BHH Brent Harrow Hillingdon Clinical Commissioning Groups

BUSINESS CASE

Children & Young People's Emotional Health and Wellbeing Targeted Service

26 October 2016

1.0 Background information

1.1 Project team

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Date	Author	Summary of changes

1.3 For PMO use

EQIA required?
NO
Business Case required?
YES
Service Specification required?
YES
Service Specification approved?

Approved by PMO
Approved by Workstream
YES
Approved by QIPP and Finance Committee
Approved by Governing Body

2.0 Table of contents

3.0 Introduction

3.1 Background

This business case outlines the plan to jointly commission an early intervention children and young people's emotional health and wellbeing targeted service to support children and young people with emotional health and wellbeing needs in Harrow. This service will be funded by the 'Future in Mind' investment through Harrow's Local Transformation Plan, together with matched funding from the Local Authority, and additional investment from Harrow schools. The business case has been developed in collaboration with Harrow's Future in Mind Transformation Board, which includes representation from the CCG, Harrow Council, Public Health, and Harrow schools. It has also been informed by the views of children, young people and professionals in the borough, through focused consultation and engagement work.

There is an acknowledged gap in Harrow at present in terms of an early intervention therapeutic service for children and young people. Whilst schools have attempted to address the need through buying-in individual counselors, therapists and training; the quality and consistency of this support varies greatly from school to school. The overall lack of early intervention and preventative emotional health and wellbeing provision in the borough puts increased pressure on Child and Adolescent Mental Health Services (CAMHS Tier 3), as children and young people's needs escalate, which could be prevented or reduced through earlier intervention. Inappropriate referrals that would not meet Tier 3 thresholds can also be avoided, reducing demand on Tier 3, through a triage function within the new service.

'Future in Mind' is a national report that was published in March 2015 by NHS England and the Department of Health, its purpose to promote, protect and improve children and young people's mental health and wellbeing. The report was produced by the Children and Young People's Mental Health and Wellbeing Taskforce. The Taskforce was mandated to consider ways to make it easier for children, young people, parents, and carers to access help and support when needed, and to improve how children and young people's mental health services are organised, commissioned and provided; working towards preventative, integrated provision, to maximise children and young people's health outcomes.

This project is priority 5 of the NWL CAMHS Transformation Plan: Transforming Pathways – A Tier Free System. Harrow CCG's local priority (in partnership with social care and education) is to develop a joint Emotional Health and Wellbeing Targeted Service (Tier 2/2.5).

3.2 Project Scope

This service will support those children and young people aged 0 to 18, or up to 25 with a Special Educational Need or Disability (SEND), with emotional health and wellbeing needs, that meet the threshold criteria for Tier 2. In Harrow this covers approximately 3695 children and young people (Office for National Statistics mid-year population estimates for 2012). The service will include assessment, diagnosis, and treatment through a range of short to medium term therapeutic interventions.

In scope:

- Children and young people aged 0-18 (or up to 25 with SEND) that live, go to school, or are registered with a GP in Harrow, AND that have low to moderate emotional health and wellbeing and/or behavioural difficulties/concerns that do NOT require a CAMHS multidisciplinary team approach.
- BOUNDARY ACCESS: Children and young people aged 0-18 (or up to 25 with SEND) that are:
    - Resident in Harrow and/or
    - Registered with a Harrow GP Practice or
    - Attend a Harrow School and are resident and/or Registered with a Harrow GP Practice

Children and young people who attend a Harrow School but are not resident or registered (GP) in Harrow will be considered on a case by case basis and agreed with commissioners, this may involve a recharge to the resident and/or registered (GP) borough

- This could include the following issues/concerns:
    - anxiety
    - low mood/depression
    - low self-confidence/esteem
    - concerns/issues about attachment
    - behavioural difficulties/challenging or defiant behaviour
    - aggression
    - withdrawn behaviour
    - poor/distorted body image
    - issues regarding: identity/gender/sexuality/race/culture/acculturation
    - repetitive problematic behaviours
    - compulsive or obsessional behavioural patterns
    - bereavement and/or loss (including anticipatory)
    - sleep problems
    - eating issues
    - family relationship difficulties
    - experience of abuse (physical, emotional and sexual) and/or neglect
    - peer relationship difficulties
    - experience of bullying
    - self-harm or self-injurious behaviour.
- This would also include: children and young people with Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorders (ASD), Special Education Needs and Disabilities (SEND), Learning Disabilities (LD), young carers, Children in Need (CIN) and Children Looked After (CLA).

Out of scope:

- Children and young people without an identified, sustained emotional health and wellbeing need requiring targeted intervention (or 'Tier 1')
- Children and young people requiring longer term therapy, who would be eligible for Tier 3
- Children and young people requiring longer term therapy at Tier 4
- Children and young people requiring drug-based therapy
- Children and young people in crisis, or requiring emergency or 'Out Of Hours' support
- Children and young people with severe eating disorders, that meet the referral criteria for the Eating Disorders Service
- Children and young people with psychosis
- Young adults aged 18 and over (or 26 and over for young people with SEND)

3.3 National and Local Strategic Priorities

3.3.1 National Priorities

In March 2015 the Government published **Future in Mind**, their strategy for promoting, protecting and improving children and young people's mental health and emotional wellbeing. Future in Mind sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. The report made 49 recommendations to improve young people's mental health services over the next five years, grouped under five headings:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers

- Care of the most vulnerable
- Accountability and transparency
- Developing the workforce

In January 2010 the Department of Health, and the Department for Children, Schools and Families (DCSF) published **Keeping Children and Young People in Mind**, a response by the Government to the independent review of CAMHS which reported in November 2008. In addition, in February 2010, the DCSF published **Promoting the Emotional Health of Children and Young People, guidance for Children's Trust Partnerships including how to deliver National Indicator 50** (the emotional Health of Children and Young People). The document also makes reference to National Indicator 51 (The effectiveness of CAMHS) and National Indicator 58 (Emotional and behavioural health of looked after children).

No Health without Mental Health is a cross-Government mental health outcomes strategy for people of all ages. The strategy was published in 2011; its' objective is for all people with mental health needs to have improved outcomes. The strategies that have followed No Health without Mental Health are **Crisis Care Concordat** (DH & signatories, 2014), **Closing the Gap: Priorities for essential change in mental health** (2014) and **A Call to Action**: **Achieving Parity of Esteem** (2014).

The national mental health strategies, as outlined above, underpin the work of the Children and Young People's Mental Health and Wellbeing Taskforce that produced the Future in Mind vision.

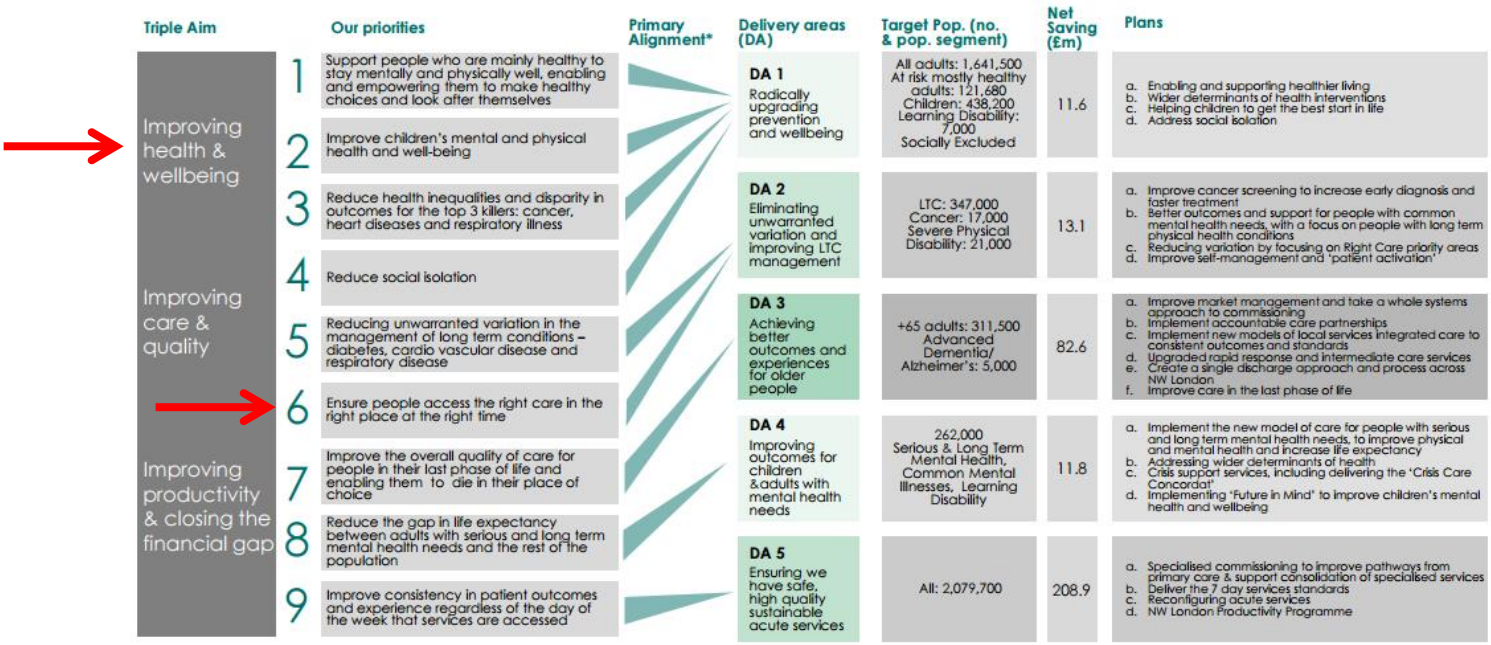
Other key reports that have informed the development of this project are:

- **The Children and Young People's Act** (2014)
- **Mental health & behaviour in schools** (DfE, 2015)
- **Counselling in schools, A blueprint for the future** (DfE, 2015)

3.3.2 Local Priorities

This project aligns with Harrow's 2016/17 Key Priority 9 (Harrow Clinical Commissioning Group Commissioning Intentions 2016-17): *'We will work with other commissioners and providers to develop better and more integrated mental health and children's services (Children's, Mental Health Workstreams)'*, and sits within Service Area 5, Children and Young People. In particular, the project relates to the following action: *'offer more children's services to children and young people (CYP) at home and in educational settings'* (Harrow Clinical Commissioning Group Commissioning Intentions 2016-17, p. 43), as this project will be offering support for children's emotional health and wellbeing needs within schools and the community.

