs led system.

1.1.4 Create a simplified public facing version and ensure that it is well communicated to the wider system.

1.2 CYPMH Digital Strategy to outline the transformation to provide both digital mental health support, but also to develop digital infrastructure and digital capability, in place to improve data recording & analysis, release clinical time and reduce administrative burden.

1.2.1 Virtually every aspect of modern life has been, and will continue to be, radically reshaped by innovation and technology – and healthcare is no exception. Sustained advances in computing and the democratisation of information are driving choice and control throughout our daily lives, giving us heightened expectations around digital services and transformation. NHSE are proposing that in 5-10 years' time the existing models of care will look markedly different. The NHS will offer digital first options and people will be encouraged to stay well, recognise important symptoms early and to manage their own health supported by digital tools. A digital strategy can help North Yorkshire CYP MH services become an intelligent health system by

- Getting basic infrastructure and digital capability in place to release clinical time and reduce administrative burden
- Keep staff and service users at the forefront of digital disruption and enabling good information access
- Improve data and insight and enable decision making processes both from a strategy and clinical perspective
- Build digital skills across the workforce and embed digital working
- Improve interoperability between systems and allow systems to speak to each other across organisational boundaries
- Increase the use of artificial intelligence and machine learning in line with the NHS long term plan

1.2.2 In North Yorkshire rural communities are impacted by digital poverty, so digital support should be supplemented by a localised approach as outlined under structure and system and not regarded as the solution for rural communities.

1.3 Develop a system wide SEMH workforce strategy to audit skills and plan staff recruitment and training. Ensure a focus on specific vulnerable groups such as CLA and foster carers

1.3.1 Auditing the current skillset will more accurately identify gaps in evidence based, digital and Thrive skills such as using paired outcomes. This can be developed into an annual survey and strategy to expand and up skill the workforce.

1.4 Invest in additional experienced and empowered capacity at the strategic level to support providers as the 'engine-room' of the system-wide transformation plan.

1.4.1 Across Commissioners there is some good progress in terms of the joint working across the CCG and County Council's Children's Services. However, there is limited

capacity and there is not a joint or integrated commissioning team supporting this work. Experienced staff should be empowered with specific remits to drive this change.

2. Structure & System

- Across all interviews and questionnaires there was a clear and consistent concern and frustration about the ability to access suitable and timely mental health support.
- A confusing system from consistent feedback that services and families did not know where to go to get help or got rejected and had to try and find another service themselves. Some people found some services easy to access but many directed families to their GP.
- Difficulty in understanding what services were available for what needs
- Parallel pathways and lack of interconnected services leading to a scatter gun referral approach and having to tell your story more than once.
- Postcode lottery of support i.e. better coverage in some areas, especially in rural areas requiring much travel for families and professionals
- A lack of early intervention support and perceived high CAMHS thresholds.
- Most referrals and waiting times have increased. This is in line with the national pandemic impact.
- A scarcity of digital mental health support offer to complement face to face as both a choice but also to support while on a waitlist for face to face support.

2.1 An urgent waiting times initiative is created to look at shortening the waiting times to within agreed standards with a particular focus on eating disorders.

2.1.1 This should include how the pathway can be broken down into smaller parts across the system from informative and accessible prevention work in schools, online self-help and additional staff training to guide children and young people through the materials available on the Go-To website.

2.1.2 Similar work should take place for the neuro diversity assessment and learning disability services. There are regional learning opportunities in the Bradford DATA1 Neurodiversity Future Pathway Project.

2.2 Increase capacity in early intervention and prevention models of care to respond earlier and reduce the pressure and need for specialist CAMHS support. Develop these universal and targeted evidence based strategies through joint investment across the system including training for frontline staff.

2.2.1 Ensure retention of MHSTs once funding goes into the baseline by presenting well evidenced arguments to the required board around the full extent of their work across all three functions: whole school, direct support and advice/ consultation/ onward referral.

2.2.2 Bid strongly for the next wave of MHSTs

2.2.3 Ensure a roll out of whole school mental health frameworks and mental health lead training (DfE funded) beyond MHST supported schools.

2.2.4 Early intervention staff such as Primary Mental Health Workers could be recruited into the newly developed SPA to not only triage, but also offer brief interventions.

2.2.5 Develop the digital offer (see digital) for a broader offer meeting a range of needs and choices of support.

2.2.6 As part of the workforce audit, identify targeted workforce such as learning mentors in schools, school nurses, support workers, VCSF volunteers & paid staff who could be trained in evidence based targeted programmes such as Emotional Literacy Groups[1], Drawing & Talking[2], Webster Stratton parenting & classroom, bereavement[3], alongside validated assessments. Provide funding for such training.

Digital

2.3 Develop digital and artificial intelligence options including expanding and upgrading the Go To website as the one place for all children and young people's mental health information in North Yorkshire

2.3.1 Access digital transformation funding streams to support digital expansion

2.3.2 Share learning and insight from other areas through digital community of practice sessions

2.3.3 Upgrade the Go-To website to become the one, authoritative, well organised and regularly updated website, giving professionals and families a walk through from their needs through prevention, effective and authoritative self-help to suitable support. Ensure all other information sources about mental health guide people to this website. This should cover the entirety of North Yorkshire, from an inhabitant's geographical perspective, including Vale of York and Craven. Given the internet access issues of rural areas of North Yorkshire printed versions could be made available in local rural GP surgeries, council buildings and schools. Posters in internet access spots and rural bus/ train advertising would increase reach. This should be accompanied by a communications plan to ensure all partners have a clear understanding of where to find up to date information on services, self-help and how/ where people should ask for help.

2.3.4 Expand the evidence based child / YP friendly guidance and self-help offer for both informed self-care, but also useful activity while on a waitlist and guided self help which will increase the capacity in the system for lower level need for much less investment than face to face. Examples such as child focused ADHD awareness[4]. This can be hosted on the Go-To Website

2.3.5 Transform the Go-To Website to include Artificial Intelligence capabilities that will enable accurate and quick online referrals from professionals / CYP / Parents & Carers. This will enable guided, effective referrals reducing capacity on clinicians providing them with required information and baseline standardised assessments.

2.3.6 Improve interoperability between Clinical systems improving data and patient flow

2.3.7 Recruit digital apprentices to keep CYP at the heart of digital transformation

2.3.8 Invest in cost effective (compared to face to face) digital offers that have an evidence base matched to the identified needs from SPA referrals e.g. anxiety / phobias/ boys: https://www.bfb-labs.com/luminova (exposure therapy embedded in a mobile game); anxiety: https://www.silvercloudhealth.com/uk (guided self-help from locally

[1] https://www.gl-assessment.co.uk/assessments/products/emotional-literacy/

[2] https://drawingandtalking.com/

[3] https://www.mentalhealth.org.uk/sites/default/files/MHF%20Scotland%20Mapping%20interventions%20bereavment.pdf

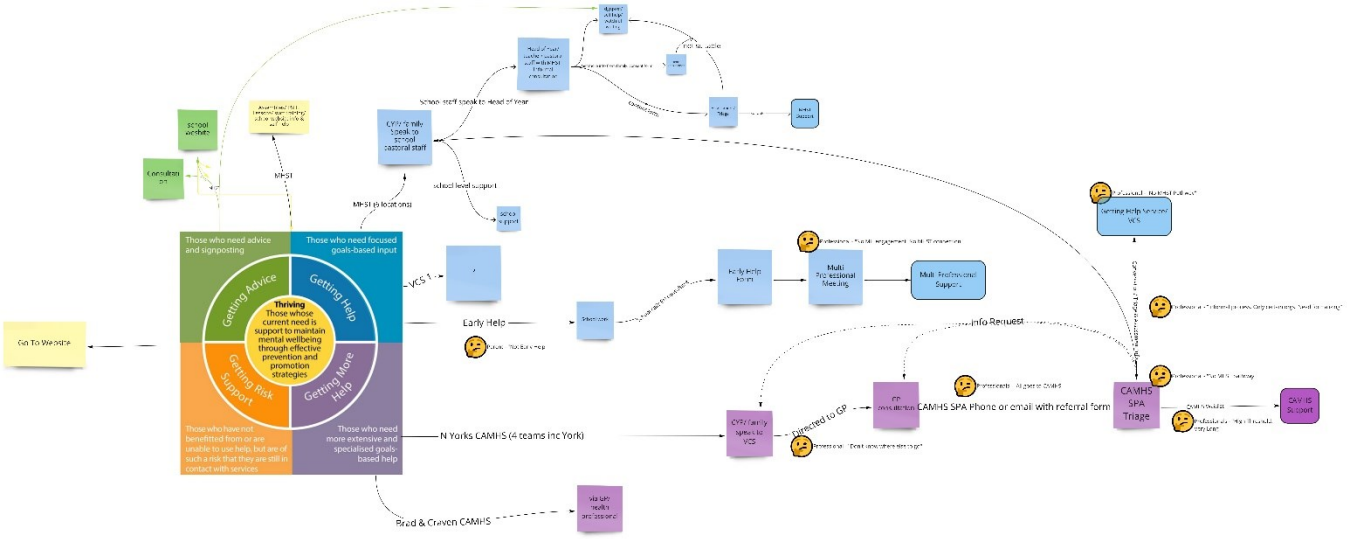
trained staff); eating disorders - http://mytransitions.co.uk (guided self-help from trained staff). Digital solutions should be introduced using the Digital Technology Assessment Criteria (DTAC)[5] process.

2.3.8.1 Be mindful that investment in digital technologies requires promotion, culture and practice change in addition to the commissioning. "*The most challenging part of implementing digital technology is not the technology itself, but the engagement, skills, behaviours and organisational culture required for effective change. It requires strong leadership to support practices and networks".*[6]

Integrated Working

2.4 Align systems and services under the Thrive quadrants with shared overlap to ensure the gaps between tiers are not transferred to this model.

2.4.1 This should start with a mapping exercise to outline not just offers but how the services interact to identify processes and issues that need resolving/ developing to a consistent approach. Overlaps of service, where user choice, current waitlist times influence decision making, are important to avoid the issues of the tiered model where users fall between service offers. This has been started here and could be used as a starting point.

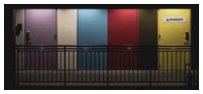


2.5 Plan & work as a single system, overarching public facing service, not separate systems providing separate parts requiring family and professional navigation

2.5.1 This should start with an overarching co-created SEMH strategy designed to address the main concerns and needs of North Yorkshire's children and young people's mental health including universal social & activity contributions such as youth

[5] https://www.nhsx.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/

[6] https://www.england.nhs.uk/wp-content/uploads/2020/01/online-consultations-implementation-toolkit-v1.1-updated.pdf



centres. This should fit under the expected overarching ICS children and young people's mental health strategy.

