

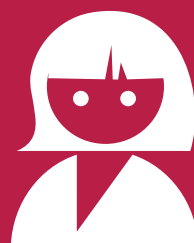
Progress and challenges in the transformation of children and young people's mental health care

*a report of the Education Policy Institute's
Mental Health Commission*

Emily Frith
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**Children and
Young People's
Mental Health**



About the author

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About

The Education Policy Institute is an independent, impartial and evidence-based research institute that aims to promote high quality education outcomes for all children and young people, regardless of social backgrounds.

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Foreword by Rt. Hon. Norman Lamb MP



When I launched *Future in Mind* in March 2015, my aim was to modernise the way children and young people's mental health services operate. Central to this objective was the need to tackle the treatment gap that exists. Far too many children and young people in this country are unable to get the help they need in a timely way. Our current child and adolescent mental health system is often geared towards intervening only when a crisis is reached. The vision of *Future in Mind*, with the additional funding secured in the Budget last year, is to move towards a system focused on prevention and early-intervention, where specialist services are integrated with wider health and care support.

This report explores progress over the first year of the programme. A huge amount of work has been going on across the country to explore new ways of working, reduce waiting times and increase access for young people. I pay tribute to the dedication and commitment of people working within Child and Adolescent Mental Health Services who do not always get the thanks and attention they deserve. These clinicians and other workers share our vision of a different approach. Nevertheless, they are often frustrated in their endeavours by working in a system which is not yet fit for purpose.

This report shows wide variation in progress achieved so far, and aims to help those areas of the country which are struggling with the challenge to learn from areas which are leading the way. Our analysis of published plans does not claim to provide a detailed exploration of progress in each area but simply to demonstrate the variation within the plans as they were written and to highlight where improvements can be made as the process of transformation continues.

We have also identified the key barriers to progress, the most concerning of which relates to the workforce. Unless there is a concerted effort at a national level to tackle the workforce shortages and training needs that exist, we will not be able to close the treatment gap and ensure that our children and young people can get the support they need. In addition, the workforce of the future must have the right skill mix to achieve far better prevention and early intervention as envisaged by *Future in Mind*.

Rt Hon Norman Lamb MP

Introduction

The Education Policy Institute (previously known as CentreForum) established a Commission on Children and Young People's Mental Health in December 2015. Chaired by former Mental Health Minister Rt. Hon. Norman Lamb MP, the Commission aims to understand and explore progress in transforming children and young people's mental health services in England. The other Commissioners are:

- Roy Blatchford, Director, National Education Trust
- Sarah Brennan, Chief Executive, Young Minds
- Professor Tanya Byron, clinical psychologist, writer, broadcaster and government advisor
- Kat Cormack, mental health consultant
- Jacqui Dyer, adviser to Department of Health and NHS England, service user and carer
- Professor Peter Fonagy, Chief Executive, Anna Freud Centre, London
- Dr Lise Hertel, GP, Clinical Lead for Mental Health, NICE, Newham CCG
- Tim Horton, Health Foundation, former advisor to Ed Miliband MP
- Dr Charlie Howard, Founder, MAC-UK
- Dan Mobbs, Chief Executive, MAP, advice and counselling service, Norfolk and Norwich

Our first report, *Children and Young People's Mental Health: The State of the Nation* was published in April 2016.¹ This found that child and adolescent mental health services are turning away, on average, nearly a quarter (23 per cent) of the young people referred to them for help. Our analysis of services' eligibility criteria showed that this is often because there are high thresholds for access to their services.

Once a referral is accepted, young people frequently have to wait many months for treatment. Indeed, the average of trusts' longest waiting times was nearly ten months between referral and the start of treatment. There was also significant variation in waiting times between providers. The average waiting time in Gateshead was five times as long as for those just down the road in Tyneside. Similarly, waiting times in North West London vary widely from two months in Kensington and Chelsea, to nearly six months in Brent.

In this, our second report, the Commission has focused on progress in transforming services since the publication of the Coalition Government's strategy, *Future in Mind*, in March 2015.² Accompanied by announced investment of £1.25bn over five years, the strategy aims to improve the care offered to children and young people in England by 2020. This report explores what progress has been made in the first year of the programme and the barriers and risks which could hinder the process of transformation.

Note on Methodology

The Commission was very concerned about ensuring the voice of young people was central to our work. After careful discussion on the best approach to this, we recruited a Youth Reference Group, inviting and supporting young people to apply via a number of organisations. We would like to thank our Youth Reference Group members for their invaluable advice. They included: Jessica Mell, Foyez Syed, Zoe Johnson, Lucas Shelemy, Denis Kirya, Sai Kadirrajah, Laura Cocks, Holly Cookson, Jasmine Wyeth, and Naomi Barrow. Several members of our Commission continually work directly with young people in their services and Kat Cormack has extensive experience of services both as a client and supporting young people who are currently in treatment.