The project also aligns to Delivery Area 2 *'Improve children's mental and physical health and well-being'* (below) of the North West London Sustainability and Transformation Plan currently being consulted on (draft, June 2016) – through an emphasis on prevention and emotional health and wellbeing.



(NW London Sustainability and Transformation Plan Draft V1.0, 30 June 2016)

Like Minded is the Mental Health and Well Being Strategy across North West London. The Like Minded initiative has identified a set of mental health and wellbeing priorities for the North West London strategy, which includes improving the mental health offer for children and young people and supports the **Future in Mind** transformation work.

In 2015, the Government committed capitated borough funding for five years to support achievement of the ambitions set out in Future in Mind and requested that CCGs lead on the CAMHS transformation agenda. In order for the CCG to receive the allocated funding, a Local Transformation Plan (LTP) for Children and Young People's Mental Health and Wellbeing was submitted across eight CCGs (Harrow, Ealing, Hounslow, Brent, Hillingdon, Hammersmith and Fulham, Central and West) to NHS England. Appropriate themes that align across all 8 boroughs are being managed jointly to maximise resources, with outcomes aligned to local transformation plans. Harrow's Local Transformation Plan is available in Appendix A.

4.0 Purpose

4.1 Purpose

This project relates to Harrow CCG's local priority to develop a joint Emotional Health and Wellbeing Targeted Service, as outlined in the Local Transformation Plan (priority 5):

		Harrow CCG/Harrow Council Local Approach: In Harrow transition is a joint and local priority. Their ambition is to increase the transition age up to 25years. Harrow CCG will commit funding for a joint project resource to plan this priority and to scope possibility to join cross-borough and to work with Adult Mental Health. Harrow CCG will commit further funding for the following years to implement and deliver Transition up to 25years. Harrow has a further local priority to develop a joint Emotional Health and Wellbeing Targeted Service (Tier 2/2.5). This will be an early intervention/prevention provision, offering open access for young people with an identified need. Working to target identified vulnerable children and young people in Harrow such as: Children in Need, Children Looked After, and children and young people with challenging behaviour, bereavement, life events, school exclusion, OCD, difficulties with eating/sleeping, ADHD and ASD. To initiate this work Harrow CCG will commit funding in 2015/16 for a Tier 2 clinician (pilot piece) to begin assessments and for project management of this local priority and the other priorities stated. In the following years, the annual allocation will be a contribution to implement and run the new service. This service will be jointly commissioned with the Local Authority with buy-in from local schools. Further investment from the CCG is planned through service redesign, the Local Authority and Schools. Harrow CCG will also work with local stakeholders to plan and deliver an Integrated Single Point of Access across Harrow, that will intake and triage referrals quickly, efficiently and ensure that patients receive a service that is right first time.	2015/2016: £170,000 2016/2017: £270,000 2017/2018: £270,000 2018/2019: £270,000 2019/2020: £270,000

The Transformation Plan was approved by NHS England in December 2015. The apportioned funding to the development of the emotional health and wellbeing service through Future in Mind is £270,000 annually over 5 years.

The Transformation Board was established (formerly Harrow's Emotional, Behavioural and Mental Health Group), to progress the implementation of the Local Transformation Plan. The Transformation Board meets monthly and includes the following members:

- Clinical Director with lead for Paediatrics (Chair)
- Divisional Director Children and Young People Services
- Children Services Commissioner, Harrow Council
- Integrated Children's Commissioning Manager, Health and Social Care
- Head of Service, Early Intervention, Children's Centres and YOT
- Deputy Head, Canons High School
- Head Teacher, Kingsley High School
- Head of Alexandra School
- Head Teacher, Roxeth Primary School
- Public Health Strategist - Children

Local providers and services, including CNWL, a Consultant Paediatrician, and Kids Can Achieve, are also invited to attend the first section of the meetings.

The 2015/16 and a proportion of 2016/17 investment was committed to two dedicated roles to support the development of the new emotional health and wellbeing service. Following recruitment, a Project Manager and a Participation and Engagement Lead commenced post in April 2016.

The Participation and Engagement Lead initiated an engagement plan, consulting with a wide variety of forums and facilitating workshops across Harrow with children, young people, parents and professionals.

Two ongoing young people and parents' panels have been established to support the procurement process. A monthly Harrow Future in Mind newsletter is circulated to over 300 stakeholders, including professionals from education, health, social care and the voluntary sector, providing updates on the project.

4.2 Pilot Project

Funding has been invested in a pilot project which was established in June 2016. Providers were invited to bid to deliver two small pilot projects; one with mainstream schools and the other with special schools. The findings from the pilots will inform the development of the new emotional health and wellbeing service. Providers were invited to put forward expressions of interest that were innovative and flexible, offering short to medium term intervention to children and young people with an identified (low to moderate) emotional/mental health need to prevent further escalation of needs, and to enable children and young people to be empowered and more resilient. This could include direct 1:1 therapy, group counselling and advice for parents, carers and professionals. Four providers put forward expressions of interest to deliver the pilots.

Schools were also invited to express their interest in being a pilot site, as part of a school cluster, to which there was a very positive response by all school clusters, as the majority recognise the gap in provision for early intervention at present. The CCG and colleagues from the local authority came together to evaluate the expressions of interest and awarded the pilot contracts to The Brandon Centre and CNWL. The Brandon Centre for the mainstream pilot within the Central Harrow School cluster (consisting of Harrow High School, and Norbury, Belmont and Elmgrove Primary schools) and CNWL for the special schools pilot with Alexandra and Shaftesbury Schools.

The pilots commenced in June 2016 and referral processes and thresholds for schools have been developed. The Brandon Centre will be introducing the whole-school Solihull approach across all of the cluster schools, which includes training for all school staff.

4.3 Current Provision - Morning Lane

The Local Authority Systemic Early Intervention and Social Work Support Service model was designed in August 2012 with the aim of strengthening social workers' and early interventions workers' abilities to help children, young people and families take control of their lives and relationships and increase their self-esteem and emotional resilience.

There are three key areas of service delivery:

- Leading reflective consultation in group systemic units/pods where families presenting particular clinical difficulties are discussed and social workers are encouraged in their practice of systemic ideas.
- Providing one-to-one clinical support to Social Workers seeking further consultation beyond the group setting.
- Working directly with families and children where clinical expertise has the potential to break the cycle of repeated family breakdown or stabilise placements.

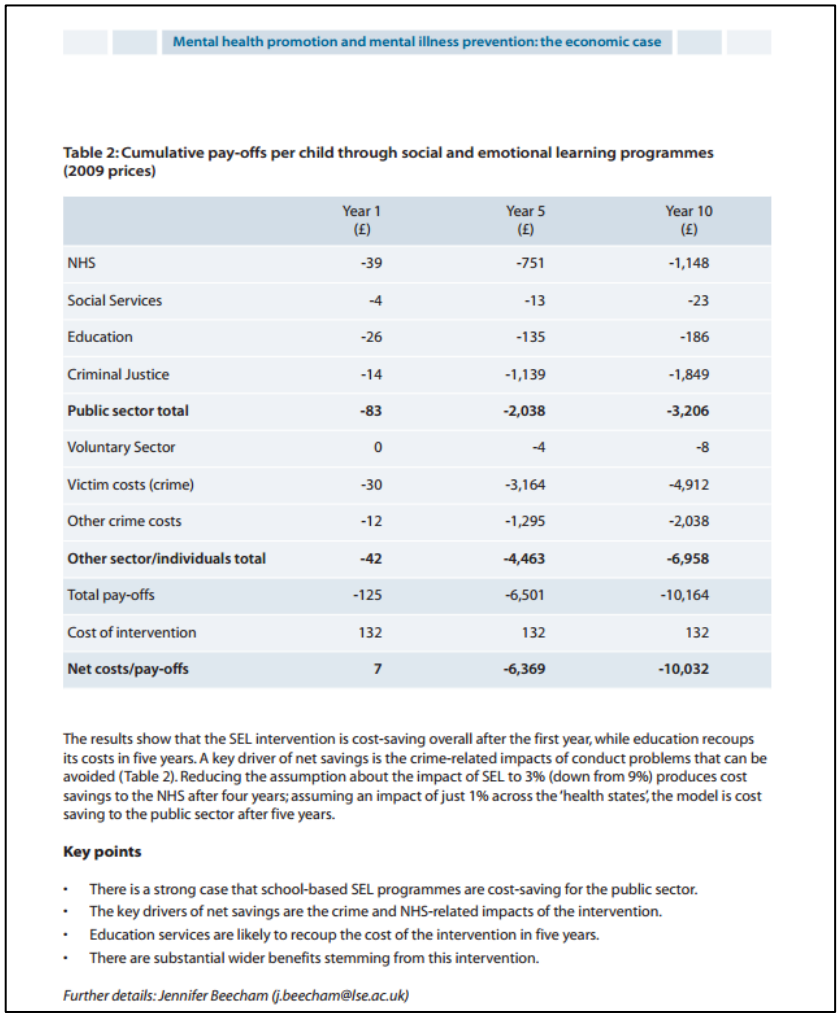
On October 13th the Local Authority will be requesting Cabinet to give approval for an extension to the current service provider to ensure there is a continued service provision to Children Looked After/Children in Need until the new Future in Mind service is implemented. See Appendix D for the Local Authority Business Case.