2.5.2 Re configured leadership & partnership arrangements to formalise CYP, family and VCS presence to enable joined up co production of strategy & commissioning. This can be formalised in the SEMH Strategic Group with cross partnership leadership sign up

2.5.3 A common, written and agreed understanding of Universal/ Thriving, Targeted/ Early intervention/ Early Help/ Getting Help, Specialist/ Getting More Help using a common approach such as Thrive with widespread staff & service training & signup

2.6 **Develop multi professional teams, with direct links to a single point of access, to formulate accurate assessment of need and support plans in local settings. Use national models for delivery such as combining Family Hubs and MHSTs or Primary Care Networks to develop the system locally at place. One way in, one effective conversation, one action plan, one process.**

The complex geographical boundaries and rural spread was a very common source of problem for both providing services at place where people live without the need for long journeys, but also a very varied service offer due to commissioning boundaries. A common description was of services located in population centres with both families and professionals needing to travel long distances to access support or visit communities

MHSTs are located in mainly high population centres. As a potentially mobile workforce supporting individual schools where children and young people go most days this is an opportunity to provide MH services in and around rural communities.

2.6.1 Commissioning is based on too broad population data which results in services being located in population centres. Commission services jointly, founded on ensuring all communities have equitable access. These can be centred in schools/ GP surgeries and council buildings for local, rural delivery in local settings. Using existing national strategies of MHSTs, Family Hubs and PCNs, this will develop over time but strategically planned, these can offer a more consistent offer across the county.

2.6.2 Some stakeholders liked the locality-based meetings as an opportunity to improve communication as well as address operational issues. The development of the Family Hubs is as an opportunity to deliver provision in a more integrated and local way.

2.6.3 Joint assessment multi professional teams across health, social care and education, following a set model such as 5P to unpick needs and multi-agency solutions closer to home. These should be at various levels of the system to identify needs appropriately and accurately as early in the life of the issues as possible.

2.6.3.1 One should be in and around schools using the emerging MHSTs with family hubs aligned with the early help pathway. Prioritise rural areas for future MHSTs to provide more service at place locally.

2.6.3.2 MHSTs should integrate their pathways with this multi professional offer to enable the right conversation in the right place at the right time.

2.6.3.3 Across the UK many local areas struggle with tensions over high-cost placements being either secure, out of area or mental health tier 4. This reflects the complexity of the young people's needs. Their needs could include neurodiversity, challenging behaviour and potential mental health diagnosis.

Building upon the 'no-wrong door approach in North Yorkshire it is proposed to develop a joint multi-professional unit. This would focus on the complex needs of the young person trying to formulate a package of support keeping the young person close to home. Such develops have taken place in Cardiff and are being considered in other local authorities.

For more complex needs a joint assessment/ multi professional team/ unit should be developed, as a joint business case, commissioned across the Local Authority and CCG/ICS. This could include working with families in their home, additional support for foster carers, more detailed assessments to clarify needs and step-down for tier 4 provision. It would be staffed by a multi-professional team to draw on best practice from mental health and social care and would be trauma informed.

The business case would focus on both the potential financial savings, and improving the quality of the offer to this complex group of young people. For example, it would reduce the use of hospital wards which are often seen as unsuitable for such young people and are costly. It would help resolve existing tensions and most importantly offer a better response to this complex group of young people. It would bring together professionals to offer an integrated model of best practice nationally.

2.7 Develop the CAMHS SPA as a cross service single Point of Access

In our view, developing and implementing the single point of access (SPA)is a priority, and one that needs to be brought into the new governance structures outlined above (and not a stand alone workstream). An effectively functioning SPA is the centre of gravity for a whole system, person led response.

The current SPA in TEWV is operating a no rejection policy, however, too many referrals that do not meet the threshold for specialist CAMHS intervention are processed here putting a strain on clinical and admin time. Signposting, rather than agreed onward referral (though that has been achieved with some services as a model to build on) for many non CAMHS referrals means parents then need to then re refer to that service, meaning a time delay, a risk of rejection and an additional referral in the system.

System join up, learning and effective referrals require a multi professional triage team to be put in place that links directly with the whole system offer. The SPA will require a full partner steering group to oversee developments to ensure setup and ongoing development meets the expected vision over time.

We acknowledge that establishing a successful SPA is challenging. There are the immediate challenges of developing an effective operating model within a complex provider landscape, but also the SPA can only be as effective as the services that surround it. As a result, it would be sensible to take a phased approach to implementation aligned to other priority workstreams. Phasing should be considered for access and acceptability criteria, response times and prioritisation.

2.7.1 Jointly created pathway with LA/ Health/ Families to co create systemic approach

2.7.2 One, jointly commissioned, single point of access with support for children and their families with easily available generic advice, specific tailored advice and “hand holding” through the process to eliminate “parents needing to be the experts"

2.7.2.1 It is imperative that a SPA steering group is set up and considers how to:

- achieve a consistent and standardised approach to screening/ assessment/ triage and ensure rapid screening by a mental health professional, reduce admin processes and hand offs within the referral pathway
- streamline the referral process and improve access to services to ensure all service providers including MHSTs accept referrals via the SPA. This will include agreed consent for all services to share information via an updated and simple referral form/ online form/ phone call/ AI system
- ensure there is appropriate alignment with other routes into children’s services, such as integration with Early Help services.
- Explore digital algorithms and AI as part of NHS digital ambitions

2.7.3 Ensure Bradford & Craven and North Yorkshire, when developing their SPAs, use similar principles and agreed referral processes to share data, assessments and triage judgements to accept referrals for cross boundary cases. This is to enable a seamless experience for families by removing the need for additional triage.

2.7.4 Wide ranging comms plan to communicate the system offer and changes to both families, children and young people and professionals. This should include all partner websites directing referrers into the SPA via the Go-To website with technical support to embed links and graphics where necessary.

2.7.5 Multi professional triage team with a range of partners e.g. Compass, early help to develop an understanding of what service offers are and ways of working.

2.7.5.1 All service multi professional networking group to complete tasks such as Thrive quadrants work and networking

2.7.5.2 Care Navigators function with extensive knowledge of the system to enable service access, check ins with guided self help and advice. Specialisms such as ADHD. This could be part of triage staff role or an independent named lead worker for families responsible for identifying and working with interdependent services to ensure a cohesive plan fit for purpose with regular family updates. Workers need delegated authority and direct connections to team managers/ Care professionals / SENCOs. Enable "telling story only once". Feedback into QA process to capture voice of the family.

2.7.6 Thrive quadrant analysis for clear service offer. This should include flexible thresholds based on need and staff skills as previously described.

2.7.7 All services listed on Go-To websites and offer including staff skills & USP to enable choice.

2.7.8 Ensure choice built in for children and young people e.g. digital, face to face, self help, type of service

2.7.9 Embed digital & extensive self help / guidance/ information offer for waitlist based on need e.g. anxiety / ADHD query

Data, Reporting and Recording

2.8. Develop a common approach to identifying needs tracked over time and key criteria such as complexity. This should use MHSDS compliant SNOMED codes. This should start with a system review

2.8.1 More detailed and common use of prevalence, need and service data at CCG, county and rural community location level to identify

2.9. Integrated reporting, with tracking over time, of children and young people's needs, staff skills and outcomes to commissioners with common and agreed headings, measures and report structure.

2.9.1 A common data dashboard for all commissioned or part commissioned services with common requirements for reporting needs, referrals, outputs and outcomes.

2.9.2 Types and numbers of needs being referred

2.9.3 Service access to identify equality of service across rural and high population levels

2.9.4 Outcome data demonstrating improvements to mental health

2.10 Increased use of MHSDS paired outcomes, in a sensitive manner with children and young people, reporting against set targets for use to commissioners.

2.10.1 Through staff and service training enable consistent use of a select few MHSDS compliant paired assessments relevant to the service offer and user need, set against a 40% target. This will enable both accurate identification of impact but also support Thrive endings.

3. Shared Values

There is clearly a great deal of dialogue and commitment to the social, emotional and mental health needs of the children and young people in North Yorkshire with joint meetings and good engagement. There is a clear opportunity with the arrival and emergence of integrated care systems to look at this differently. However, there are several differences which need to be worked through in order, to move forward together and as an integrated system. The Thrive model has begun to be introduced into North Yorkshire but is not embedded nor fully understood

3.1 Align systems and services under the Thrive quadrants with shared overlap to ensure the gaps between tiers are not transferred to this model.

3.1.1 Joint training for staff, alongside multi professional setup to understand, sign up to and work within the full Thrive model.

4. Staff & Skills

There were a broad range of skills listed in interviews but not necessarily well established, evidence based, Universal and Targeted approaches nor an embedded understanding of the Thrive model.

4.1 Staff Training & Development: Develop staff understanding of Thrive model and Single system approach.

4.1.1 Staff should be trained in understanding the full Thrive model to enable a better understanding of joined up and flexible working as well as the other key elements of the approach

4.1.2 Use Growing up In N Yorks survey to highlight areas of need for promotion, prevention and self help as well as staff skills training

4.2 Workforce Change Increase Getting Help/ Early Help/ Targeted capacity at a more localised level

4.2.1 Increase capacity throughout the system through additional funding opportunities such as HEE funded posts[7]

4.2.2 Ring fence MHST baseline funding to protect the service

4.2.3 Increase the early help/ early intervention/ targeted/ Getting Help offer of support to enable quicker access to an understanding of need and suitable, effective support from universal to self help, digital and face to face support. Build this on existing structures such as MHSTs to enable local offers and consistency of offer.

4.2.4 As part of commissioning change to more localised offers, develop staffing models to be centred in schools/ GP surgeries and council buildings. local, rural delivery in local settings

5. Style & Culture

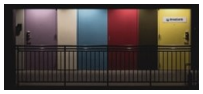
Current services are all working hard to provide quality services but often work in silos created by commissioning arrangements. Different organisational cultures exist within the NHS, Local Authorities and across different providers. This is exhibited with different operating systems, understanding and definition of thresholds. North Yorkshire is no different to many other Children's system in this regard.

5.1. Develop a person centred and needs led system where the journey and needs of the person requesting support becomes paramount, offering a seamless and informed journey from the first point of contact to receiving the right support.

5.1.1 Continue the development of partnership boards and networking

5.1.2 Multi professional SPA developments will develop this element strongly as it requires joint working and a Thrive led approach focused on needs.

[7] New IAPT High-Intensity Psychotherapeutic Counselling Training Pilot



Options and Costings

1. Single Point of Access (Structure and Systems: 2.3 and 2.7)

Examples and Costings

These are examples taken from other areas, both established and emerging to fit the North Yorkshire situation. Exact models and costs will vary depending on local decision making, funding and number of anticipated referrals. This must be worked through locally in the correct steering group and working parties.
Training must be costed in for staff around both pathways but also system and Thrive model knowledge.
There are a range of capital national funding sources both CCG/ LA and VCS providers, including CQUINS, to bring additional resource to develop services. Experienced consultants would be able make successful bids to add to baseline funding e.g. digital infrastructure.

A triage team should be a range of different professionals that can provide a mix of triage/ system knowledge/ pro active information finding and potentially low intensity direct support or supported self help. Roles include

- Triaging
- Collecting information
- Referral proposals / decisions
- Care navigator
- Checking in with / updating family/ YP
- Direct low intensity support and supported self help

Examples from other areas with outline costings to create North Yorkshire team. These can be a range of part time staff working in other N Yorks services.