The research for this report was based on analysis of local transformation plans, which every area in

1 Children and Young People's Mental Health: State of the Nation, CentreForum, April 2016: <http://epi.org.uk/report/children-young-people-mental-health-state-nation/>

2 Future in Mind, Department of Health and NHS England, March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

England has developed as a condition of receiving additional investment under the *Future in Mind* programme. The methodology for this analysis is described in more detail in Chapter One of this report.

In addition, the Education Policy Institute issued a Call for Evidence in February 2016. This was distributed widely to key stakeholders in the field of children and young people's mental health. It asked for views on the barriers and risks which could hinder progress in transforming services and recommendations for policy change. We received 64 responses from a wide range of organisations and practitioners, which have contributed to this report.

We held roundtables with the Association of Colleges and the Association of State Girls' Schools to inform our research on mental health and education. We also conducted 51 interviews with professionals across the child and adolescent mental health system and three visits to schools and mental health services.

The Education Policy Institute sent out a freedom of information request to 61 CAMHS providers (all providers of specialist services with the exception of private providers who are not obliged to complete freedom of information requests). We received substantive responses from 41, a response rate of 67 per cent.

Executive Summary

In order to assess progress in the delivery of *Future in Mind*, the government's strategy to improve children and young people's mental health, the Education Policy Institute's expert Commission has conducted an analysis of the local transformation plans that have been developed by local partnerships of health and care leaders across the country. These set out each area's strategy for improving services in line with the vision of *Future in Mind* and are a condition of receiving the first year's tranche of the additional investment announced as part of the programme.

Local children and young people's mental health services have been working very hard to improve support and there are some excellent examples of good practice highlighted in this report. In particular, clinicians within services are, for the most part, driven to improve their services and ensure that these services are centred around the needs of young people. They are often frustrated in doing so by operational policies and systemic problems, and it is these problems and frustrations which this Commission seeks to address.

Our research finds that the process of implementing *Future in Mind* has led to some positive changes, including:

- Every area of the country has developed a plan, shining a spotlight on children and young people's mental health and ensuring that all areas have become more aware of the gaps in provision in their locality;
- Local health and care leaders have been working together to coordinate the design of new services;
- The process has delivered some much needed transparency to the system, with local plans including service level information that had previously not been available at a national level;
- Data is now beginning to be gathered nationally to inform service improvement;
- Some excellent examples of local transformation plans, set out in detail in Chapter One of this report.

Nevertheless, our analysis shows wide variation in the quality of local delivery. Of the 121 published plans,³ **only 18 areas (15 per cent) have 'good' plans. 58 plans (48 per cent) 'require improvement' and 45 plans (37 per cent) 'require substantial improvement'.**

It is important to note that our analysis was of **published** plans. Many areas included a lot more information in their internal submissions and it was not possible for us to review those. The local transformation plans represent a moment in each area's transformation process. We could only analyse the information contained in the plans and it may be that there is good work going on in some areas which was not covered in detail in their published plans. As this methodology has not been used previously, it is not possible to know how far it will act as a marker for whether outcomes of services will be improved in each area. This analysis is therefore not a league table or final assessment of progress in each area. It is intended as a useful tool for areas to measure their progress against their peers. It is also intended to aid transparency by encouraging local health and care leaders to demonstrate their activity in their public plans. We recognise that the plans capture a snapshot of activity at a local level, and that areas were starting from very different positions. A good plan may misrepresent what is happening locally and an area with a less effective plan may have made extensive progress since the plan was produced. Our next report will explore further progress in six areas.

In this report, plans were judged on five measures. These were:

³ The plans have all, apart from one area (Greenwich) been published online. Some have only been published in summary form or do not include the background documents submitted to NHS England for assurance.

- Transparency;
- Involvement of children and young people;
- Level of ambition;
- Early intervention, including links with schools and GPs;
- Governance.

For further information about the methodology, please see Section One of the full report.

Overall, the plans were particularly weak on involving children and young people, level of ambition for service reform, and having strong governance to ensure effective implementation.

On average, localities in the Eastern and West Midlands regions performed best. The mean score for the Eastern region was 34.9, while the mean score for the West Midlands was 34.4. Plans from the rest of the South East and the East Midlands received the lowest mean scores: 30 and 29.3 respectively. There was, however, wide variation within regions between different local plans.

Barriers to Transformation

The Education Policy Institute has identified six key barriers to effective delivery of *Future in Mind*:

- i. Workforce (both recruitment difficulties and training needs);
- ii. Funding;
- iii. Commissioning;
- iv. Data;
- v. Fragmentation (the complexity and gaps between services);
- vi. Intervening too late.

Workforce

In order to investigate the problems within the workforce in more detail, the Education Policy Institute sent a freedom of information request to CAMHS providers. The key findings were as follows:

- 83 per cent of trusts which responded stated that they had experienced recruitment difficulties.
- The same proportion had had to advertise posts on multiple occasions to fill roles.
- Mental health nurses were the most difficult profession to recruit, followed by consultant psychiatrists.
- These recruitment challenges had led to an 82 per cent increase in expenditure on temporary staffing in the last two years. In 2015-16 nearly **£50m** was spent on agency staff by 32 trusts.
- There was regional variation in recruitment difficulties, with six providers (15 per cent) not experiencing any problems, in particular trusts in the Midlands and some Northern trusts.
- Trusts were asked to state how many applicants they had per post when they most recently advertised different staff positions. In total the 41 trusts mentioned 51 instances of a post being advertised and receiving two or fewer applicants.