4.4 Case for Change

In Harrow over £1.5 million is spent each year addressing mental health issues for children and young people, while the wider health, social and economic impact of mental health is far greater. Tackling the cost of mental illness has been identified as a priority and poses a challenge across Harrow. By collaborating jointly with Harrow Council and Harrow schools, the CCG's investment is maximized. The Local Authority is matching the CCG's contribution of £270,000, with a further £270,000. The full target contribution being asked of schools to invest is £540,000 (although this is dependent on the number of schools that choose to buy-in) this will provide a potential service funding of **£1,080,000**. Furthermore, the number of children and young people with needs that the service can work with is multiplied through joint commissioning. Working in partnership develops the ownership and responsibility of all stakeholders, and supports the ongoing sustainability of the service beyond the life of the contract. Through commissioning collaboratively, services are less siloed; promoting integration, and overheads are reduced; offering a better value for money service. For families, this also means more joined-up, streamlined services, with clear pathways and consistency of service.

In the long term, investing in early intervention has been well documented as having a substantial impact on reducing, delaying and preventing mental health needs from occurring. Not only this, but the service will promote resilience and self-help approaches, with the aim of reducing referrals to Tier 3 and A&E, when needs have progressed and worsened.

There is a strong social and economic case for addressing child and adolescent mental health needs through early intervention. Department of Health research carried out by the London School of Economics has shown that the potential savings to the public purse, relating to an individual case of mild conduct problems in children are estimated at £75,000, with potential savings of £150,000 for children with severe conduct problems (Knapp, McDaid, & Parsonage, 2011, DOH). Costs relating to crime are the largest component, accounting for 71% of the total, followed by costs resulting from mental illness in adulthood (13%) and differences in lifetime earnings (7%). *(Source: Knapp et al., 2011, DOH)*



Mental health promotion and mental illness prevention: the economic case

Table 2: Cumulative pay-offs per child through social and emotional learning programmes (2009 prices)

	Year 1 (£)	Year 5 (£)	Year 10 (£)
NHS	-39	-751	-1,148
Social Services	-4	-13	-23
Education	-26	-135	-186
Criminal Justice	-14	-1,139	-1,849
Public sector total	**-83**	**-2,038**	**-3,206**
Voluntary Sector	0	-4	-8
Victim costs (crime)	-30	-3,164	-4,912
Other crime costs	-12	-1,295	-2,038
Other sector/individuals total	**-42**	**-4,463**	**-6,958**
Total pay-offs	-125	-6,501	-10,164
Cost of intervention	132	132	132
Net costs/pay-offs	**7**	**-6,369**	**-10,032**

The results show that the SEL intervention is cost-saving overall after the first year, while education recoups its costs in five years. A key driver of net savings is the crime-related impacts of conduct problems that can be avoided (Table 2). Reducing the assumption about the impact of SEL to 3% (down from 9%) produces cost savings to the NHS after four years; assuming an impact of just 1% across the 'health states', the model is cost saving to the public sector after five years.

Key points

- There is a strong case that school-based SEL programmes are cost-saving for the public sector.
- The key drivers of net savings are the crime and NHS-related impacts of the intervention.
- Education services are likely to recoup the cost of the intervention in five years.
- There are substantial wider benefits stemming from this intervention.

Further details: Jennifer Beecham (j.beecham@lse.ac.uk)

Future in Mind (2015, Department of Health/NHS England) sets out the following drivers for change:

- Children with mental health problems are at greater risk of physical health problems;
- It is estimated that as many as 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age.
- Research on the longer-term consequences of mental health problems in childhood has found associations with poorer educational attainment and poorer employment prospects, including the probability of 'not being in education, employment or training' (NEET).
- The impact of mental health disorders extends beyond the use of public services. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child (Parsonage M, Khan L, Saunders A (2014) *Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health).
- The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively. For example, the table below details the impact of group cognitive behavioural therapy for depressed adolescents. It is important to note that this does not include wellbeing gains, but does measure the financial benefit to an individual due to improved employment opportunities as a result of managing their condition. The benefits included in a benefit:cost ratio are in addition to the mental health and wellbeing improvements associated with evidenced interventions. In general, measured benefits include two main elements: (i) reductions in the use of public services because of better mental health, and (ii) increases in earnings associated with the impact of improved mental health on educational attainment. In the case of conduct disorder, there are also benefits to society resulting from reduced offending, including costs to victims and the community.

Group Cognitive Behavioural Therapy (CBT) for depressed adolescents[31]	
Aim	Group CBT for depressed adolescents aims to improve general functioning and prevent the risk of a major depressive episode from occurring. It is a series of group sessions lead by a therapist, involving exploring ideas related to the condition and how to handle it. There is a suggested duration of three months of weekly meetings.
Unit Cost	£229
Total lifetime benefit	£7,252
Lifetime benefit to taxpayers	£3,520
Lifetime benefit to participants	£3,455
Lifetime benefit to others	£277
Lifetime benefit-cost ratio (benefits/costs)	31.67

(Source: Investing in Children. Group Cognitive Behavioural Therapy (CBT) for Depressed Adolescents. Available at: http://investinginchildren.eu/interventions/group-cognitive-behaviouraltherapy-cbt-depressed-adolescents, cited in: Future in Mind, 2015, DOH/NHSE)

4.5 Needs Analysis

Of the 242,400 people in Harrow 60,031 are children and young people aged less than 19 years; almost 1 in 4 of the Harrow population are under 19 (JSNA Refresh 2013/14 Children and Young People – Harrow).

The population of Harrow is projected to grow over the next ten years, with the greatest growth in the older groups' age groups; however there is also a predicted increase in numbers of children aged 0 to 15 and a predicted reduction in the 15-44 age group.

Estimates for North West London suggest that around 25,000 5-16 year olds will have a mental health disorder. Conduct and hyperkinetic disorders are more common among boys and emotional disorders among girls with an estimated need of 12,000 children and young people. There are estimated to be around 7,000 young people aged 16-19 with neurotic disorders (including anxiety, depressive episodes and phobias), most of which are more common among girls.

Mental health problems are also more common among young offenders; this is thought to be associated with the offending behaviour, as endured by over three-quarters of the young people who had a full assessment in 2014/15. National research has found that among Looked After Children, 38%-49% (depending on age) have a mental health disorder.

Among 11-16 year olds, the ONS survey found that over a quarter of those with emotional disorders, and around a fifth of those with conduct or hyperkinetic disorders or depression said that they had tried to harm themselves. Deliberate self-harm is more common among girls than boys and in girls is more common in the mid-teens, while among males it is more common in 19-24 year olds. Between 2001/02 to 2010/11, rates of hospital admission due to deliberate self-harm have increased nationally by around 43% among 11-18 year olds (to around 17,500 in 2010/11).

The table below shows the breakdown of the local demography, in relation to children and young people. Harrow has a similar proportion of 'Children in Need' (CiN) compared to statistical neighbours; the rate has been increasing since 2012 in Harrow (Harrow Joint Strategic Needs Assessment 2015-2020). This is likely to result in additional demand on both universal and specialist services. There were 2,305 referrals made to children's social care services during 2013-14 compared to 1,529 in the previous year. Nationally there has been a rise in referrals by approximately 11% (Harrow Joint Strategic Needs Assessment 2015-2020).

Harrow children and young people's population 2015/16	
Harrow's CYP population[1]	**Population**
Total residents	**247,130**
Resident 0-19yrs	**58,611**
Vulnerable Groups[2]	
Children Looked After	**177**
Young Offenders	**86**
Child Protection Plan	**207**
Children in Need	**1166**
Children with disabilities	**159**
Unaccompanied asylum seeking children	**98**
Young Carers	**93**
Special educational needs (total)[3] of which:	**4570**
Access special schools[3]	**421**
Moderate learning difficulties[4]	**708**
ASD[4]	**414**
Profound and multiple disability[4]	**44**

[1] Based on ONS mid-year estimate 2015
[2] Local authority approximate figures at 31 July 2016
[3] Includes maintained and direct grant nursery schools, maintained primary and secondary schools, city technology colleges, primary and secondary academies including free schools, special schools, special academies including free schools, pupil referral units, general hospital schools, alternative provision academies including free schools and independent schools.
[4] Includes maintained and non-maintained special schools and special academies, including free schools. Excludes general hospital schools.