- Statutory – Primary Mental Health Worker or equivalent : Band 6 Mid point: £34,172
- Statutory– Social Worker, Family Hub Worker or equivalent: C£40k with experience
- VCS from N Yorks system- therapist Band 6 equivalent Mid point: £34,172
- VCS from N Yorks system: Mental health support workers: Band 4 mid point £24,882
- Mental health social prescribing link workers: Band 4 mid point £24,882
- Assistant Psychologist: Band 4 mid point £24,882
- VCS – CYP Mental Health Coordinator: Band 4 equivalent mid point £24,882
- VCS – MDTT Project Lead: Band 5 equivalent mid point £27,780

Current CAMHS SPA team costings

- Team Leader: Band 7 £45k
- Band 6 x 5 x1 Band 7 (clinical nurse specialist) £170K + £45k= £215k
- + 2 admin staff (assume B4) £44k

Approx. £300k plus on costs

Pros

- No rejection policy
- Some developed formal pathways

Cons

- Lack of full system pathway
- Inconsistent assessments
- Staff heavy time to aid effective referrals
- CAMHS focused, rather than whole system, approach
- Uses all CAMHS clinicians, taking from clinical workforce
- Lack of full self help and supported self help waiting list options
- Much signposting
- Many GP referrals which typically lack detail

Proposed Teams

(based on 5000+ referrals pa taken from 12 x 255 CAMHS referrals a month (from last 12months) = 3060 (plus 423 x 4 quarters Compass Phoenix) = 1692)

1. Basic SPA to take all MH referrals and pass onto any partner in the system (no agreed formal pathways) following triage from one service
    - Current Setup
2. Full SPA – take all MH referrals in a variety of forms (professional, self, online, phone) with agreed referral pathways to all partners on a no rejection policy, following effective triage from multi professional team. Upgraded one stop shop Go-To website with extensive and effective self help and education materials.

Cost element	Annual cost	Recurrent/ Non-Recurrent	Notes
8A Clinical Lead	£53,219.00	Recurrent	Mid Point Annual basic salary only
B7 Team Manager	£42,121	Recurrent	Band 7 Mid Point Annual basic salary only
Primary Mental Health Worker or equivalent x2	£68,344	Recurrent	Band 6 Mid point: Annual basic salary only
VCS from N Yorks system- therapist	£34,172	Recurrent	Band 6 equivalent Mid point
B4 Admin staff x2	£49,764	Recurrent	Band 4 mid point Annual basic salary only
VCS from N Yorks system: Triage & Community connectors x2	£ 49,764	Recurrent	Band 4 mid point Annual basic salary only
Communications	£15,000.00	Non-recurrent	
Go-To website development costs	£20,000.00	Non-recurrent	
System development	£13,500	Non-recurrent	(including full service mapping, formal pathway development, consistent assessment use)

Thrive and system staff Training	£5,000.00	Non-recurrent	
Capital and IT costs	TBC		
Total	**£310,884**+ on costs		

Pros

- No rejection policy
- Developed formal pathways
- Whole system focused approach with no signposting and less scattergun referrals
- Fewer CAMHS clinicians (more available for face to face work)
- Consistent assessments

Cons

- Staff heavy time to aid effective referrals
- Lack of full self help and supported self help waiting list options

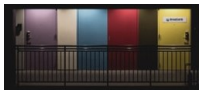
3. Advanced SPA – As full but with short term low intensity support and supported self-help using direct and digital interventions (see 2 below)

Cost element	Annual cost	Recurrent/ Non-Recurrent	Notes
Full SPA costs	£310,884+ on costs		
Primary Mental Health Worker or equivalent	£34,172	Recurrent	Band 6 Mid point: Annual basic salary only. Face to face & online low intensity support
Silvercloud	£ 15k – 20k (approx.		TBC
Luminova	£23,000		Anxiety & phobias : 400 children and young people £57.50 per treatment block
My Transitions	£50,000		100 referrals (includes 1:1 clinical staff support) = £500 per 7 session treatment block
Total	**£435,056**		+ on costs

Pros

- No rejection policy
- Developed formal pathways
- Whole system focused approach with no signposting and less scattergun referrals
- Fewer CAMHS clinicians (more available for face to face work)
- Consistent assessments
- Additional range of easily accessible early intervention capacity without additional onward referral.

Cons



- Staff heavy time to aid effective referrals
    - **Advanced +** SPA - as advanced but with an advance AI referral system with in built assessments (see 1.1. below)

Cost element	Annual cost	Recurrent/ Non-Recurrent	Notes
Advanced SPA costs	£435,056		+ on costs
E referral form IT / AI Scoping and planning	£40,000	Non Recurrent	Development and interoperability. (Between £30 – 50k, depending on scoping)
AI system	£30,000	Recurrent	
Digital Consultant	£13,500	Non Recurrent	Capital funding bids, AI & digital consultancy
Total	**£518,556**		+ on costs

Pros

- No rejection policy
- Developed formal pathways
- Whole system focused approach with no signposting and less scattergun referrals
- Fewer CAMHS clinicians (more available for face to face work)
- Consistent assessments
- Additional range of easily accessible early intervention capacity without additional onward referral.
- More efficient referrals system with prompts for self referrals as well as SPA staff to create effective and informed referrals with built in assessments.
- Access to capital funding from NHSE
- Efficiency savings: Reducing staff admin and clinician time on information collection, new assessments and multiple referrals
- Reduced NHS choice options from families for waiting times outside of legal maximums
- Reduced scattergun referrals
- Reduced multiple referrals from signposting
- Quicker access to the right support
- Reduced complaints

Cons

- Staff development time

Example specifications can be shared and developed as part of any additionally commissioned work

1.1 Artificial Intelligence referral system (Digital 2.3)

To avoid referrals going directly into TEWV, an AI the system could redirect all referrals into CYP MH services to the Go-To Website. If you are a CYP, Professional or Parent you would refer directly into a website "chat" with digital algorithms prompting questions, including standardised assessments, from the information entered. Clinical teams would receive a far more complete referral enabling quick triage across the system to relevant referral points ranging from digital self-care tools (e.g. Kooth/ Silvercloud/ Luminova) early intervention or specialist CAMHS (TEWV).
The AI system would integrate required (MHSDS, validated, SNOMED coded) assessments as part of the process e.g. GBO, SDQ as well as prompting additional strands of questions from user answers e.g. indicators of autism may lead to AQ10 assessment questions for immediate filter / flag of specific need or to specific anxiety assessments.
This is an investment to save as the reduction in clinical time, increase in effective referral and inbuilt assessments at an early stage will save many hours of clinician and family time.

The Go-To Website would need to be repurposed with additional features and a machine learning algorithm developed.

A good example of a system that has adopted referrals into one website is Forward Thinking Birmingham (FTB) - https://forwardthinkingbirmingham.nhs.uk (FTB are currently scoping algorithms to support the referral process).

FTB had 21,000 referrals made into the website in 2020-2021 and 24,000 between 2021-2022. Of the referrals that came into the website 75% in both years were directed to the early intervention offer. Ensuring a stable and consistent VCS offer to compliment the SPA is crucial if North Yorks are to succeed with this ambition.

In order to maximise on the digital developments and external funding available for Digital Transformation we recommend a digital consultant is hired to scope out the possibilities of the expansion of the Go-To Website (see below) and also advise on early intervention digital first interventions that can be utilised to support pathways.

Costings (Please be advised these are estimated)

- Digital Consultant x 30 Days - £13,500.00
- Go-To Website developments (Online Referral Development and Machine Learning) - £30,000 - £50,000

2. Increasing early intervention system capacity (Structure and System 2.2)

2.1 Strengthening the Go-To website with an exhaustive and authoritative set of mental health information and self help on all key issues such as anxiety, depression, ADHD, autism etc with in built wide ranging self help materials. This can be created from existing ICS wide websites and workstreams (e.g. current autism ICS resource workstream) and resource collection as well as both clinical lead knowledge and family support groups created resources and knowledge so information and self help is created by users for users with expert clinical knowledge.

This again is an investment to save as an exhaustive and authoritative range of information and self-help will save both family and clinician time and be a highly useful waiting list intervention. This can be recorded as both indirect/ direct support e.g. watchful waiting/ supported self-help as part of MHSDS returns to illustrate the support on offer as opposed to waiting without any type of support as is currently the case. This will bring both cost and time savings as well as expanding capacity.

Costing

This would have to be confirmed following digital consulting scoping

2.2 A range of digital offers provides both distance support and waiting list directly out of SPA. SPA staff would be trained to identify relevant needs and allocate the support. These are simply examples with an evidence base used in other SPAs/ MHSTs

- My Transitions (Digital GSH Eating Disorders) £50k – 100 referrals (includes 1:1 clinical staff support) = £500 per 7 session treatment block
- Silvercloud costings £15k - £20k. Numbers supported TBC
- Luminova costings

Indicative Costs - Licence Quantity Based

Preferential pricing available for multi-year contracts

Apr 2022

No. of Licences	**100**	**250**	**500**
Annual Cost per Licence (ex.VAT)	**£230**	**£225**	**£220**
Estimated No. CYP given Access*	***400***	***1000***	***2000***
Approx. cost per CYP * (ex. VAT)	***£57.50***	***£56.25***	***£55***
Includes	Collaborative pathway mapping session to ensure deployment is customised for the service / locality **Access to the therapeutic game facilitating graded exposures: clinically meaningful contact** **Access to VitaMind Hub - User management + progress and MHSDS recognised outcomes scales data** **Licences can be re-assigned unlimited times** Self-led training videos + up to 3 live Q&A training sessions (remote) for professionals giving young people access to the game Online tech support and helpline: Account setup Comms & Marketing materials (including flyers, information sheets) for schools, allied professionals, local stakeholders Resources for parents/guardians Quarterly service iteration reviews		
Total Cost per Annum (ex.VAT)	**£23,000**	**£56,250**	**£110,000**
Cost Per CYP per Month (ex. VAT)	***£4.79***	***£4.69***	***£4.58***

**Assumes each young person has access to Lumi Nova for ~12 weeks. We recommend allowing young people to access it over the holidays too.*

2.3 Strengthening the pathways in the VCS by developing a talking therapies collaborative would enable the system to increase capacity within early intervention and prevention and engage with VCS providers that are currently not commissioned. A talking therapies collaborative supports the development of a lead provider model that enables CCGs and commissioners to work with smaller VCS services and avoids having to contract with the individually. A collaborative was set up in Bradford during covid to support with increased referrals into services and more information can be found here.

https://www.bacp.co.uk/news/news-from-bacp/2020/12-may-coronavirus-bradford-counselling-collaborative-commissioned-for-bereavement-support/

Lead provider collaborative is an NHS strategy[8] (though led by NHS services rather than a VCS lead. Calderdale Open Minds Partnership[9], by way of example, is taking a VCS led collaborative approach)

Purpose of a talking therapies collaborative

- To increase awareness of new organisations across the VCS sector and mechanisms to engage with them
- Raise awareness and profile of talking therapies and how it can support CYP MH referrals
- To be a route through which all new commissioned work for talking therapies in the district comes through
- Offer an all-age approach to referrals linking to CYP & Adults services
- Provide additional capacity to referrals coming into CYP MH services
- Provide immediate support for system pressures (waiting lists)

Costings

- Talking Therapies Collaborative (Lead Provider Scoping and Management Costs) - £50,000 - £70,000)
    - This should be in addition to the grants offered here to bring providers under a single system approach.