Funding

The £1.25bn over five years announced in March 2015 equates to £250m per year. Only £143m was released in the first year, and of that only £75m was distributed to local health leaders. It is not yet clear how much of this has been spent on frontline services.

For 2016-17, £119m has been allocated to local areas, but this has been included in their total baseline allocation. It has not been ring-fenced and so there is a risk that it will be spent on other priorities.

Additionally, as specialist services sit within a wider network of support, from youth services to local authority funded charities and social care, there is a risk that the overall budget for children and young people's mental health may not increase or may even be reduced due to wider austerity measures.

Commissioning

A recurrent theme in our research was the complexity and quality of local commissioning (the system by which local services are planned and paid for). Commissioning is fragmented across national and local bodies, which causes conflict and confusion. Clinical commissioning groups and local authorities do not always have the expertise in mental health to design services effectively and hold them to account.

Data

Child and adolescent mental health services are still operating without the data they need to plan services effectively. There is no up to date information on how many young people need treatment and what the projected increase in prevalence is over the next five years, which makes it difficult for services to know by how much they need to increase capacity. Similarly, there is no nationally agreed measurement of waiting times or access thresholds, which means that it is very difficult to benchmark performance and hold providers to account.

Fragmentation

A key barrier to delivering services more effectively is the way in which children and young people's mental health care is delivered across so many different organisations. This causes fragmentation in the system and risks young people falling through the gaps between services. For example, there is division between early intervention, specialist community and inpatient services. More widely, mental health is often organised in isolation from wider community health and hospital services even though people who use these services often end up needing both physical and mental health treatment (for instance those who self-harm). There is also a divide between mental health services and the education system, where young people spend the majority of their time and which is a more suitable setting for the identification and early support of vulnerable young people.

Intervening too late

A consequence of the fragmented system is that young people frequently find it hard to access the care they need. Our research has found that this is often a result of a system which is set up to focus on specific diagnostic thresholds. While a diagnosis is important for the delivery of evidence-based treatment, there are young people with risk factors or symptoms which have not reached a particular diagnostic threshold who might benefit from early assessment, detection and intervention. This might include young people with behavioural issues in school or those who have experienced bereavement or trauma. The process of transformation needs to take into account the way the current system often intervenes too late and to encourage a preventative approach.

Next steps

This autumn, the Education Policy Institute's Commission will make recommendations based on the evidence we have gathered to date. These will be aimed at government and local health and care leaders to highlight how to overcome the barriers identified in this report. Our aim is to enable the delivery of effective service transformation in order to tackle the problems of access and quality that were identified in our first report.

1. Local Transformation Plans

Future in Mind set out a vision for the transformation of children and young people's mental health services, giving ownership to frontline commissioners to manage the programme. All local areas were tasked with developing local transformation plans to set out their strategy for improving children and young people's mental health care. 122 plans⁴ were developed by partnerships between the NHS and local authorities across the country, some covering just one town, while others involved county-wide collaborations. The plans were developed as a condition of receiving the new investment. After a process of assurance, all areas received their funding allocation.

Analysis of the Plans: Methodology

The Education Policy Institute worked with our expert Commissioners to develop a scorecard in order to categorise local plans into one of three distinct groups. These were 'good', 'requires improvement' or 'requires substantial improvement'.

Our Commissioners brought a wealth of expertise, both clinical and operational, to the development of the scorecard. They have experience spanning healthcare commissioning, the voluntary sector, education, service user involvement and direct service provision.

Plans were given a score out of 50 based on five measures, each worth 10 points. These were:

1. Transparency

In this category, plans were assessed on the following indicators:

- Understanding their local level of need. This included using national and local data to estimate current and future prevalence rates and need for services at different levels, such as universal/targeted/specialist or inpatient care;
- Honesty about current service provision, highlighting where problems exist rather than including only positive information;
- Clearly setting out the current problems challenges they face;
- An understanding of workforce development needs.

2. Involvement of children and young people

In this category, plans were assessed on the following indicators:

- How far children and young people were consulted as the plan was developed;
- How far co-production with young people is built into ongoing plans;
- What mechanisms were used to engage young people;
- Whether young people were involved in co-production of services.

3. Level of ambition

In this category, plans were assessed on the following indicators:

- How far the plan is aligned with the key priorities identified in *Future in Mind*;
- Whether the local area is seeking to transform provision, for example through redesigning the whole service model;
- Whether the plan focused on simply increasing capacity in current services;
- Whether the plan seeks to remove tiers and gaps between services and design a smooth pathway

⁴ The Greenwich plan was not available at the time of this study so our analysis covered 121 plans in total.

from first referral to specialist treatment.