The table below shows referral data for Harrow's Child and Adolescent Mental Health Service, delivered by CNWL. The figures roughly correlate with the ONS estimates of eligible numbers of children and young people at 'Tier 3'; i.e. 980 children and young people estimated to be eligible for a response from Tier 3 CAMHS, compared to 1012 referrals to CAMHS of which 106 were inappropriate (2014/15). Anecdotal evidence from some schools and GPs has been that referrals may be refused when children and young people's needs do not meet the threshold for Tier 3.

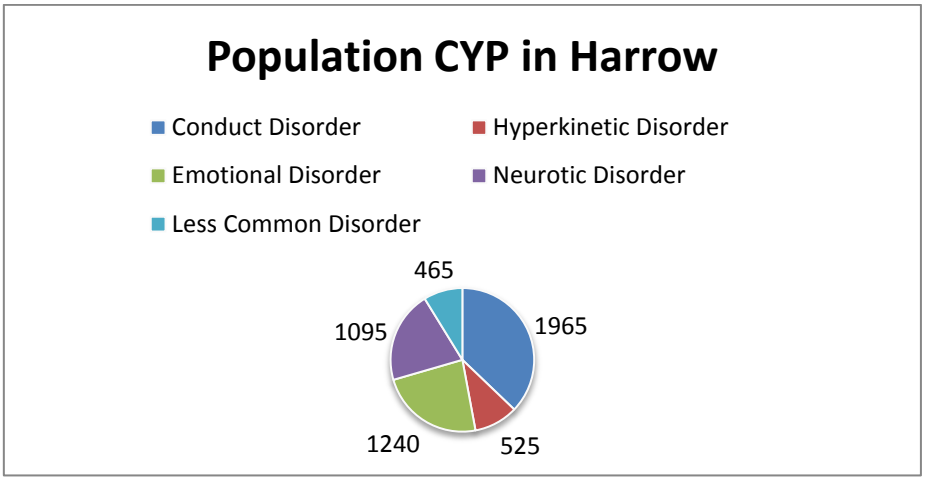
CNWL Harrow CAMHS service referral snapshot year 2014/15	
Harrow CAMHS referral data	**Total for year**
Number of referrals received from GP that have been initiated from the CYP's school	**Not measurable from CNWL's Jade data.**
Number of Harrow CYP referred to Harrow CAMHS	**1012**
Average waiting time from GP referral to 1st appointment	**37 days ***
Number of referrals received by:	
GP	**700**
School Nurse & Educational Service	**24**
Consultant paediatric	**76**
CAMHS clinician	**39**
Other health professional	**141**
Other referral source	**32**
Total number of referral refused	**162**
Reason for referral refusal	
Client Refused	**23**
Inappropriate Referral	**106**
Other	**6**
Out of Area	**26**
Referral to Adult Mental Health Services	**1**
Hospital admissions	
Mental health disorder admissions (2011/12)	**30**
Self-harm emergency admissions	**32**

Source: CNWL referral data 2015

4.6 Harrow's Prevalence Rates

Below are the expected number of CYP with Mental Health conditions at any one time, calculated using prevalence estimates from 'Paying the Price' (Kings Fund, 2008); conduct disorder followed by emotional disorder and neurotic disorder being the most common.

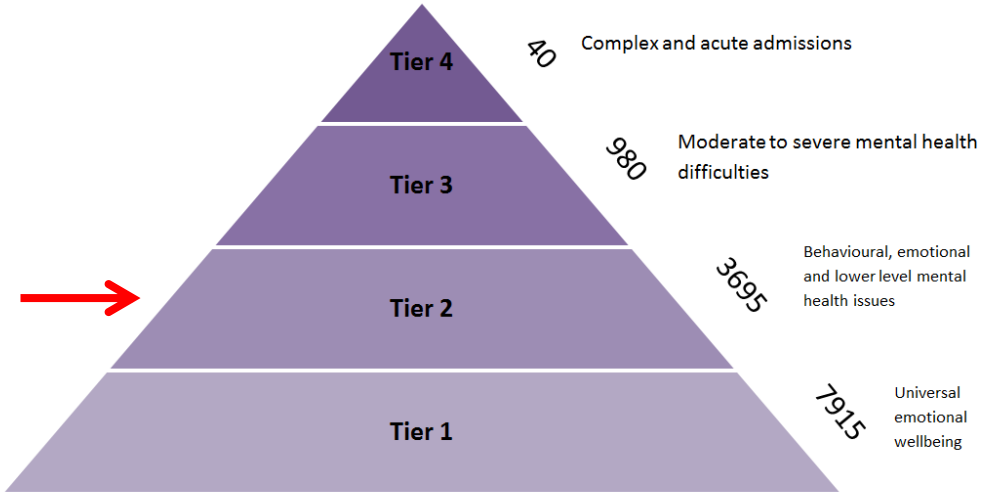
Fig 1: **Estimated number of children with mental health needs in Harrow**



Source: Office for National Statistics mid-year population estimates for 2012.

According to ONS estimates (2012) there are approximately 3695 children and young people with needs eligible for Tier 2 CAMHS within Harrow.

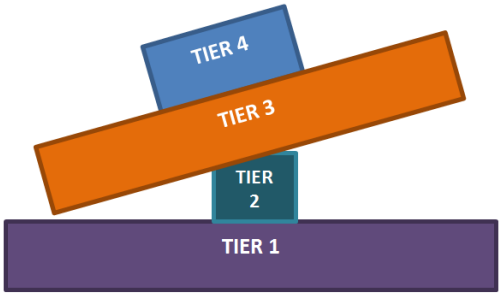
Fig 3: **Estimated total of children resident who may experience mental health problems appropriate to a response from CAMHS; 'Paying the Price' (Kings Fund, 2008)**



Date source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al 2004

Without an appropriate level of service for these young people there is a high risk of needs escalating, and children and young people appearing at Tier 3 with needs that may have been prevented or managed more appropriately at Tier 2, and Tiers 3 and 4 becoming oversubscribed (see Figure 2).

Fig 2: **Potential impact on Tiers 3 and 4**



5.0 Objectives

The service objectives have been developed by the Transformation Board and through the ongoing consultation work with children, young people, parents and professionals.

The vision is to develop a targeted emotional health and wellbeing service in Harrow that is community based with outreach to schools that provides appropriate, early intervention. The service will complement and work closely with relevant services to ensure that children and young people are seen holistically. The service will provide short to medium term therapeutic intervention, with an ethos that encourages choice by putting children and young people at the centre.

By offering targeted early intervention for children and young people with emotional health and wellbeing needs that is flexible and easy to access, the numbers of children and young people requiring more intensive intervention at tiers 3 and 4 are likely to reduce. Through promoting prevention, resilience and self-help as far as possible, the number of reactionary admissions to A&E will also lessen over time. The service will deliver the following high-level objectives:

1. Provide a **variety** of **multi-disciplinary therapies** and therapeutic approaches for children and young people, allowing for **flexibility** and **choice**.

2. Referral to the service through a **Single Point of Access (SPA)** with **clear pathways**, making it **straightforward** and **easy** for young people, professionals, and families to access.

3. Support which is **timely** and **scheduled around the needs of the individual** child/young person, both inside and outside of school hours, including evenings, weekends and school holidays.

4. **Early intervention** that prevents the need for more intensive CAMHS intervention at Tiers 3/4.

5. An **equitable** service across Harrow, targeted at those children and young people with the greatest need (including those with SEND), and children, young people and parents feel they are treated fairly.

6. **Joined-up** support that complements and integrates with existing provision, through **partnership** working with other health, education, social care and voluntary sector agencies in Harrow.

7. Where children and young people need to be referred between services, the service ensures there are **smooth transitions**.

8. The ethos of **community service provision** is to provide care for children, young people and their families within or as close to their family homes as possible, enabling intervention to be embedded into a child or young person's home, school and community environment, therefore services should be provided in appropriate community environments including but not exclusively:
    - Schools and Further Education establishments
    - Family homes
    - Children's Centres
    - Youth Centres
    - GP practices
    - Other community settings where children and young people wish to be seen

9. Children and young people should be **at the centre** of the intervention, and the culture of the service should be **participatory** and genuinely led by children and young people, and they should feel listened to.