Please be advised that the Talking Therapies Collaborative workstream would need funding per intervention delivered once the lead provider had scoped all the capacity available and developed the model. We advise that an intervention of counselling be costed at £50.00 per hour which is a national average as mentioned from BACP.

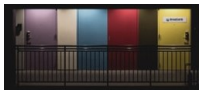
Pros

- Decrease pressure on specialist services
- Provide additional capacity from VCSE Sector
- Reduce contracting burden by working with lead provider
- Getting help sooner without waiting for lengthier specialist pathway (Thrive compatible)
- More choice (Thrive compatible)

Cons

- Up front investment
- Requires setting up leadership capacity

[8] https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/
[9] https://openmindscamhs.org.uk/



3 Locality Family Hubs

Nationally funded strategy to enable a local single point of access. Additional cost will depend on the Talking Collaborative expansion into these local structures e.g. care navigators to enable service navigation and access and mental health support, alongside access to a digital offer.

Ideally these would be in conjunction with a Single Point of Access to support a simplified way of accessing support and provide a range of expanding local, at place support offers. In Leeds, school multi professional clusters work in this way.

Without a Single Point of Access all referrals would go into the local family hub. This is not feasible until all Family Hubs are created in each locality

Services can be co commissioned with early help & schools to provide early intervention mental health support where MHST does not exist at reduced central cost.

This offer will not be available across all of North Yorkshire but brings an opportunity to develop at place services in more rural areas. It gives an opportunity to build an offer alongside Primary Care Networks

Digital offers can be provided across the range of family hubs

Cost: depends on setup but service joint funded by early help, school and CCG/ VCSF lottery funding

Per Family Hub

- One Band 6 equivalent mental health professional £34,172 + on costs
- 0.5 Band 4 Community connector: £12,441 + on costs
- Share of digital offer divided by number of family hubs e.g. £23,000 / 10 hubs = £2,300
- Capital etc will dependent Family hub venues setup but typically provided by Family Hubs to share.

Pros

- At place local support
- Time saving travel for families and professionals
- One referral that can be facilitated onwards with accurate information
- One pathway across health/ education and early help

Cons

- Without SPA not feasible for whole county until Family hubs fully rolled out.
- Will need a community connector / care navigator in each site to have knowledge of the system and manage any onward referrals

4 Mental health offer in GP surgeries via Primary Care Networks (PCN) (Structure and System 2.6)

A national strategy to bring NHS services closer to where people live at their GP surgeries including some mental health and social prescribing support. This offer will vary in each PCN but should at the very least have a formal ink to the SPA and family hubs. This is another location where a Talking Therapies Collaborative or digital offer could be attached.

Service options to offer

- Triage in line with SPA approach
- facilitated referral into SPA
- surgery staff awareness training e.g. mental health 1st Aid
- brief interventions including guided self help and group work
- social prescribing into local support and wellbeing groups
- community connectors to develop social prescribing offers and link into other support – trained in whole system knowledge and onward referral into SPA

Cost: depends on setup but service joint funded by local GP primary care networks and CCG/ VCSF lottery funding

Per PCN

- One Band 6 equivalent mental health professional £34,172 + on costs
- 0.5 Band 4 Community connector: £12,441 + on costs
- Share of digital offer divided by number of PCN e.g. £23,000 / 10 hubs = £2,300
- Capital etc will dependent Family hub venues setup but typically provided by PCNs in GOP surgeries.

Pros

- At place local support directly controlled by GPs
- Time saving travel for families and professionals
- One referral that can be facilitated onwards with accurate information

Cons

- Potential single service offer rather than whole system
- Will need a community connector / care navigator in each site to have knowledge of the system and manage any onward referrals
- Without SPA not feasible for whole county until PCNs fully rolled out and requires care navigator to have detailed system knowledge.

5. More Complex Needs (Structure and System 2.6)

Complex placements/tier 4 will continue to be a challenge to the system. The cost of this multi-agency unit would depend upon the number of beds, availability of premises or Council housing stock and how it would draw upon existing professional teams. The range of costs for residential placements for the most complex can be between £5-10,000 per week and hospital beds cost £3,500 per week. For example, some staff could be part time. The Cardiff model is registered as a children's home and has 'wrap-around' multi-professional support from partner agencies. Alternatively, a strategic partnership could be commissioned with a residential provider to offer this provision.

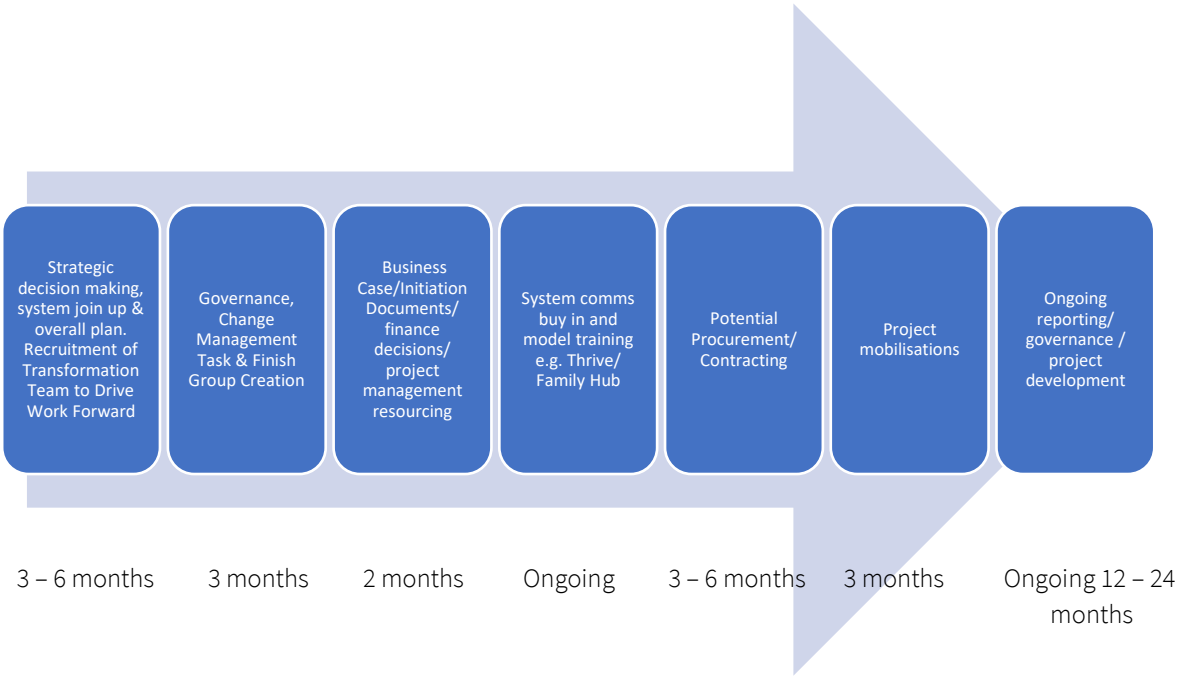
Pros

- Is a proactive response to a national challenge.
- Resolves current challenging placements.
- Is local to North Yorkshire and consistent with the current NWD model.
- Enables young people to remain local maintaining links with friends, family and schools.

Cons

- Needs additional resource but would save money medium-term
- Requires a joint commissioning approach
- Partners will need to support a multi - agency staff team and approach
- Will be a complex project to deliver

Timeline



The above are key steps and outline potential timings. These will vary significantly depending on options, pace of change, partnership working and capacity in the system to develop this change.

Typical considerations when developing system change

- System buy in to Thrive framework including workforce training
- Length of procurement and partner timelines & capacity e.g. Family Hubs development
- Appropriately funded pathways / capacity and setup
- System consultation & development on referral pathways including unified assessment framework and scoring system (algorithm)
- Digital procurement process
- Additional funding sourcing

Summary Findings (Feedback)

Full survey findings can be found in Appendix 2

Strategy

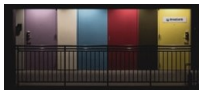
- From our discussions, a theme that emerged was the need to think more deeply about how CYP mental health services might in future be more integrated with wider children's services – a model of 'horizontal' integration. The underpinning rationale for this is two fold. Firstly, there is a consensus that in any future model of care there needs to have a much stronger focus on universal services and (as far as possible) meeting children's needs in that setting, rather than 'pulling' up into specialist services. Secondly, and more pragmatically, there is increasing recognition that there is a high degree of overlap between those children and families that are in receipt of mental health services and those that are known to and involved with other children's services, such as looked after children. This also extends to thinking about the links between CYPMH and other important aspects of the statutory environment, such as safeguarding arrangements.

- Leadership of mental health services for children and young people is fragmented across the system, and individuals frequently lack a clear mandate from their partners. Clinical leadership in planning and commissioning services is limited.
- We found a lack of clarity over how the views of professionals are sought, and considerable frustration at a perceived inability to influence service delivery.
- The existing governance and decision making arrangements for children and young people's mental health are complex, bureaucratic and fragmented. It is unclear where decisions get made, there is duplication across the different groups and there is a lack of accountability
- Resources to support the planning and commissioning of mental health services for children and young people are fragmented across the system. Leadership of this agenda is also fragmented: at present no one individual has the explicit role or mandate to bring together the full range of skills required to commission effectively or to act as the focus point for this service area.
- At present there is no clear picture of the total investment the system makes in mental health services for children and young people. Financial contributions are largely driven by history, rather than as the result of a clear strategy, and decisions about future levels of investment are largely taken within organisational silos.
- It is not clear where decisions about priorities, investment or services are made
- The boundaries of authority of each group are not defined
- Because there are multiple groups with overlapping remits, there is considerable duplication - but there are also gaps
- There is a lack of accountability in the system, both for individuals and for groups
- Strategic and operational issues are often blurred
- Although there are a plethora of groups, some stakeholders feel that they are excluded from key decisions
- There is confusion about which groups need to be 'commissioner only' and which should include service providers

Structure and System

- There is a focus on achieving high levels of performance against a small number of national metrics, which tends to mask significant pressures and challenges in existing services and risks distracting attention from local service improvement.
- The types and breadth of data currently collected is inconsistent and fragmented and, as a result, so there is no single system narrative that clearly sets out how services are performing.
- Currently services are delivered through a traditional tiered approach from different providers with different referral processes and access criteria. This results in a confused and fragmented system which bounces children and young people between tiers and allows others to fall between services.
- The is no single service across the system with considerable variation between the pathways currently commissioned. The focus is mainly on diagnostics with little or no pre and post diagnostic support.
- The existing services are under pressure and long waits have developed in parts of the system. This, and the lack of integration, prevents young people from being able to step up and down and this lack of throughput adds to the capacity constraints
- Referrers, young people and their families are confused and frustrated by the existing neurodevelopmental and learning disability service offer.
- Partners are unclear on where to access information nor the best way t make a referral e.g. CAMHS SPA access is hard to find on Go-To website
- Often information on support services is just a collection of several services[10] with no organization or guidance for families on which services are suitable, or their specific mental health needs, which reflects verbal feedback from people interviewed when asked about what services are available for what needs. Sometimes links are out of date[11]. More organized websites also provide a collection of services rather than one place for a family, child, young person, professional or volunteer to get help and understand what service is most relevant. Feedback is that this is confusing.