4. Early intervention including links with schools and GPs

In this category, plans were assessed on the following indicators:

- To what extent the plan invests sufficient resource in outreach;
- Whether the plan includes clear proposals for integrated service provision with universal services such as GP practices and schools;
- To what extent the plan focuses on preventing problems escalating to a point where specialist services are needed;
- How far have they developed plans for use of innovative digital technologies such as online counselling;
- What involvement has there been of voluntary sector providers.

5. Governance

In this category, plans were assessed on the following indicators:

- How likely it is that the plan will be delivered;
- Whether there are clear mechanisms to track progress, such as measureable and ambitious key performance indicators;
- Whether there is sufficient oversight at a senior level. For example, through a partnership steering group or board. How frequently they plan to meet;
- Whether the plan includes an action plan with timelines and deadlines;
- Whether the plan includes a risk register.

Given the wide-ranging scope of the plans, the analysis had to choose to focus on these core measures, rather than commenting on every aspect. We were not able to look in detail at proposals on eating disorders, perinatal care, access for vulnerable groups or crisis support. We also could not look in detail at important elements such as improving the competencies of staff with better assessment, supervision and training as this was not covered in detail in many plans.

Plans were rated by the same person and scores were referenced to previously assessed plans to aid consistency.

It is important to note that these plans capture a moment in each area's transformation process. In some parts of the country, local commissioners had already undertaken extensive reviews of services and were much further ahead in designing and delivering new provision. Others had not focused on this agenda before the publication of *Future in Mind* and so were clearly much further behind. Where local commissioners had a clear plan on how to move forward, this was recognised in our analysis, even if they were not yet at the same stage in the process as others. In our final report, the Education Policy Institute will look in more detail at six local areas (three rated 'good' and three rated 'requires substantial improvement') to explore how the plans are being implemented in practice.

Analysis of the plans: Results

There was wide variation in the quality of plans, with scores ranging from 17 to 46 out of 50.

Only 18 plans (15 per cent) were rated ‘good’ – having a score of 40 or higher.

58 plans (48 per cent) were rated ‘requires improvement’, based on a score between 30 and 40.

45 plans (37 per cent) had a ‘requires substantial improvement’ rating of lower than 30.

Greenwich’s plan was not publicly available at the time the analysis was undertaken.

Figure 1: The twenty highest scoring plans (in alphabetical order)

Local Area	Transparency	Ambition	CYP Involvement	Early Intervention	Governance	Overall Rating
Barnet						
Bedfordshire						
Birmingham						
Buckinghamshire						
Camden						
Croydon						
Dudley						
Essex						
Herefordshire						
Kirklees (Huddersfield & Kirklees CCG)						
Liverpool CCG						
Oxfordshire						
North Somerset						
Sheffield						
Shropshire						
South Tyneside						
Stockport						
Tower Hamlets						
Trafford						
West Sussex						

Figure 2: The twenty lowest scoring plans (in alphabetical order)⁵

Local Area	Transparency	Ambition	CYP Involvement	Early Intervention	Governance	Overall Rating
Barnsley	Red	Red	Red	Red	Red	Red
Bury	Red	Red	Amber	Red	Red	Red
Calderdale	Amber	Red	Amber	Red	Red	Red
Cumbria	Red	Red	Red	Red	Amber	Red
East Berkshire	Red	Red	Red	Amber	Red	Red
Hampshire Cluster	Red	Red	Red	Red	Red	Red
Isle of Wight	Red	Red	Amber	Red	Amber	Red
Knowsley	Red	Red	Red	Red	Red	Red
Lambeth	Red	Amber	Red	Amber	Red	Red
Norfolk	Amber	Red	Red	Amber	Red	Red
North Lincolnshire	Red	Red	Red	Amber	Red	Red
Portsmouth	Red	Red	Red	Amber	Red	Red
South Devon and Torbay	Red	Red	Amber	Red	Red	Red
South Gloucestershire	Red	Red	Red	Red	Red	Red
South Sefton & Southport & Formby	Red	Red	Red	Red	Red	Red
South Tees	Amber	Red	Amber	Red	Red	Red
Southampton	Red	Red	Red	Amber	Red	Red
Southwark	Amber	Red	Amber	Red	Red	Red
Staffordshire	Red	Red	Amber	Amber	Red	Red
Wigan	Red	Red	Red	Red	Red	Red

Features of the best and worst local plans

Our analysis identified some common features of excellent local transformation plans:

- A high level of ambition to transform the way services are run, in combination with detail on how this vision can be achieved.
- Detailed analysis of local prevalence data and risk factors, combined with an assessment of current service gaps.
- Full and meaningful engagement with children and young people, both those using services and those not currently engaged.
- Excellent partnership working, such as with schools and the voluntary sector, in the design of plans.
- Clear governance structures with dedicated project management, detailed implementation plans with clear objectives, and regular oversight from senior local leaders.

⁵ Green = good (scoring 8-10). Amber = requires improvement (scoring 6-7) Red = requires substantial improvement (scoring 0-5). A table of all 122 published plans rated by category and with an overall rating is included in Appendix A.