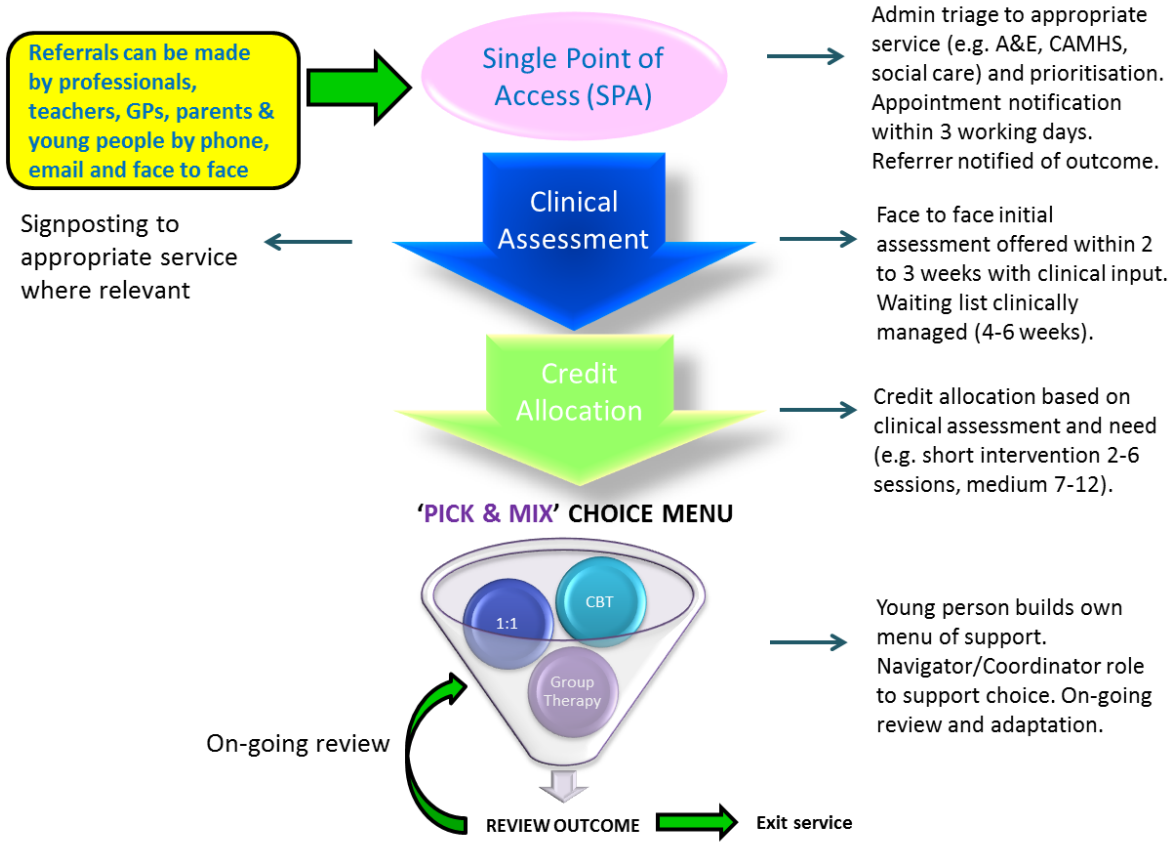
10. **Specialised, expert** support for **vulnerable groups (including SEND, ASD, and ADHD)** to ensure they can access the service and that the setting and therapeutic interventions available meet their needs.

6.0 Proposed Model

The proposed model outlined below has been informed in consultation with young people, parents, and professionals. It has also been developed with the help of the young people's service user group. The model provides a high-level framework upon which providers can build, whilst incorporating the key service objectives that have been endorsed through stakeholder engagement.

Other models, including the traditional CAMHS Multi-Disciplinary Model, have been considered and rejected as not fit for purpose for this particular service. The reason for this is that the majority of young people engaged with stated that they wanted choice, and a variety of different approaches to choose from, including alternatives to one-to-one talking therapies, that a traditional model does not necessarily offer. The 'Core, Flex and Choice' model that has been developed incorporates choice as a fundamental principle of day-to-day service delivery; explained below.

CORE, FLEX AND CHOICE



Single Point of Access (SPA)

In order to ensure that children and young people receive the right support, at the right time, first time; all referrals will come through a Single Point of Access (SPA). Referrals will be accepted from the following referral sources:

- Children and young people (self-referrals);
- Parents;
- General Practitioners (GPs) and Primary Care professionals;
- Pre-schools and Nurseries;
- Primary schools, secondary schools, Pupil Referral Units, and further education centres (up to the age of where the CYP has an Education Health and Care Plan);
- Children's centres;
- Children's Social Care, including the Children in Need (CIN) team, Children Looked After (CLA) team, Disabled Children's Team (DCT) and the Multi-Agency Safeguarding Hub (MASH)
- Youth services and the Youth Offending Team;
- CAMHS;
- Voluntary sector providers;
- Public Health practitioners;
- Accident & Emergency.

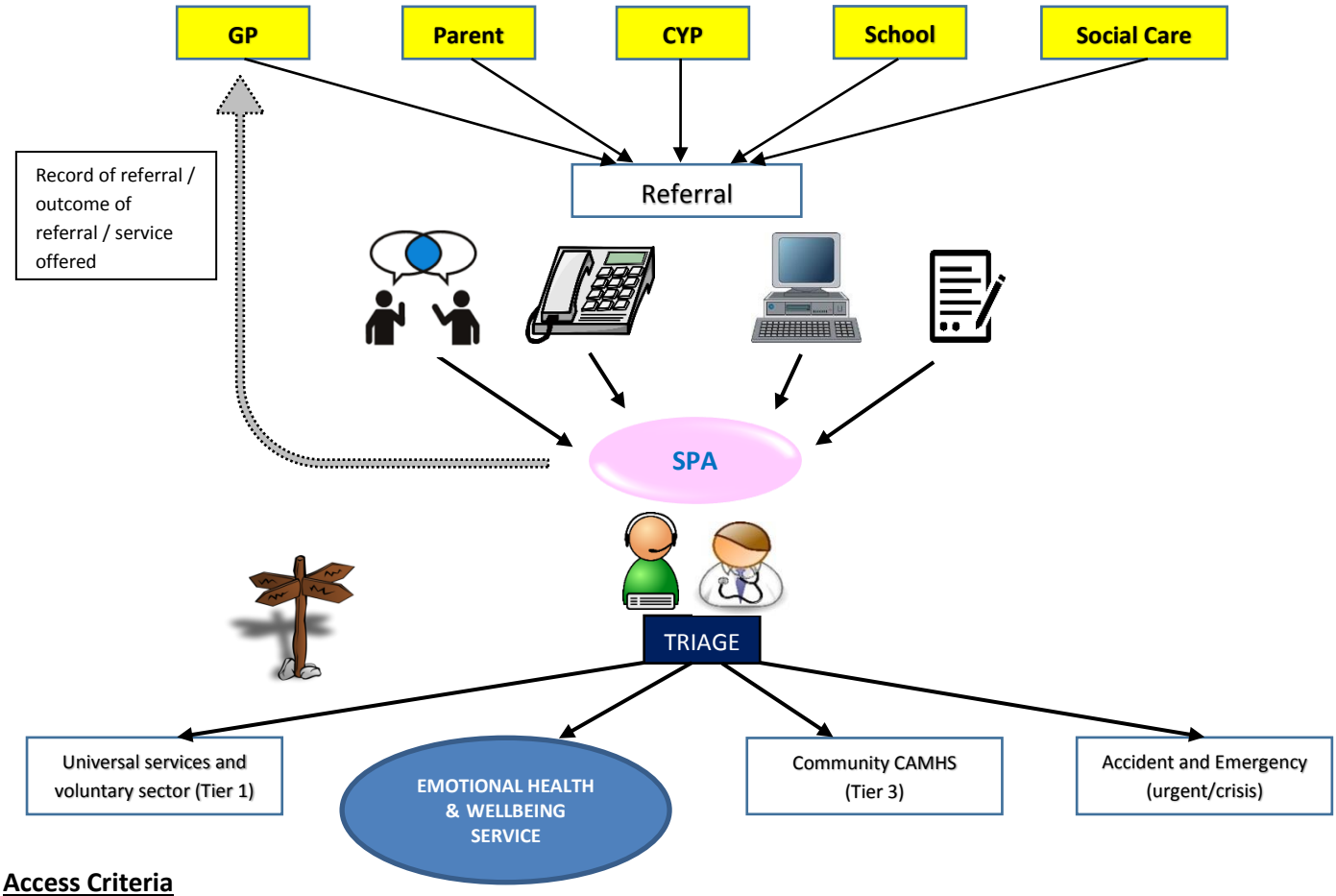
The SPA will be managed by a suitably qualified administrative triage team, clinically supervised by a clinical manager, and will have a base within a central location within the Harrow community. The team will hold responsibility for the receipt and triage of all referrals for the emotional health and wellbeing service; ensuring that children and young people receive the right service, first time.

There will be one generic referral form that will be submitted to the SPA by a secure electronic system (email), which will be determined by the service provider in collaboration with commissioners. Referrals can also be made by phone (the form to be completed by the administrative team over the phone); and by walking into the service (face-to-face), in which case referrers would be given a paper form to complete.

It is expected that the SPA will operate from Monday to Friday from 8.00am to 8.00pm (dependent on demand), and on Saturdays from 10.00am to 4.00pm. Operation times will be reviewed 6 monthly during the life of the contract to ensure that they adequately meet the needs of the service. Where changes to the operating times are required they will be mutually agreed between commissioners and the service provider. Referrals would be responded to within 3 working days and an appointment offered within 2 to 3 weeks from the day of a referral. Referrers would be notified of the high-level outcome (i.e. if an assessment is being offered or not).

On occasion, where a referral is deemed to be more complex and/or serious, the referral will be reviewed by the clinical manager, who will co-ordinate the required involvement from the various healthcare professionals, education, social care and family, or, escalate as necessary (e.g. to CAMHS or A&E). However, it will be emphasised that this is a non-emergency service only, and any urgent referrals will be appropriately transferred to the Out Of Hours (OOH) service or emergency services. Children and young people experiencing eating disorders are also to be referred to the Eating Disorder Service.