[10] http://healthyschoolsnorthyorks.org/wp-content/uploads/2020/06/Support-for-pupils-and-parents-in-primary-schools-in-relation-to-mental-and-emotional-wellbeing-NYES.pdf
[11] https://www.northyorks.gov.uk/support-children-young-people-and-their-families



Glossary

- **5P Formulation:** A specific approach, derived from CBT, to understand a person's experiences and inform practice.
- **CAMHS**: Child and adolescent mental health services. Traditionally run by NHS trusts and more recent abbreviated to CYPMHS (Children and Young People's Mental health Services) to describe the broader range of services available.
- **CCG**: Clinical Commissioning Group (NHS): Due to be replaced by Integrated Care Systems (ICSs) in 22
- **CBT**: Cognitive Behavioural Therapy: an evidence-based therapy
- **CLA**: Children Looked After
- **CYP:** Children and Young People
- **DTAC:** Digital Technology Assessment Criteria: new national baseline criteria for digital health technologies entering into the NHS and social care.
- **EHWB**: Emotional Health and Wellbeing
- **EMHP**: Education and Mental Health Practitioner
- **HEE:** Health Education England https://www.hee.nhs.uk/
- **FTB:** Forward Thinking Birmingham https://forwardthinkingbirmingham.nhs.uk
- **IAPT:** Increasing Access to Psychological Therapies
- **ICS:** integrated care system. Regional collaborative bodies to replace CCGs in 2021/22
- **ICP:** Integrated Care Partnership: local collaborative partnerships that are core elements of the ICS. They are designed to support partnerships and integrated working across places, at system level, specifically looking at broad health and care experiences and outcomes that cannot be solved by one organisation or place alone.
- **IPT:** Interpersonal therapy: An evidence-based therapy
- **LD:** Learning Disability
- **LGBQT+:** Lesbian, gay, bisexual, transgender, queer or questioning, transgender
- **Quarter**: 3 month period. Q1: April – June; Q2: July – Sept; Q3: Oct – Dec Q4: Jan – Mar
- **MH**: Mental Health
- **MHSDS:** Mental Health Services Dataset: national NHS mental health reporting tool[1]
- **MHST:** Mental Health Support Team
- **NHSE&I**: NHS England and NHS Improvement. 2 bodies that now work as one to lead the NHS in England setting the Long Term Plan
- **PCNs:** Primary Care Networks: GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices
- **SEMH:** Social, emotional and mental health needs: title used by Special Needs Code of Practice (Education)
- **SNOMED:** an international, structured vocabulary for use in an electronic health record
- **TEWV**: Tees, Esk and Wear Valley NHS Foundation Trust
- **VCSE:** Voluntary, Community and Social Enterprise

Appendix 1 – National and Local Contexts

Relevant national Strategies These will give the national levers for change	There are a variety of national strategies and trends. In general, mental health spend is increasing and should increase faster than overall NHS spend[12] with increased access to support. There are no mandated wait times but this should be in line with 18 week non urgent maximum wait times[13] with a pilot in some areas of 4 week wait times. GPs often cite a lack of time to talk to children and young people properly about their mental health in consultations, lack of knowledge about how and where to refer to and the ease of having a mental health practitioner on site[14]
1. Transforming Children and Young People's Mental Health Provision: a Green Paper[15]	Outlines key government strategic approaches including Mental Health Support Teams, school based mental health lead training and 4 week waiting list
2. NHS 10 Year Plan[16]	The plan outlines the strategy for the NHS which includes being more joined-up and coordinated, more differentiated in its support offer to individuals prevention, digitally enabled care, ICS & local authority partnerships.
3. NHS Mental Health Implementation Plan 2019/20 – 2023/24[17]	Following on from the 5 year forward view outlines the funding and expectations for mental health services up to 23/24. This references ICS 5 year plans; MHST roll out; crisis, eating disorder and suicide prevention services; alignment with SEND & children and young people's services; digital offers; local flexibility; provider led collaboratives; data quality; workforce expansion Local systems will have flexibility to tailor local pathways, staffing mix etc. to their local needs. All systems are expected to achieve the same end point by 2023/24 and to provide a local year-on-year phasing for delivery in their 5-year plan.

[12] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/
[13] https://www.nhs.uk/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7606150/
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[16] https://www.longtermplan.nhs.uk/
[17] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

3. *Health and Care Workforce Strategy: Facing the Facts, Shaping the Future*[18]	With mental health one of its 4 priorities, the draft strategy promotes prevention promotion as the 1st line of support for all clinicians including the benefits of exercise on physical and mental health; parity of esteem between physical and mental health; modern & flexible ways of working; benefits of multi-disciplinary teams & locally integrated care; Putting people first (patients and staff), focusing on what works (evidence base for interventions and for staff retention); investing in staff training, including widespread digital solution use, retaining and expanding the workforce.
4. Rural Proofing in England 2020[19]	This strategy outlines the need to level up rural communities including internet and service access using available grants and new community services formula.
5. National Digital strategy[20]	Better use of data and technology has the power to improve health, transform the quality and reduce the cost of health and care services. It can: • give patients and citizens more control over their health and wellbeing • empower carers • reduce the administrative burden for care professionals • support the development of new medicines and treatments This framework has been developed based on evidence from many sources, including civil society and patient organisations, as well as directly from service users. This is not a strategy in the conventional sense. It is not a national plan, but a framework for action that will support frontline staff, patients and citizens to take better advantage of the digital opportunity. The National Information Board will report annually on progress made against the priorities detailed in this framework and review them each year to reflect changing technology and accommodate new requirements from the public and staff. The proposals in this framework are not comprehensive but they represent the core and immediate priorities for delivery of modern digital health and care services.

[18] https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf

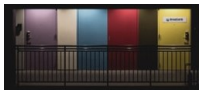
[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982484/Rural_Proofing_Report_2020.pdf

[20] https://www.gov.uk/government/publications/personalised-health-and-care-2020

1.2 Local Context

Relevant Local Strategies These will give the local levers for change	North Yorkshire comprises of several boundaries including two councils, 3 CCGs and 3 ICS[21] . This creates issues around consistency of approach and governance. Therefore national and common ICS strategies are helpful points of consistency. Humber and North Yorkshire Health and Care Partnership was created in shadow form on 1st April 2022 to become a statutory body on 1 July 2022[22] Key Boards o Children's Trust Board for North Yorkshire o North Yorkshire Safeguarding Children Partnership (NYSCP)[23]
1. ICS Humber Coast & Vale Partnership Long Term Plan[24]	Important and relevant extracts include a. A shift to prevention b. Personalisation c. Mental health as one of four priority areas
2. Humber, Coast and Vale Health and Care Partnership Mental Health, Learning Disabilities and Autism Collaborative Programme[25]	Important and relevant extracts include a. *better access to services and more support both at home and at school* *b. a large expansion of community mental health teams…. who will work closely with the developing primary care networks, linking mental health and primary care. This work will provide opportunities for the integration of mental health support with the wider community support network.* *c. Families and carers (our 'experts by experience') are key in the development of our work, their input is fundamental to every stage of our process….. 'to be part of steering groups, ensuring strategic decisions are well informed, reflect service users' needs and models of care are co-produced* *d. Key outcome: I have the same access to health and care support as everyone else* *e. Strategic Outcome: Schools and health and care services work together to provide a seamless service and equip families and children with the tools to manage their own health* f. VCSE into strategic decision making and equal partners

[21] Map
[22] https://humberandnorthyorkshire.org.uk/developing-health-and-social-care-in-humber-and-north-yorkshire/
[23] https://www.safeguardingchildren.co.uk/wp-content/uploads/2019/09/NYSCP-MASA.pdf
[24] https://humbercoastandvale.org.uk/partnership-long-term-plan/
[25] https://humberandnorthyorkshire.org.uk/wp-content/uploads/2021/11/HCV-HCP-MH-LDA-Strategy-Final.pdf



3. Young and Yorkshire 2 plan[26]	The council plan outlines a number of priorities which includes a. *Improve social, emotional and mental health and resilience.* *b. Ensure that the continuum of provision for social emotional and mental health needs across health, education and social care is co-ordinated and that services commissioned meet the needs identified locally* *c. Ensure timely access to specialist mental health services for children, young people and their families when required* d. *Support peers, family members and professionals to be better equipped to identify need early, working seamlessly across organisations to provide the right support at the right time and by the right agency.*
4. Being Young in North Yorkshire, the safeguarding partnership strategy (2021-24)[27]	Social, emotional and mental health is one of three focus areas: • Work with partner agencies to collaborate improved SEMH service. • Expand support delivered through the Mental Health Support Teams in schools
5. Corporate Parenting Strategy[28]	The strategy makes one of its priorities improving social, emotional and mental health and resilience. This is based upon performance data showing North Yorkshire scores higher on the SDQ scores for its looked after children and young people.
6. Humber Coast And Vale ICS Children And Young People's Mental Health Strategy North Yorkshire CCG[29]	Provides a review of current work in North Yorkshire and opportunities for development. One priority is outlined for 21/22, but without an implementation plan and no priorities for 22/23.