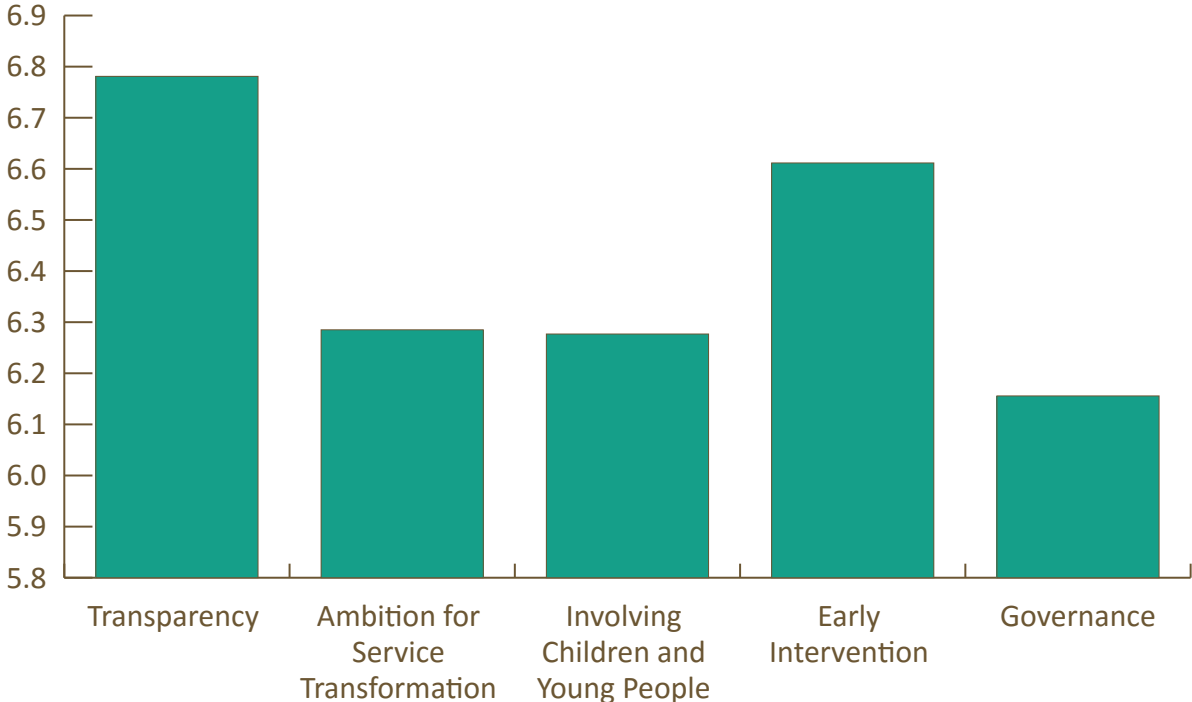
Conversely, there are key themes which characterise those plans which have received a lower score:

- A lack of ambition for service redesign, with plans focused on small scale projects or increasing the capacity of current services without transformation.
- A lack of engagement with the wider agenda behind *Future in Mind*, with a greater focus instead on how to spend the additional funding.
- A lack of focus on the key challenges which will impact upon delivery, such as workforce capacity, information technology and data. Objectives and/or implementation plans are not clear and governance structures are confusing.
- Inclusion of a lot of detail on government policy or the structure of current services and not much information on future plans.

Scores by category

There was not a wide variation between categories. On average, the plans score well on the measure of transparency. They also score better on early intervention, such as awareness campaigns or peer support programmes. The lowest average scores are for level of ambition, involvement of young people, and governance, but these are not far behind the top two measures.

Figure 3: Average scores for local transformation plans by category



Note: The scale of the y axis has been chosen to demonstrate more easily the variation between plans, but the variation was tightly distributed.

Transparency

The best plans in this category include national and local data on prevalence of mental health problems, broken down by condition, age, gender and the likely impact on each tier of services⁶. They include projections for future demand and compare this to the provision of current services. Many have either undertaken or are planning to undertake a full Joint Strategic Needs Assessment focused on emotional wellbeing for children and young people⁷. They use this effectively to influence the development of their strategy. For example, City and Hackney's plan includes a clear comparison between planned provision and projected demand as part of a detailed gap analysis which is then linked closely to the priorities set out in the plan.

The best plans also provide detailed information and analysis about current service performance, including access thresholds and waiting times. They set out what services are on offer locally and are honest about the challenges they face and the gaps in local service provision. This information is also used to influence their priorities for transformation. They recognise the need for a strong focus on workforce audit and training.

The plans that score less well in this category are those which are not transparent about their current service offer and seek to highlight only the positive aspects of their provision, without a full understanding of the challenges they face.

Ambition

Plans that score well in this area are thinking innovatively about how to meet the needs of their local population. For example, Birmingham has established a new service for children and young people from birth to 25. Oxfordshire is redesigning its whole service model to remove artificial thresholds between services. The best plans have detailed proposals on how they will make the changes, such as through retendering the services.

The plans are, for the most part, aligned to the priorities set out in *Future in Mind*. They often mention increasing access for vulnerable groups, moving away from 'tiers' of service and introducing a Single Point of Access.