The process for the triage of the referrals is depicted below:



Access Criteria

Access criteria is still to be determined, and is to some extent dependent on the size of the financial envelope (awaiting confirmation of schools' contribution), however, the following information provides some guidance to help inform when emotional support offered by the service would be beneficial for a child or young person.

As a general guideline this service is for those children and young people who have low to moderate problems/concerns and do not require a CAMHS multidisciplinary team approach. These children/young people are unlikely to have a diagnosable mental health condition however would be in emotional distress that would benefit from counselling or other therapeutic interventions.

They may be experiencing one or more of the following issues:

- Anxiety
- Low mood/depression
- Low self-confidence/esteem
- Concerns/issues about attachment
- Behavioural difficulties/challenging or defiant behavior
- Aggression
- Withdrawn behaviour
- Poor/distorted body image
- Issues regarding identity/gender/sexuality/race/culture/acculturation
- Repetitive problematic behaviours
- Compulsive or obsessional behavioural patterns
- Bereavement and or loss (including anticipatory)

- Sleep problems
- Eating issues (mild to moderate)
- Family relationship difficulties
- Experience of abuse (physical, emotional and sexual) and/or neglect
- Peer relationship difficulties
- Bullying
- Self-harm or self-injurious behaviour

Within a school setting, the following symptoms may be recognised:

- Decrease or changes in day to day functioning i.e., attendance, punctuality, attainment/achievement within school, truancy, exam difficulties, change in appearance or behaviour.
- Emotional distress; crying, tearful easily upset or frustrated/anger, 'acting out'
- Social withdrawal; lack of concentration/focus in class room setting, withdrawn/shy/introverted with peer group and or adults/staff and poor/change in academic performance.
- Lack of interest/hope/enjoyment which affects level of activities, friendships and a sense of tiredness/lethargy.
- Changes in or poor sleep (lack of, disrupted or disturbed/nightmares), poor appetite (changes such as lack of or increase in eating patterns), poor body image and poor self-care.
- Reported feelings of guilt, hopelessness, thoughts of wanting to die and self-harming/self- injurious behaviour and/or use of substances.

Clinical Assessment

The assessment would be carried out by a clinician, in conjunction with other partners including social care and education, within 2 to 3 weeks of the initial referral. The specific type of assessment would be determined by the provider in conjunction with commissioners; however, it would draw upon additional professionals and disciplines where necessary, and would include multiple factors, including social impacts such as housing and Looked After status. The least resource intensive assessment available is preferable.

Whilst the majority of inappropriate referrals would have been triaged at the initial contact by the SPA, where an assessment has been undertaken and it is felt that the child/young person does not meet service thresholds, or where their needs are higher than service thresholds, they would be re-directed to the most appropriate provision (e.g. universal tier 1 services, Community CAMHS/Tier 4).

Where a young person is eligible for the service they would be allocated a number of credits according to their needs. They would be prioritised appropriately according to need. Prioritization criteria would be determined by the provider, in consultation with commissioners. CYP with similar clinical priority should be admitted predominately in the order of the longest waiting CYP first. The waiting list for therapy would be clinically managed and should not exceed 6 weeks (with a target of less than 3 weeks waiting time).

Credit Allocation

'Credits' refer to therapeutic sessions, which hold different value weightings. Following assessment, credits would be allocated by the clinician according to the needs of the individual child/young person. The credit rating of a particular intervention may be linked to its value in terms of cost, or, certain therapies that may be less popular but that achieve well-evidenced outcomes may be rated with lower credit values to encourage uptake.

Where there is only one therapeutic intervention recommended by the clinician, based on clinical evidence, they would be allocated sessions in that therapy without the credit allocation/choice menu being offered.

The maximum number of sessions a child/young person would receive is 12, with the average being 6.

'Pick & Mix' Choice Menu

A designated 'Navigator' would support the young person/parents to determine how to use their allocated credits. Where a young person has the capacity to be involved in this choice every effort should be made to involve them. However, where this is not possible, for example with very young children, parents would be involved in determining how credits are used.

The 'Pick & Mix' menu (below) is an example of therapies that could be offered. However, therapies offered would always be based on clinical advice and what is best to meet each child/young person's individual needs.

This aspect is based on the principle that children and young people's engagement in their therapeutic intervention can achieve better outcomes. The inclusion of 'self-help' options (e.g. mindfulness and coping skills) also supports a preventative model that promotes resilience.

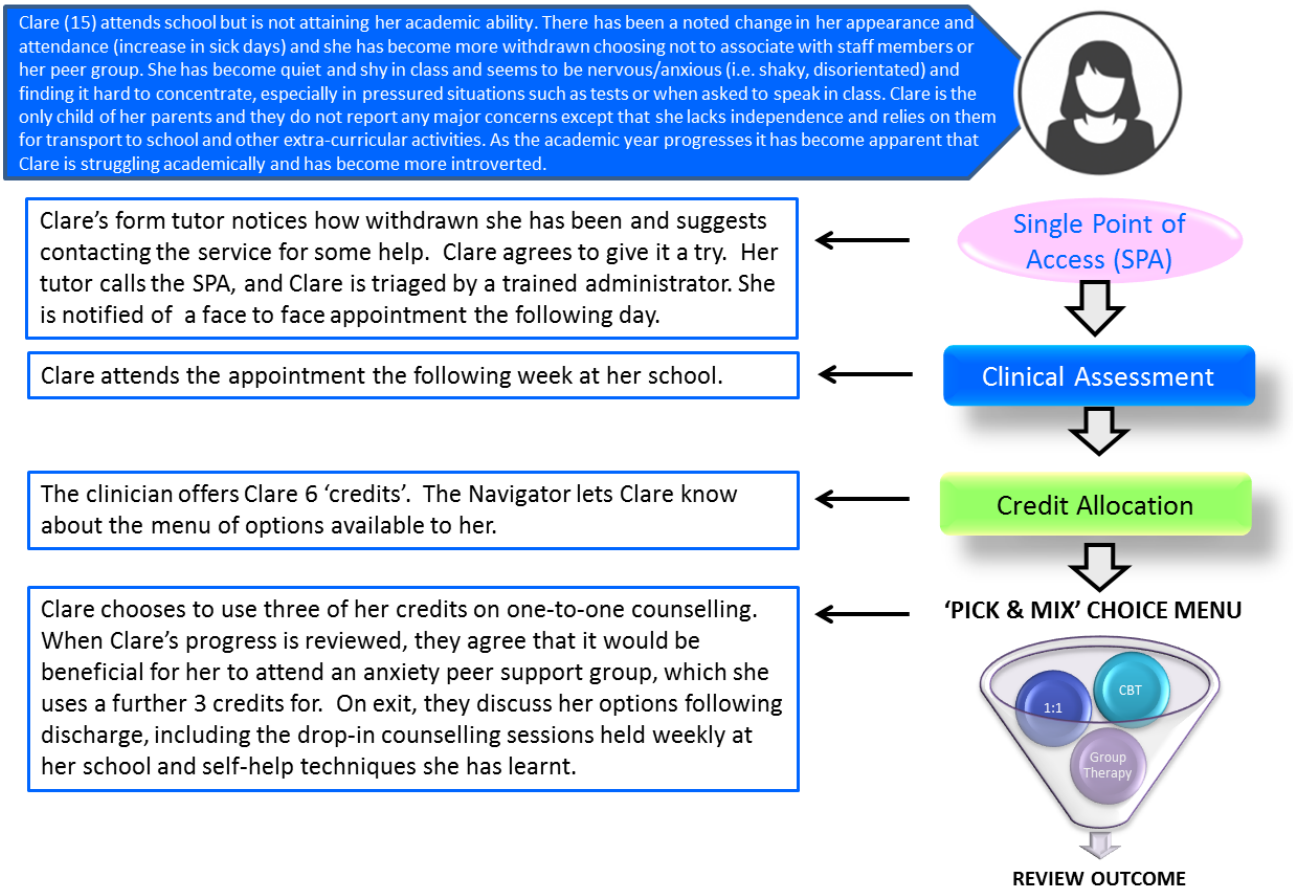
EXAMPLE PICK & MIX MENU	
HIGH/MEDIUM	**LOW**
Drama, Music, Art therapies	Coping skills (e.g. exams)
1:1 psychotherapy/counselling	Breathing techniques
Group therapy	Mindfulness
Multi Systemic Therapy	Peer to peer
Cognitive Behavioural Therapy	Yoga
Family Therapy/Family Based Therapy	Group activities/support (e.g. anxiety group)
	Parent training

Review Outcome

Progress would be monitored on an ongoing basis and reviewed following a course of therapeutic intervention. If the child/young person does not feel they are progressing with a particular approach, the reasons for this would be reviewed with them, and where appropriate they could select a different session from the Pick & Mix menu.

If the outcome is positive, an appropriate exit plan would be developed with the individual to include resilience techniques to support them in future.

Core, Flex and Choice Example Case Study



7.0 Options considered

There are three main options for consideration, as follows:

- **Option 1:** **Do not invest in the new service**
- **Option 2:** **The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service as the Lead Commissioner, with a joint commissioning agreement with the Local Authority, and a Service Level Agreement with Harrow schools**
- **Option 3:** **The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service, without joint investment from the Local Authority or Harrow schools, as the sole commissioner**

7.1 Option 1

Option 1: Do not invest in the new service

Description	• The CCG will continue not to invest in preventative and early intervention services for children and young people with identified needs at 'Tier 2' in Harrow. Without appropriate provision that may prevent or delay children and young people's needs from escalating, referral pressures will remain on Community CAMHS.