[26] https://www.northyorks.gov.uk/young-and-yorkshire-2

[27] https://www.safeguardingchildren.co.uk/wp-content/uploads/2021/09/82425-Being-Young-in-North-Yorkshire-Amendments_V2_Screen-Version.pdf

[28] https://www.northyorks.gov.uk/sites/default/files/fileroot/About%20the%20council/Strategies,%20plans%20and%20policies/74706%20LAC%20strategy%202018%20Looked%20After%20Children%20-%20Accessible.pdf

[29] https://thegoto.org.uk/wp-content/uploads/2022/03/October-2021-Children-and-Young-Peoples-Mental-Health-Staretgy-NY-CCG-FINAL.pdf

1.3 Data

Relevant Local Data	N Yorks 5 – 18 population is estimated from 2016 at around 94,00 children and young people[30] with Harrogate and Rural District having the highest population levels Datasets can be hard to compare due to measurement differences, out of date data and boundaries
1. PHE Fingertips data31	PHE prevalence indicates 10,755 children and young people needing support (2017/18) (approx. 11% of the 5 – 18 population)
2. Mental Health Referrals data[32] (May need to filter for suitable CCG and data points)	NHS digital numbers via the MHSDS indicate around 2,000 children and young people per month are "in contact with mental health services 0 – 18" and Open Referrals[33].
3. 25/02/22 Scrutiny Report	This data shows an average of 217 new referrals a month into CAMHS over a 21 month period rising from 100 a month (April 20) to 200 a month (dec 21) with a peak of over 300 in March/ May 21. Eating disorder referrals decreased but have almost now doubled. Crisis referrals rose but then settled back to April 20 levels of 60 per month over the same time period. This does not appear to include MHST referrals. Referrals into the Compass Phoenix services have grown over the last year. In quarter 2 (July-Sept) there were 298 referrals but during the third quarter this has grown to 423 referrals
4. Growing Up in North Yorkshire[34]	This survey is competed by pupils. The reports do not show longitudinal data but scrutiny report data shows an overall decline in resilience and wellbeing scores since 2016 & 2108 surveys. E.g. 10% Year 6 Low wellbeing = approx 1300 pupils. This survey is referenced in several strategies. No data was seen at localised rural levels nor for per head spend No waiting time data was seen

[30] https://hub.datanorthyorkshire.org/dataset/population-estimates
[31] Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)
[32] Microsoft Power BI
[33] Microsoft Power BI
[34] http://healthyschoolsnorthyorks.org/wp-content/uploads/2021/09/NYork2020summary.pdf

North Yorkshire Fingertips PHE data

☑ CIPFA nearest neighbours to North Yorkshire

Indicator	Period	N Yorkshire			Neighbrs average	England	England		England
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Estimated number of children and young people with mental disorders – aged 5 to 17 ⚠	2017/18	–	-	10,755	-	-	-	-	-
Estimated prevalence of emotional disorders: % population aged 5-16 ⚠	2015	–	2,607	3.3%*	3.4%*	3.6%*	2.8%		4.2%
Estimated prevalence of conduct disorders: % population aged 5-16 ⚠	2015	–	4,001	5.1%*	5.3%*	5.6%*	4.0%		6.9%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16 ⚠	2015	–	1,066	1.4%*	1.4%*	1.5%*	1.1%		1.9%
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24 ⚠	2013	–	7,395	7,395*	143617	*	-	-	-
Prevalence of ADHD among young people: estimated number aged 16 - 24 ⚠	2013	–	8,167	8,167*	153507	*	-	-	-
Percentage of looked after children whose emotional wellbeing is a cause for concern	2019/20	→	72	38.3%	-	37.4%	59.3%		17.5%
Hospital admissions as a result of self-harm (10-24 years)	2019/20	→	395	449.9	-	439.2	1,105.4		126.2
Hospital admissions as a result of self-harm (10-14 yrs)	2019/20	→	65	189.7	-	219.8	580.6		46.2
Hospital admissions as a result of self-harm (15-19 yrs)	2019/20	→	175	550.1	-	664.7	1,640.8		151.1
Hospital admissions as a result of self-harm (20-24 yrs)	2019/20	→	150	585.8	-	433.7	1,280.0		86.3
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)	2020	↑	1,006	2.24%	-	2.45%	4.05%		1.35%
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)	2020	↑	942	2.59%	-	2.67%	4.71%		1.28%
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)	2020	↑	2,103	2.56%	-	2.70%	4.40%		1.50%
Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)	2019/20	–	-	19.3%	-	25.8%	42.7%		11.8%

35

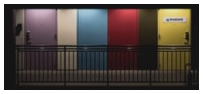
Referrals and Waiting times

2 Eating Disorders: There is a waiting time standard regarding eating disorders. In North Yorkshire the increased demand has impacted upon achieving this standard. This is unsurprising given the significant demand for eating disorder support. For routine cases (aim to be seen within 4 weeks) this was achieved 48.5% of cases. For urgent cases (aim to be seen within 1 week) this was achieved 25% of cases.

3 The increase in demand for Compass Phoenix means the numbers of young people waiting doubled from 51 to 117. This resulted in the average waiting time increasing from 22 to 39 days as at December 2021.

4 CAMHS waiting times are important, including being a data request from Ofsted. Waiting times show that in January 2022 of the 149 waiting for assessment only 3 will wait longer than three months to be assessed. However, this does not tell the whole picture. This does not tell us the time waited for interventions to start.

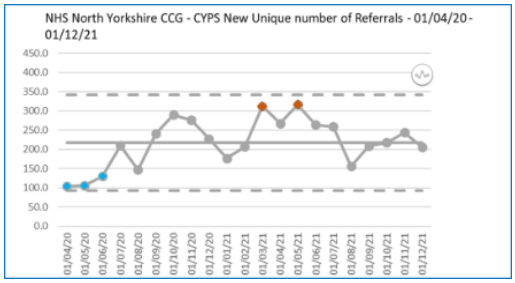
[35] Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)



Demand for services– CAMHS

SPC chart of the number of new unique children and young people referred during the period of April 2020 – December 2021 to North Yorkshire CCG

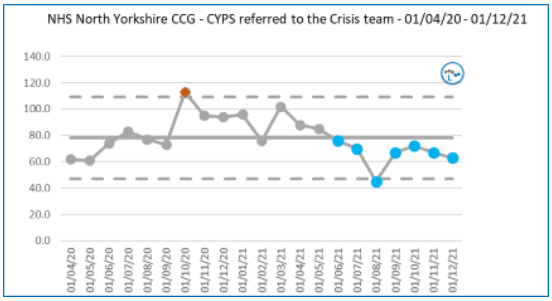
	Metric Name	Performance	Assurance	Latest Value	Lower process limit	Upper Process limit	Mean
1	NHS North Yorkshire CCG - CYPS New Unique number of Referrals			206.0	92.8	342.3	217.5



Demand for services– CAMHS

SPC chart of the total number of CYPS referred to the NYY Crisis team for NY CCG during the period April 2020 – December 2021

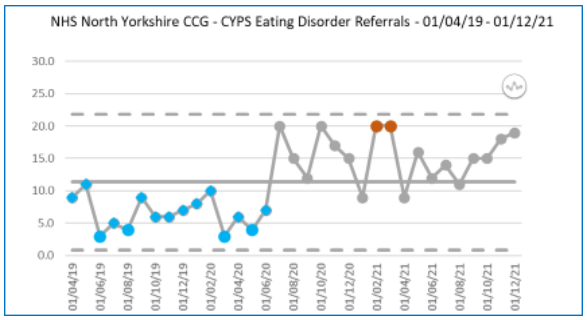
	Metric Name	Performance	Assurance	Latest Value	Lower process limit	Upper Process limit	Mean
1	NHS North Yorkshire CCG - CYPS referred to the Crisis team			63.0	47.1	109.0	78.0



Demand for services– CAMHS

SPC chart of the number of CYPS referred to the NYY Child Eating Disorders service for NY CCG during the period April 2020 – December 2021

Metric Name	Performance	Assurance	Latest Value	Lower process limit	Upper Process limit	Mean