A subsection of those which score less well focus on increasing capacity in current services without thinking about new ways to deliver care. Another group which scores badly in this category consists of plans which reflect the language and principles of *Future in Mind* but are vague on detailed implementation plans and it is therefore difficult to gauge what practical changes will be introduced as a result.

For example, some plans talk vaguely about introducing a 'Single Point of Access' but it is unclear what this will mean in practice. It could simply mean a single entry point for specialist services, which still have a high threshold of access. Alternatively, a single point of access could cover all services, including early-intervention, and provide a source of consultation and advice for those referring to it.

While some areas have ambitious local plans, overall the level of ambition is disappointing. Very few areas are following the lead of Birmingham and extending services up to the age of 25. While most areas mention exploring the use of new technologies, very few set out in detail radical plans for introducing digital support. In addition, only 15 areas mention plans to encourage staff to offer outreach within communities. The Essex strategy, however, demonstrates innovation on both of these fronts: it sets out how it will work with young people to design self-help apps building on their existing online

⁶ CAMHS services are traditionally broken down into four 'tiers'. The best plans estimate demand for universal services (tier one), community targeted counselling support (tier two), specialist community services (tier three) and inpatient care (tier four).

⁷ A Joint Strategic Needs Assessment is an important part of health service planning. It is an ongoing process by which local authorities, clinical commissioning groups (CCGs) and other public sector partners jointly describe the current and future health and wellbeing needs of its local population and identify priorities for action.

resource, *The Big White Wall* and includes plans for workers to outreach into community settings such as children's centres and other familiar and convenient places.

Involving Children and Young People

There is strong evidence that involving children and young people in service design improves the quality of service offered,⁸ but this involvement can often be tokenistic⁹. Our analysis found that nearly every area has conducted some form of engagement with children and young people, but in many areas this has meant a survey or one or more limited engagement events. Overall, plans score poorly in this area.

The best areas in this category have a much stronger focus on co-production of new services with children and young people. For example, Camden has undertaken extensive engagement work, including the recent launch of a young people's outreach service, 'The Hive', designed and run in partnership with the young people who will use it. Sheffield and Newcastle Gateshead have both trained young people to be co-commissioners, involved in the design of service specifications. Dorset is amongst those areas giving young people a formal role on their transformation plan steering group.

Early intervention

Plans which score well in this category have clear proposals for joining up specialist services with early intervention support in the community. They might propose named specialist links for GP practices and schools or include the role of the voluntary sector in a joined up pathway of services. For example, Liverpool's plan includes the establishment of mental health community hubs, reaching into communities to provide drop-in services and parenting programmes. It also includes plans for support in all local schools, including specialist CAMHS consultation and training for school staff.

Those which score less well in this area do not include details of how they will have a greater focus on early intervention and on preventing problems reaching crisis point. Instead they might have vague ambitions for schools and universal services to offer more support.

Our analysis found that while every plan mentions the importance of connections with schools, it was clear that school leaders were not closely involved in the development of the plans. An exception to this is the Croydon plan, which includes a proposal to co-design a programme of support in schools with the education sector, including staff training, commissioning guidance and a whole-school approach to improving emotional wellbeing. Our analysis is borne out by a recent Association of Colleges survey, which found that only about a quarter of those colleges who responded were aware of the existence in their area of a local transformation plan. Of these, half said that their school or college had a role in implementing the plan and only 39 per cent said their school or college had contributed to the plan.

Governance

Local areas with a high score in the governance category inspire confidence that their objectives will be delivered. They include clear information on who will be responsible for overseeing the process, and how often they will monitor progress. For example, Herefordshire has developed separate action plans for the different phases of implementation. It has included a risk assessment and detailed key performance indicators. It has a dedicated steering group meeting bi-monthly with quarterly reports to the Health and Wellbeing Board (the most senior joint commissioning board between the NHS and the local authority). Good plans in this category also focus on better data collection, including outcomes measurement.

8 What good looks like in psychological services for children, young people and their families, Julia Faulconbridge, Duncan Law & Amanda Laffan, The Child & Family Clinical Psychology Review No 3 Summer 2015: https://www.bps.org.uk/system/files/user-files/DCPper cent-20Facultyper cent20forper cent20Children,per cent20Youngper cent20Peopleper cent20andper cent20theirper cent20Families/public/cfcpr_3.pdf

9 Children's Participation: from Tokenism to Citizenship, Roger Hart, Unicef, 1992.

Those which score less well do not include action plans or key performance indicators in the plan itself. They do not have any evidence of risk assessment and have confusing governance structures or a lack of clarity on how frequently progress will be monitored.

Implementation process

Our analysis uncovered some wider themes about the implementation process. It showed that a great deal of work has been undertaken across the country to develop plans. This includes detailed local service assessments, engagement with stakeholders and young people, and extensive partnership working. One important success of the programme so far is the extent to which it has drawn together health clinical commissioning groups and local authorities to think collectively about how to redesign services that had often previously been commissioned in silos. This is evidenced in the way each plan has been created by a partnership between health and social care. It has also ensured that every area of the country has had to think seriously about their local services and understand the gaps which exist in their local provision. It is evident from many plans that local commissioners were only just becoming aware of how much needed to be done to improve their local offer.