Opportunities	Potential saving by not investing; although it is unclear whether this may be used for other purposes or if NHS England will require evidence of spending against the Transformation Plan that Harrow CCG has committed to.
Risks	• Continued unmet needs of children and young people in Harrow with emotional health and wellbeing difficulties. • No opportunity to reduce the numbers of children and young people accessing Community CAMHS and A&E due to escalating mental health difficulties. • Risk that by not fulfilling the commitment made to the establishment of an emotional health and wellbeing service within the Local Transformation Plan, funding could be clawed back by NHS England. • Financial dis-benefit of not investing in early intervention and risking higher costs of children and young people's needs escalating and requiring Community CAMHS, A&E and other more intensive and costly interventions. • Schools will continue to commission provision individually; however the consistency and quality across Harrow will vary and pose a potential risk to individuals; due to lack of provision, and poor quality and/or monitoring. • The continued lack of provision for schools to refer into directly impedes quick, appropriate access and reducing capacity in primary care. • Reputational risk due to the commitment made within the publically available Future in Mind Local Transformation Plan, and also through the engagement work to date (e.g. market engagement event, workshops with professionals, parents and young people, and Future in Mind newsletter to local stakeholders).

7.2 Option 2

Option 2: The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service, as the Lead Commissioner, with a joint commissioning agreement with the Local Authority, and a Service Level Agreement with Harrow schools

Description	The CCG commits investment of £810,000 over 3 years (£270,000 annually) to an emotional health and wellbeing service, with a joint commissioning arrangement through a Section 75 agreement with the Local Authority, and a Service Level Agreement (SLA) with Harrow schools. The CCG's contribution to the service is entirely funded through the funding granted by NHS England through Future in Mind, and will be used in accordance with the proposals outlined within the Local Transformation Plan. The Local Authority will match the CCG's contribution of £810,000 over 3 years, and the maximum schools' contribution will total £540,000 annually (approximately, depending on school buy-in). The total annual value of the contract will be approximately £1,080,000. The CCG will act as the Lead Commissioner, with collaboration and partnership working with the Local Authority and schools in the procurement process.
Opportunities	• There is currently an identified gap in Tier 2 provision in Harrow; this service will address this gap by supporting children and young people with emotional health and wellbeing needs to improve their health outcomes. • Investing in early intervention may produce savings in terms of reduced referrals to CAMHS and admissions to A&E due to crisis. • Social and economic long-term gains from investing in early intervention. • Promotion of resilience for families. • Through working in partnership, schools' capacity to understand and support mental health interventions with children and young people are improved. • A consistent and joined-up approach to tier 2 services across Harrow.

	• Collaborative working with schools and the Local Authority to promote joint accountability and sustainability of the service. • Joint commissioning can also maximise the benefits of the service through ensuring it is as joined up and seamless for families as possible (e.g. Single Point of Access).
Risks	• The schools' annual contribution of £540,000 may not be achieved. In the main, schools have expressed interest in investing in the service. However, as schools will be charged individually, some schools may still opt out of investing. • In addition to the risk that some schools will not invest in the service; some schools may not invest until Year 2 onwards. Financial decisions are made annually in either September or January by most schools; therefore some will not invest until Year 2, creating a potential shortfall in Year 1. • There may not be a suitable, interested provider(s) that is able to deliver this service according to the local needs and preferred service model. • There might be higher demand for this service than anticipated which the service may not be able to cope with, creating a long waiting list. • The Future in Mind funding is only sustainable for the next three years. There is a risk in raising expectations for a service that may be decommissioned at the end of the three years if funding is not renewed. • Increased support and presence in schools at this level may lead to an initial increase in identification of children and young people with mental health needs requiring intervention at Tiers 3 and 4, potentially increasing pressure on these services. However, the long term aim is to reduce numbers in Tiers 3 and 4 through early intervention and preventative work.

7.3 Option 3

Option 3: The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service, without joint investment from the Local Authority or Harrow schools, as the sole commissioner

Description	The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service, without joint investment from the Local Authority or Harrow schools
Opportunities	• The service will be able to work with small numbers of children and young people with emotional health and wellbeing needs in Harrow, where this is a recognised gap at present. • The procurement process will be somewhat less complex without the additional partners involved (e.g. there will be no need for a Section 75 agreement with the Local Authority, or SLA with schools).
Risks	• Annual investment in the service of only £270,000 will only deliver a quarter of the proposed service model, significantly reducing the numbers of children and young people that may be seen, with a majority of children and young people with eligible needs still without a service. • Increased waiting times.

7.4 Preferred Option

Option 2: The CCG commits investment of £810,000 over 3 years to an emotional health and wellbeing service, as the Lead Commissioner, with a joint commissioning agreement with the Local Authority, and a Service Level Agreement with Harrow schools

Option 2 is the preferred option. This option offers the maximum resource by working together with education and the Local Authority to address the identified gap in provision for children and young people with emotional health and wellbeing needs. Working together with schools and the Local Authority will also promote a joined-up, holistic approach, which will ultimately achieve better outcomes for children and young people. This model will commit all partners to take responsibility for children and young people's emotional health and wellbeing, which will support the sustainability of the service in the longer term. There are demonstrable social and economic gains that can be achieved through investing in early intervention and in reducing the number and severity of children and young people with mental health needs at Tiers 3 and 4.

By acting as the lead commissioner the CCG can guarantee that the service is delivered to a high standard by the most suitable provider(s); and that it meets statutory standards and clinical best practice guidance.

8.0 Benefits

The tangible benefits of commissioning this service are:

- Closing the gap in provision for children with emotional health and wellbeing needs at Tier 2 in Harrow.
- Improve outcomes for children and young people with emotional health and wellbeing needs.
- Promote resilience and early intervention approaches, to ultimately reduce and prevent needs from developing and requiring more intensive intervention at Tiers 3 and 4.
- Encourage partnership working and shared accountability between the CCG, schools, and the Local Authority for children and young people with emotional health and wellbeing needs.
- Longer term economic case – investment to save.

9.0 Timescales

Activity / Milestone	Description	Dates
Market Engagement Publish Advert and invite Expressions of Interest	Publish EOI advert through contracts finder. Direct emails to potential local providers regarding market engagement opportunity.	**Friday 3rd June 2016**
EOI deadline	Deadline for potential bidders to express interest to be involved in engagement and attend market engagement event.	**Friday 24th June 2016**
Bidder Event	Engage with potential bidders expressing interest in procurement, sharing commissioning intentions, inviting feedback from the market.	**Thursday 30th June 2016**
Business Case Sign-off (CCG)	Mental Health Workstream (CCG) (deadline for papers 15th September)	**Tuesday 20th September 2016**
Market Engagement/ 'Meet the Buyer' Event (2)	Communicate further detail around the service model and financial envelope to providers. Informal 30 minute 1-2-1 discussions with interested providers to answer more detailed questions and capture feedback.	**Monday 26th September 2016**
Business Case Sign-off	Seminar (CCG) (deadline for papers 22nd	**Tuesday 27th September 2016**

(CCG)	September)	
School- buy in	Heads and Directors Meeting – share the model and buy-in deadline (MOU)	**Thursday 29th September 2016**
Business Case Sign-off (Local Authority)	Cabinet (deadline for papers **9th September**)	**Thursday 13th October 2016**
Business Case Sign-off (CCG)	Executive (CCG)	**Tuesday 18th October 2016**
Business Case Sign-off (CCG)	Governing Body (CCG)	**Tuesday 1st November 2016**
EQIA Screening sign-off (CCG)	Quality, Safety and Clinical Risk Committee (CCG) (papers by 21 October)	**Tuesday 1st November 2016**
CCG authorisation for procurement to proceed	Harrow CCG approval for procurement to proceed.	**Tuesday 1st November 2016**
Business Case Sign-off (Local Authority/CCG)	Health and Wellbeing Board sign-off (draft of the report by 7 October (for the councillor briefing) and a final version by 21 October)	**Friday 3rd November 2016**
Issue advert & procurement documentation	Procurement advertised through Contracts Finder and all procurement documents made available to potential Bidders through the e-Procurement portal, including TUPE information.	**Tuesday 1st November 2016**
Bid Submission DEADLINE	Deadline by when Bidders must have fully completed and submitted their Bids.	**Tuesday 13th December 2016 (6 weeks)**
Preliminary review of ITT responses	SBS undertake preliminary review of all ITT responses to ensure completeness, liaising with bidders where clarifications appropriate.	**Tuesday 13th December 2016**
Bid evaluation stage	Period when Bids will be evaluated and CCG clarification questions responded to by bidders. Evaluation panel individually review and score bids, followed by moderation event to agreed consensus scores and section of the Preferred Bidder(s)	**Tuesday 13th – Friday 16th December 2016**
Evaluation Moderation Meeting	Moderation to be facilitated by SBS. All evaluators to come to a consensus score for each of the evaluation criteria.	**Friday 6th January 2016**
Prepare Procurement Outcomes Report	Prepare procurement outcomes report, including recommended contract award.	**Monday 9th January 2016**
CCG and Harrow Council authorisation to award contract(s)	CCG/Local Authority governance to consider post-procurement recommendation report regarding contract award. CCG authorise contract award.	**TBC**
CCG Executive sign-off	Executive	**TBC**
CCG Governing Body sign-off	Governing Body	**TBC**

Bidder initial notification and standstill period regarding Confirmation of a Preferred Bidder(s)	The expected dates when Bidders will be notified of the outcome of the evaluation and observance of the recommended Standstill Period	**January 2017**
Contract signature	The expected date for the signing of the Contracts between the CCGs and the successful Provider	**January 2017**
Local Authority sign-off	Cabinet paper for information (13th January cut-off for papers)	**February 2017**
Service mobilisation period	Period when the Preferred Bidder plans and delivers mobilisation activities to prepare for service commencement	**January through March 2017**
Full service commencement	Date that commencement of the new Service is expected.	**31st March 2017**

10.0 Procurement

This procurement falls under The Public Contract Regulations 2015 'light touch regime'. The process will be managed through the EU Supply tender portal. Detailed instructions including award criteria and evaluation information will be outlined within the tender documentation to potential bidders when it is advertised. Bidders will submit a single written submission followed by bidder interviews. Bids will be evaluated by a multidisciplinary evaluation panel – including representation from the Local Authority and schools.