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OFFICIAL - SENSITIVE

1.4 Geography

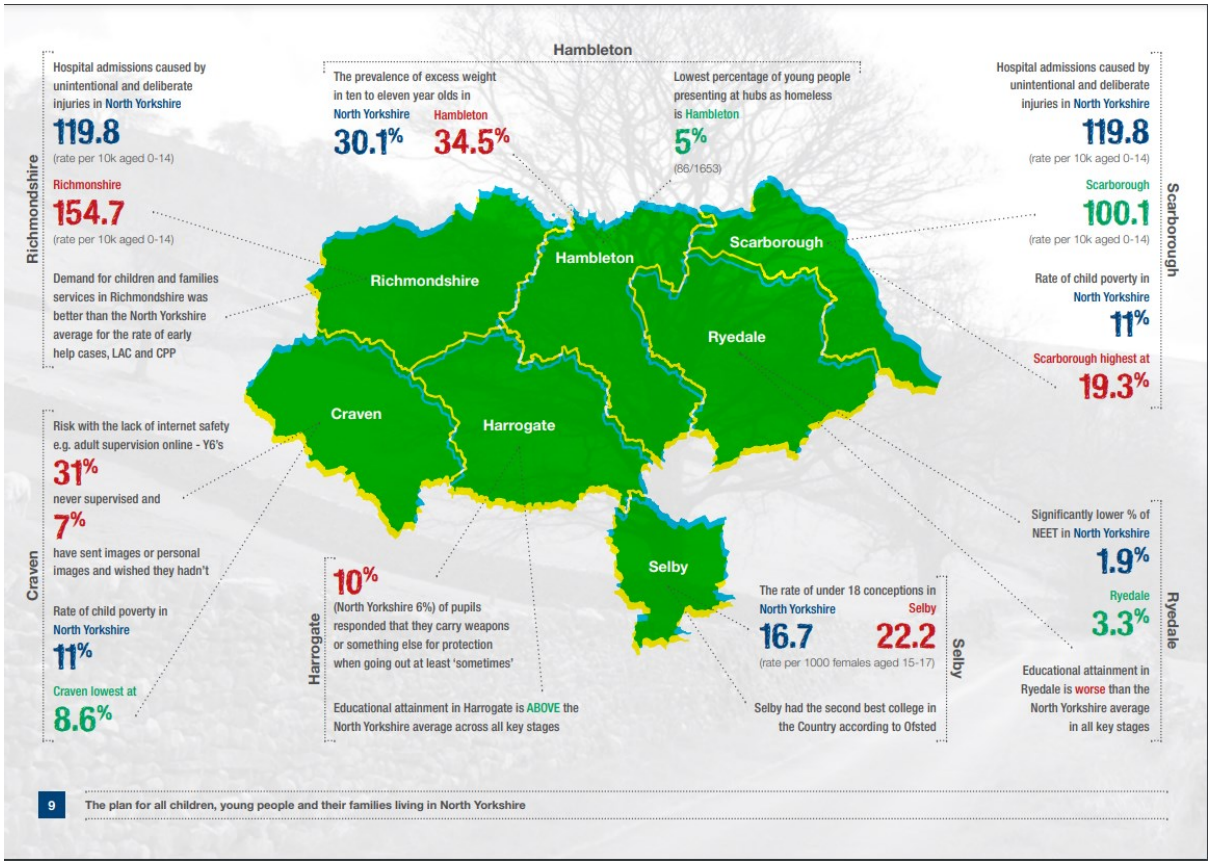
Our Partnership

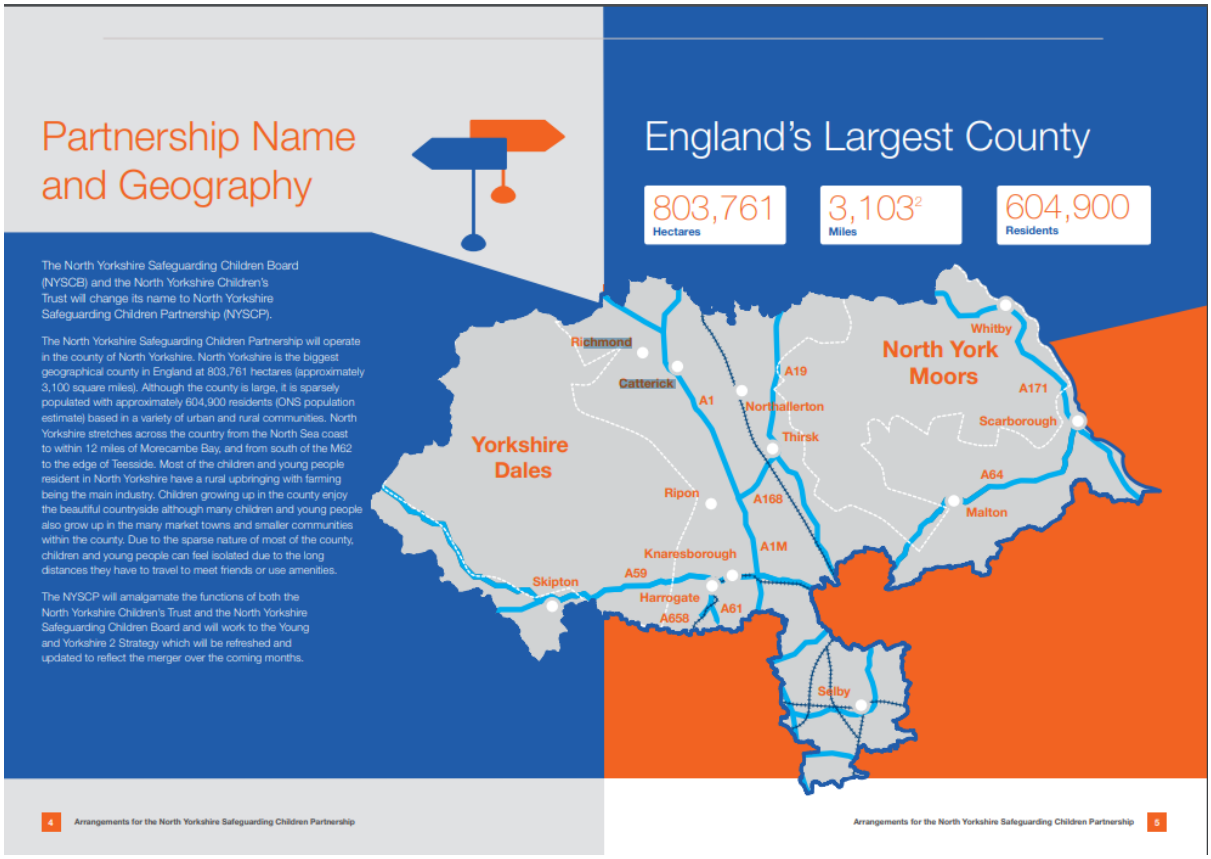
The Humber, Coast and Vale Health and Care Partnership is a collaboration of health and care organisations who believe we are stronger when working together. We are striving to improve the health and wellbeing of our population as well as the quality and effectiveness of the services we provide.

Our Partnership was established in early 2016, when 28 organisations from the NHS, local councils, other health and care providers and the voluntary and community sector came together to start thinking about the challenges facing the health and care sector over the coming years.

Since then, we have been working together within our six places, as shown on the map, and across wider areas, where it makes sense to do so, to look for ways to join up health and care services and to make them work better for local people.

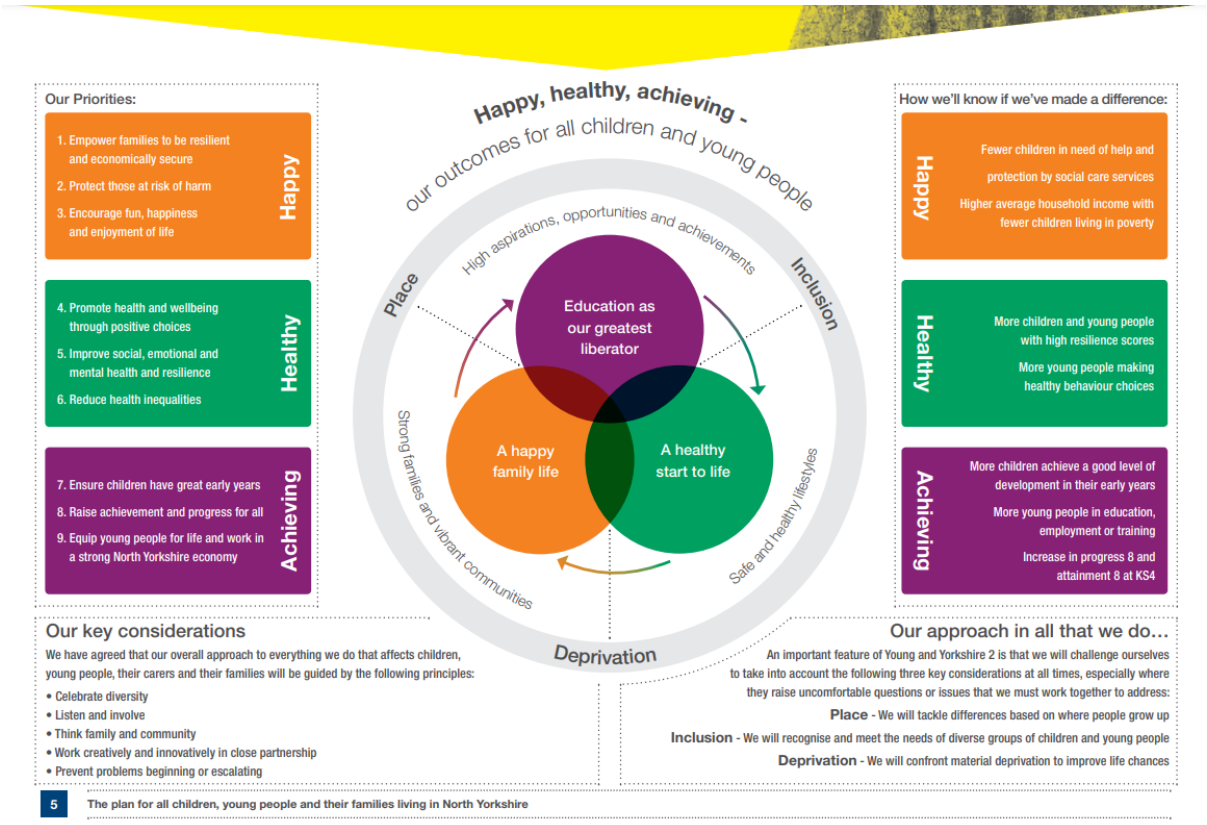
This summary document sets out our Partnership's ambitions and the difference we are seeking to make. You can read the full version of our Partnership Plan on our website.


Hambleton
Richmondshire
Hospital admissions caused by unintentional and deliberate injuries in North Yorkshire
119.8
(rate per 10k aged 0-14)
Richmonshire
154.7
(rate per 10k aged 0-14)
Demand for children and families services in Richmondshire was better than the North Yorkshire average for the rate of early help cases, LAC and CPP
The prevalence of excess weight in ten to eleven year olds in
North Yorkshire 30.1%
Hambleton 34.5%
Lowest percentage of young people presenting at hubs as homeless is Hambleton
5%
(66/1653)
Hospital admissions caused by unintentional and deliberate injuries in North Yorkshire
119.8
(rate per 10k aged 0-14)
Scarborough
100.1
(rate per 10k aged 0-14)
Rate of child poverty in North Yorkshire
11%
Scarborough highest at
19.3%
Scarborough
Richmondshire
Hambleton
Scarborough
Ryedale
Craven
Harrogate
Selby
Craven
Risk with the lack of internet safety e.g. adult supervision online - Y6's
31%
never supervised and
7%
have sent images or personal images and wished they hadn't
Rate of child poverty in North Yorkshire
11%
Craven lowest at
8.6%
Harrogate
10%
(North Yorkshire 6%) of pupils responded that they carry weapons or something else for protection when going out at least 'sometimes'
Educational attainment in Harrogate is ABOVE the North Yorkshire average across all key stages
The rate of under 18 conceptions in
North Yorkshire 16.7
Selby 22.2
(rate per 1000 females aged 15-17)
Selby had the second best college in the Country according to Ofsted
Selby
Significantly lower % of NEET in North Yorkshire
1.9%
Ryedale
3.3%
Educational attainment in Ryedale is worse than the North Yorkshire average in all key stages
Ryedale
9
The plan for all children, young people and their families living in North Yorkshire

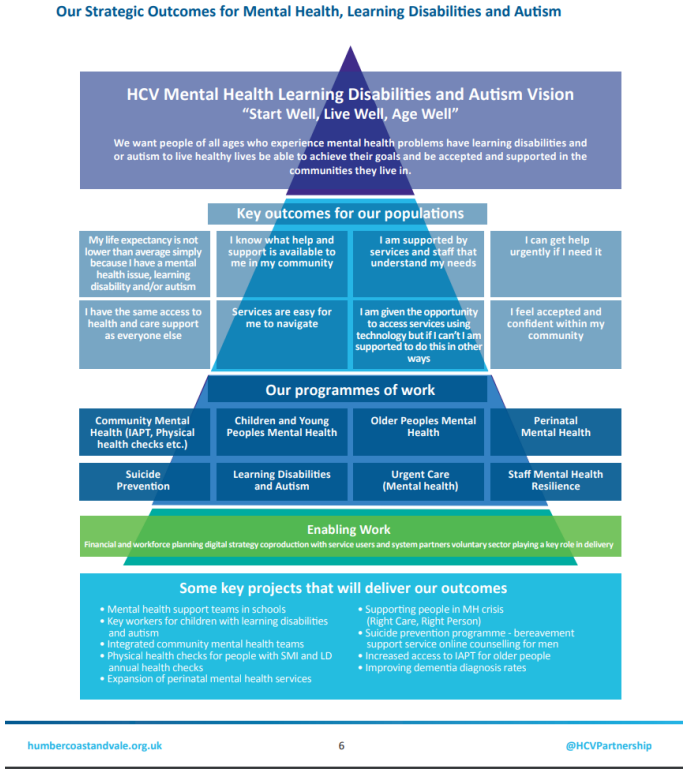

Partnership Name and Geography
The North Yorkshire Safeguarding Children Board (NYSCB) and the North Yorkshire Children's Trust will change its name to North Yorkshire Safeguarding Children Partnership (NYSCP).
The North Yorkshire Safeguarding Children Partnership will operate in the county of North Yorkshire. North Yorkshire is the biggest geographical county in England at 803,761 hectares (approximately 3,100 square miles). Although the county is large, it is sparsely populated with approximately 604,900 residents (ONS population estimate) based in a variety of urban and rural communities. North Yorkshire stretches across the country from the North Sea coast to within 12 miles of Morecambe Bay, and from south of the M62 to the edge of Teesside. Most of the children and young people resident in North Yorkshire have a rural upbringing with farming being the main industry. Children growing up in the county enjoy the beautiful countryside although many children and young people also grow up in the many market towns and smaller communities within the county. Due to the sparse nature of most of the county, children and young people can feel isolated due to the long distances they have to travel to meet friends or use amenities.
The NYSCP will amalgamate the functions of both the North Yorkshire Children's Trust and the North Yorkshire Safeguarding Children Board and will work to the Young and Yorkshire 2 Strategy which will be refreshed and updated to reflect the merger over the coming months.
England's Largest County
803,761 Hectares
3,103² Miles
604,900 Residents
Richmond
Catterick
A1
A19
Northallerton
Thirsk
Ripon
A168
A1M
Knaresborough
A59
Skipton
Harrogate
A61
A658
Selby
Yorkshire Dales
North York Moors
Whitby
A171
Scarborough
A64
Malton
4
Arrangements for the North Yorkshire Safeguarding Children Partnership
Arrangements for the North Yorkshire Safeguarding Children Partnership
5