An important benefit of the local transformation plan process is the transparency which has resulted about the current availability of services across the country. For example, plans contain information which has been collected nationally for the first time on local expenditure, workforce and access and waiting times. This will enable NHS England to have a much clearer picture of local service provision and variation than was possible before the transformation process began.

There were some inherent flaws within the implementation process. Local areas were driven to complete plans within two months of the publication of the guidance from NHS England. This was seven months after the publication of *Future in Mind* and so many areas had already begun the process and received support to do so before the guidance was published, but nonetheless it was a tight timetable to deliver radical improvement. It was challenging for areas to think strategically within this timescale about how to invest new funding in a sensible way, particularly in the first year of the transformation process. The short timescale also limited the extent to which young people could be involved in the design of local strategies. The more advanced plans were often those where local commissioners had already instigated a review of local services in advance of the national programme.

Another key stumbling block in the process is the paucity of up to date information on the level of need. Most plans use the Office of National Statistics prevalence study from 2004, so are basing decisions on prevalence data that is over ten years old¹⁰. Some areas have attempted to update this with local data on hospital admissions for self-harm, wellbeing surveys and referral rates. Worryingly, however, even where plans include detailed analysis of local need, this is not often used to inform the key decisions within the strategy.

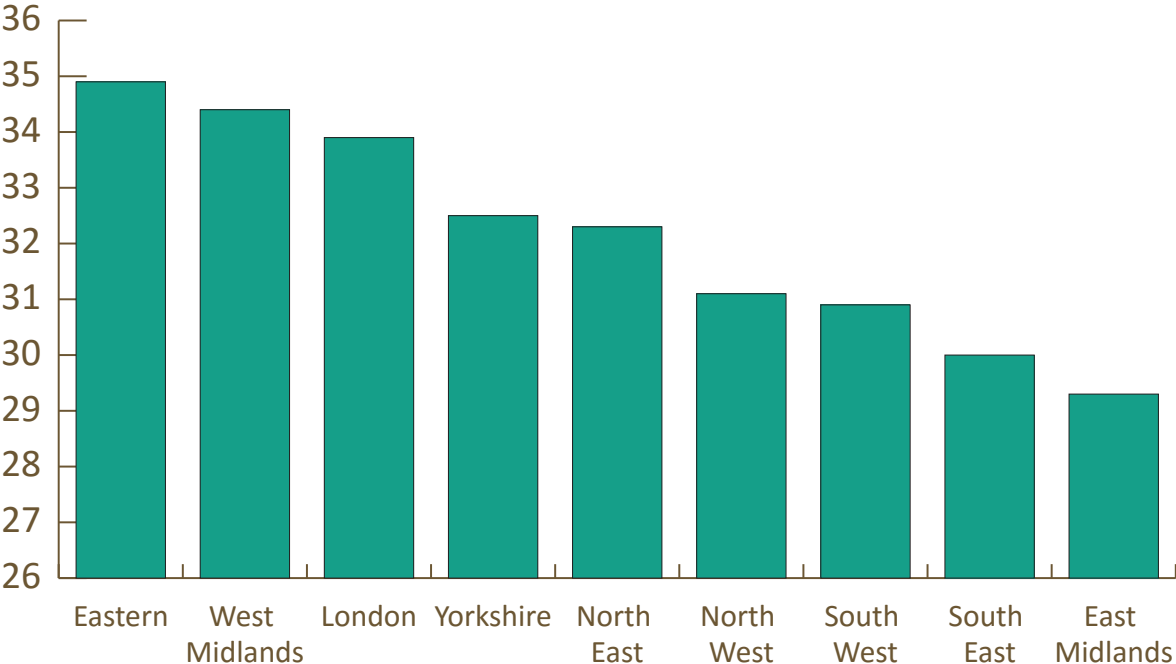
This paucity of data has meant many local health leaders have struggled to set effective key performance indicators for their plan, as they do not have data of sufficient quality about current services to set baselines for these indicators. The best plans overcome this problem by establishing interim objectives, with clear timetables for setting more rigorous KPIs when baselines have been established.

Scores by region

There are some regional differences, although these were tightly distributed. The East Midlands and the South East had the lowest average scores, and the Eastern region and the West Midlands had the highest. The mean score for the Eastern region was 34.9, while the mean score for the West Midlands was 34.4. Plans from the rest of the South East and the East Midlands had mean scores of 30 and 29.3 respectively.

¹⁰ Mental health of children and young people in Great Britain, Green et al, Office of National Statistics, 2004

Figure 4: Average scores for local transformation plans by region



Note: The scale of the y axis has been chosen in order to demonstrate variation between regions, but this was not wide.