11.0 Finance

	Timing	Funding Source	Amounts		Cost Centre
			Non-recurrent	Recurrent	
Year 1	2016/17	**CCG**		**£270,000**	
	2016/17	**Council**		**£270,000**	
	2016/17	**Schools**		**£540,000**	
Year 2	2017/18	**CCG**		**£270,000**	
	2017/18	**Council**		**£270,000**	
	2017/18	**Schools**		**£540,000**	
Year 3	2018/19	**CCG**		**£270,000**	
	2018/19	**Council**		**£270,000**	
	2018/19	**Schools**		**£540,000**	

Schools are being invited to invest in the service through an SLA; total potential investment from schools being £540,000 if all Harrow schools invest. Formal commitment from schools is currently being sought through a Memorandum of Understanding (deadline early November 2016), with key buy-in dates of: April 2017, September 2017, and January 2018.

12.0 Risks, issues and dependencies

12.1	Risks		
Risks	**Likelihood**	**Impact**	**Total**
Slippage in the timeline may cause delays to the service launch date.	**2**	**2**	**6**
Providers may not be able to mobilise quickly enough.	**2**	**3**	**6**
There may not be a suitable provider(s) that is able to deliver this service.	**1**	**5**	**5**
There might be higher demand for this service than anticipated which the service may not be able to cope with, creating a long waiting list.	**2**	**3**	**6**
The Future in Mind funding is only sustainable for the next three years. There is a risk in raising expectations for a service that may be decommissioned at the end of the three years if funding is not renewed.	**3**	**3**	**9**

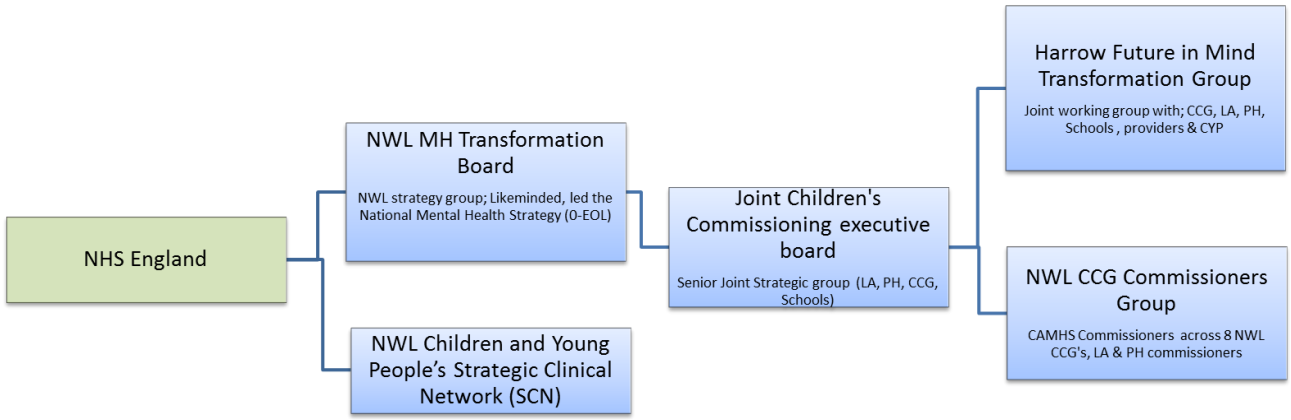
12.2	Issues	
Issues	**Mitigation**	**Owner**
School buy-in and engagement takes time to develop and to nurture the relationship between education and health/social care.	Engagement with schools through meetings with the Chair and Vice Chair of the Schools Forum and presentations to the Heads and Directors Forum are already taking place and will continue. School representatives on the Transformation Board are supporting this work. The findings and benefits of the Pilot will also be shared with schools as they emerge, to encourage buy-in to the service.	**ES**

12.3	Dependencies	
Dependency	**Impact on project**	**Owner**
The preferred option is based on school buy-in. The schools' annual contribution of £540,000 may not be achieved and/or it may not be achieved prior to the service launch date.	If school buy-in is not achieved, the service will not reach as many children and young people; thresholds will be higher and waiting times for the service may increase. The contract will be advertised at a minimum and maximum value so that providers are aware that there is potential for the service to expand; a question around providers' capacity to manage potential expansion will be included in the ITT documentation.	**ES**

13.0 Governance

Senior Responsible Officer	Sue Whiting	Assistant Chief Officer
Clinical Lead	Dr Genevieve Small	Governing Body (Clinical Director with Lead for Paediatrics)
Project Lead	Elizabeth Streeter	Project Manager, Future in Mind

Communications & Engagement Lead	Tara Curtis	Participation & Engagement Officer
Finance Lead	Lisa Money	Head of Financial Support
Contract Lead	Jessica Thom	Integrated Children's Commissioning Manager, Health and Social Care
Procurement Manager	Tom Baker	Procurement Manager, NHS Shared Business Services



Harrow Local Transformation Plan governance has representatives from: Harrow CCG • Harrow Local Authority • Harrow Public Health • Harrow Schools • NHSE •Harrow Health & Wellbeing Board • Harrow Providers incl VCS • CYP Representatives from agencies involved in the transformation plan are expected to use their agencies internal reporting governance procedures.

13.2 Engagement with Providers

A soft market engagement event was held on 30th June 2016 at Harrow Civic Centre to inform and consult with providers about the procurement. The Market Engagement Event report can be found in Appendix B.

13.1 Engagement with Children, Young People, Parents and Professionals

This business case has been greatly informed by the engagement work carried out with children, young people, parents and professionals. A series of workshops with children, young people, parents/carers and professionals were held from April to September 2016 to consult and design the service model with key stakeholders. The table below outlines a summary of the feedback and key themes that emerged.

Theme	***Comments from workshops***
Referral/ Open Access	• *The referral criteria form and questionnaire should be clear and concise. It needs to be accessible to children, young people and parents to be able to refer.* • *An assessment needs to be completed in a set timeframe.* • *Access should be made available for CYP with complex needs, LD, ASD and ADHD.* • *To be aware of CYP that may have alternative communicative needs to also be able to refer and access the service.* • *There should be awareness of cultural and diverse needs, to be considered with access to interpreters.* • *The service should allow individuals to be able to refer via the telephone.* • *There should be support offered to young carers, engaging care givers as well as*

	access for home schooled CYP. • *To recognise that 0-8yrs children need support and access.*
Thresholds	• *Professionals have sited a 'Step up and step down' approach where appropriate. It is imperative that we prevent duplication and ensure joined up working to maximise available resources. "No wrong door" working collaboratively together.*
Support in schools	• *Peer to Peer, Mentors and Service champions support was recommended as successful ways to engage and support young people.* • *Teachers to be able to recognise when CYP need support and how to support them.* • *Schools need to work together to assist CYP when transitioning to different schools.* • *Schools also need to have clear pathways to access training and gain support from the service.* • *If it is possible for schools to offer available space to access support during holidays and weekends.*
A service with staff that can work collaboratively with partner agencies.	• *Multi–disciplinary working has raised an issue with confidentiality numerous times from all professionals that work together around the child. Clarity for consent issues between schools, who provides and what are they consenting to, is to be addressed. All wanted constructive feedback after interventions.* • *Excellent communication across agencies is vital to providing an efficient service for CYP.*
Training	• *Parenting programmes should be made available where appropriate to enhance long term results.* • *Reduce stigma through training.* • *Using social media to challenge stigma and education around mental health is vital in reaching CYP.* • *Staff would need to be aware of social media pressure and the dangers associated with that.* • *A good way of raising awareness is engaging at school assemblies and PHSE classes to educate CYP around emotional health and wellbeing.*
Promotion of the service	• *This should be a service promoted by young people for young people. This was the general consensus amongst the young people of Harrow.*

The Stakeholder Engagement Report can be accessed here.

Engagement Report FINAL.docx

14.0 Equalities Impact Assessment

An EIA/Quality Impact Assessment screening tool has been completed resulting in no requirement for a full EIA. This decision report will go to the CCG's Quality, Safety and Clinical Risk Committee 1st November for endorsement.

15.0 Appendices

A	**Transformation Plan Annex E Harrow CCG**
B	**Market Engagement Event report**
C	**Local Authority Business Case**