1.5 Strategies

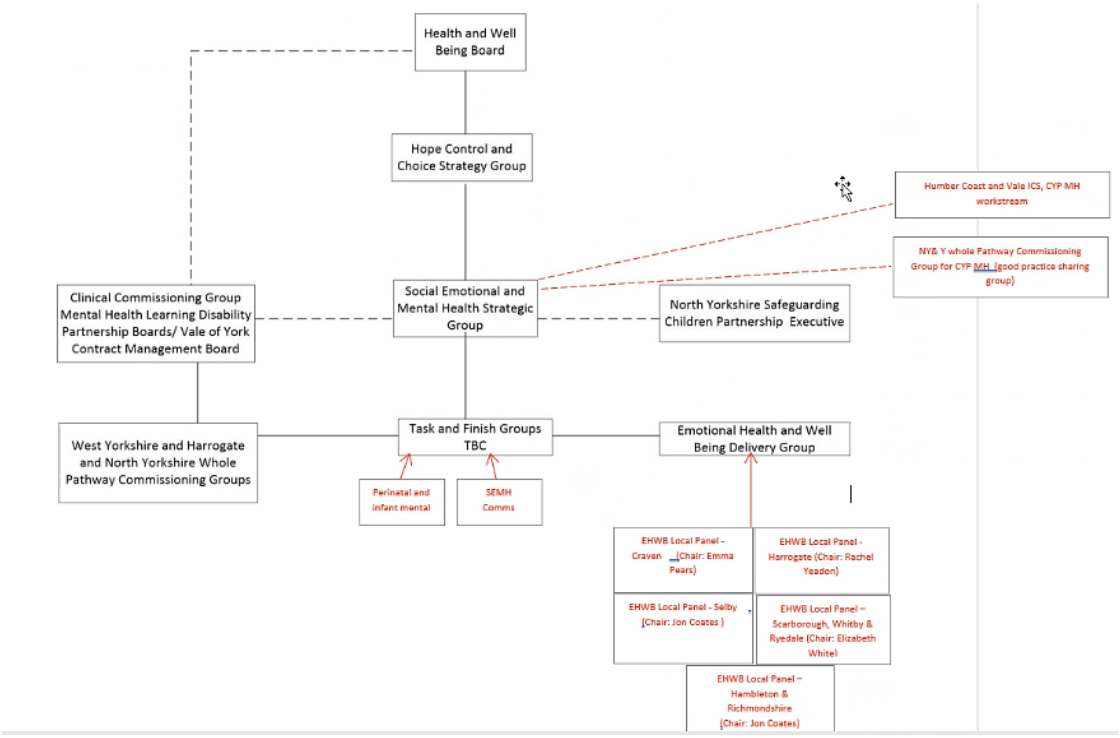
Council



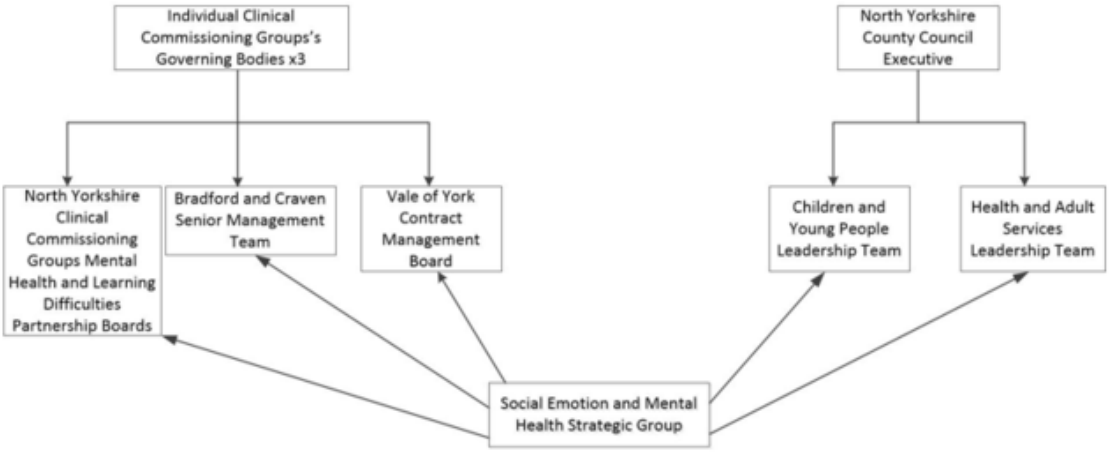
Humber, Coast & Vale ICS



1.6 Governance Structures



Organisational Decision Making



Appendix 2 - Surveys

Below are links to all the survey responses and answer collations used in the scoping interviews

Pdf summaries of interviews

188 professionals who work across statutory and non- statutory sectors supporting CYP MH services across North Yorkshire Completed the survey below

Children's and Young People's Mental Health and Wellbeing in North Yorkshire

Listed below are areas of focus for improvement based on survey responses

1. Strategic prioritisation of social, emotional and mental health
2. Demand Across the system is increasing.
3. Waiting times
4. Data and Impact
5. CYPMH Digital Strategy
6. Building a shared culture
7. Improve whole system connectivity
8. Governance
9. Capacity and Capability
10. Geography
11. Workforce Development

Of these concerns the following areas were mentioned repeatedly

- Waiting times
- Capacity and Capability
- Strategic prioritisation of social, emotional and mental health
- Demand Across the system is increasing.

Perceived shortfalls/gaps in current offering

Increased Waiting times and Capacity and capability are overwhelmingly mentioned with these themes being repeated

- CAHMS threshold is too high, and there is a gap in addressing/supporting those that do not meet the threshold
- There is need for early identification/assessment of need intervention within an MDT network
    - Ease of access to alternative service
- Need for alternative services
    - Need for non-crisis support (especially in schools)
    - Need for support and tools for families/parents/caregivers
    - Need for more support in schools like MHST
- Need to offer support/intermediate level of services while waiting
- Clear signposting of where to go for help, feedback on where you are in the system

    - Use of digital strategy more as a tool to help navigation/get you places quicker rather than as a method of therapy
- External pressures (social media, peers, community) emerging as a large challenge
    - Youth embarrassed to access services/stigma attached to accessing services
- Voice of the Child and parent needs to be listened to
- There is a need for continuity) support works dealing with cases)

Here are some sample representative responses about the challenges Children and Young People in North Yorkshire face in relation to their mental health and wellbeing

"Disjointed services and commissioning - unclear pathways, unable to access timely support, especially EARLY to prevent escalation to crisis. Huge waiting times. Situations become much worse. Help only available if at crisis, this is unacceptable."

"Focus is on mh diagnosis not need - this means there is not enough emphasis on prevention and still a significant focus on referrals to CAMHS. ADHD and ASC are still seen as MH issues and this needs separation. There is a population of young people who experience significant distress and engage in significantly risky behaviours but they don't have a mental illness; for whom there is no medication and for whom admission would be detrimental and life limiting. There is no cohesive health and social care provision for this group."

"1. The parity of esteem between mental and physical health 2. Very little trauma-informed practitioners in the services 3. Very little choice of treatment due to NHS only approving certain therapies 4. Very little integrated approaches 5. Very little money to fund an integrated approach 6. CAMHS and IAPT cannot deal with complex cases 7. CAMHS and IAPT staff are over stretched 8. Waiting list times 9. Therapies on offer are one size fits all"

"Lots of talk about identifying needs but minimal services to met identified needs. Lack of provision for children/ young people with learning disabilities/ difficulties. Poor provision of services which are able to meet need in a timely fashion . Lack of consistency in provision across postcodes. Isolation/ access to service due to geographical locations . Poverty impacting access to virtual services where you require wifi or those where you need to travel distance to access the service"

"A lack of established and effective links between CAHMs and education/Early Help services. Long waits for referrals. C&YP who fall just below the threshold for direct work but who would benefit from early preventative work."

Thoughts on priorities for workforce improvement

- Training and awareness of how SEND affects mental health
- Training in Autism, ADHD and ASC
- Childhood trauma knowledge
- Grief counselling
- Consultation skills

Here are some representative responses in this area

"Training in ADHD. The condition is exceptionally the most discriminated against due to lack of training and understanding hence why 1/4 of the jails end up with adhd people"

"An understanding between the difference between mental health issues and emotional wellbeing issues. An understanding of how to build emotional resilience to equip children and young people to deal with life's challenges. A clear understanding of autism and adhd and how it affects children and young people."

"If you are SEND many mental health services will not work with you and there is no alternative service that does"

"MHST professionals for advice of how best to support: preventative strategies and support rather than reactive: long term upskilling of teachers and support staff with a toolkit."

Appendix 3 – SPA Examples

Norfolk & Waveney Integrated Front Door Full Costing Model based on a service anticipating 35,000 referrals per year

Cost element	Annual cost	Recurrent/ Non-Recurrent	Notes
8A Clinical Lead	£53,219.00	Recurrent	Annual basic salary only
8A Operational Lead	£28,000.00 (0.5 role)	Recurrent	Annual basic salary only
Communications consultancy/design	£15,000.00	Non-recurrent	
JON/IT development costs	£30,000.00	Non-recurrent	
Wellbeing checks	£90,000.00	Recurrent	£90 x 1 hour sessions x 1000 people
Talking therapy hours	£96,000.00	Recurrent	£80 x 6 sessions per person x 200 people (Pilot only)
PR / MHSDS / ROMs / Data Dashboard / ODS	£20,000.00	Non-recurrent	12 months
7A Safeguarding Lead	£45,839.00	Recurrent	
Training	£5,000.00	Non-recurrent	

Cost element	Annual cost	Recurrent/ Non-Recurrent	Notes
7A Team Lead	£45,839.00	Recurrent	Annual basic salary only
Band 6 Practitioner	£39,027.00	Recurrent	Annual basic salary only
Band 5 Practitioner x 2	£63,068.00	Recurrent	Annual basic salary only
Band 3 Admin x 5	£108,885.00	Recurrent	Annual basic salary only Basic salary £21,777
Band 2 Admin x 3	£59,754.00	Recurrent	Annual basic salary only ; Basic salary £19,918
E referral form IT / AI Scoping and planning	£40,000.00	Recurrent	Development and interoperability
CCS Staff infrastructure budget IT / Wiring	£50,000.00	Non-Recurrent	Initial set up costs for CCS
Comms campaigns & design	£30,000.00	Partially recurrent	Will be some recurrent costs - £10,000
OD Support	£5,000.00	Non-recurrent	
Training	£5000.00	Non-recurrent	
AI Build and development	COST TBC	Recurrent	12 months