2. Barriers to transformation

The Education Policy Institute has identified six key barriers which could hinder the process of transformation. These are:

- i. Workforce
- ii. Funding
- iii. Commissioning
- iv. Data
- v. Fragmentation
- vi. Intervening too late

Barriers to Transformation: Workforce

It is impossible to deliver any plan to improve public services without considering the impact on the workforce and the capability of the workforce to deliver the transformation.

According to the Care Quality Commission, staff morale within CAMHS is already often reported as low, and there is evidence of recent reductions in staffing and difficulties in recruitment:

“A recurring theme in our inspections of CAMHS is the difficulty in recruiting nursing staff to cope with the demand placed on services”¹¹.

According to the *Five Year Forward View for Mental Health*¹², between 2013-14 and 2014-15, referral rates for CAMHS services increased five times faster than the CAMHS workforce. Some areas report one in ten appointments cancelled because of staff shortages; specialist CAMHS run by junior staff who lack the requisite skills; and too few therapists with the necessary training¹³.

The Education Policy Institute undertook a Freedom of Information request to explore the extent to which workforce difficulties could hinder the process of improving services. We sent the request to 61 trusts and received full responses from 41, a response rate of 67 per cent.

Results

83 per cent of trusts which responded stated that they had experienced recruitment difficulties. The same proportion had had to advertise posts on multiple occasions to fill roles¹⁴.

Trusts were asked to state how many applicants they had per post when they most recently advertised different staff positions. In total, the 41 trusts mentioned 51 instances of a post being advertised and receiving two or fewer applicants.

Nurses were the most difficult profession to recruit, followed by consultant psychiatrists.

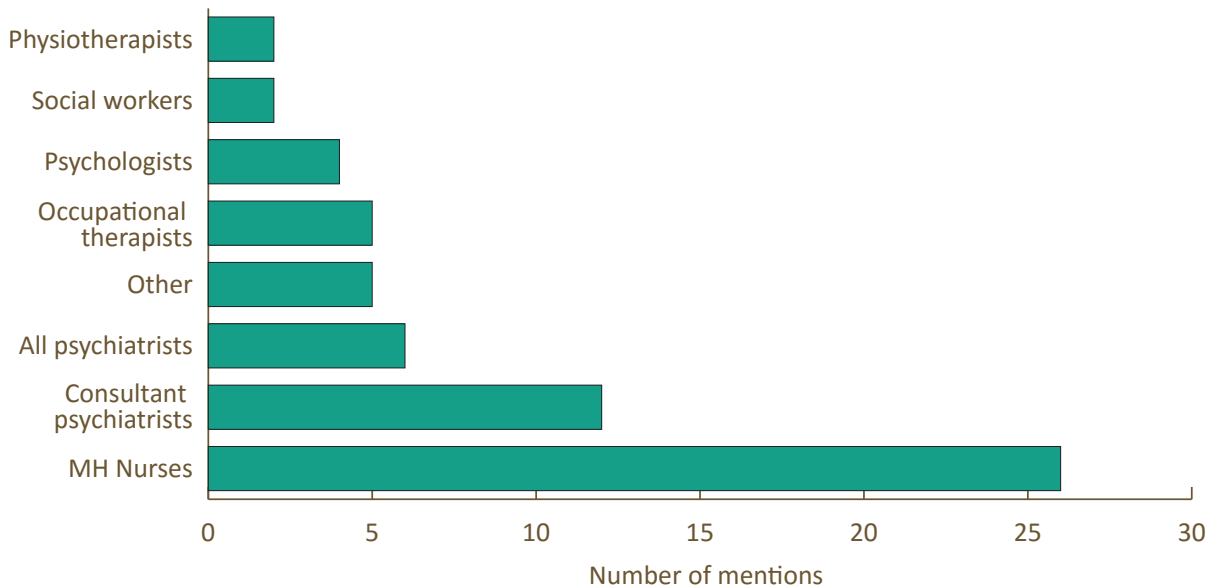
11 Care Quality Commission submission to Education Policy Institute Call for Evidence 2016

12 *Five Year Forward View for Mental Health*, A report from the independent Mental Health Taskforce to the NHS in England, February 2016: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

13 *Five Year Forward View for Mental Health*, A report from the independent Mental Health Taskforce to the NHS in England, February 2016: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

14 Trusts were asked if they had had to advertise roles on ‘more than one occasion’.

Figure 12: Recruitment challenges by professional role as reported by provider trusts



Note: Chart shows number of times the profession was mentioned by trusts as difficult to recruit. Trusts were allowed to mention more than one profession.

There was regional variation in recruitment difficulties, with six areas (15 per cent) not experiencing any problems, in particular trusts in the Midlands and some Northern trusts. Some trusts had specific recruitment difficulties because of their location. For example, Lancashire Care had particular difficulties recruiting in Fylde and Wyre, North Lancashire and West Lancashire.

“We are a fringe high cost area so have difficulties in attracting staff who are able to work within the inner or outer London areas which border our county”.

“Somerset Partnership NHS Foundation Trust is in a rural area with no university and this can limit the number of staff wanting to work in the area”.

Reasons for recruitment difficulties include the high level of speciality required and the stigma associated with this speciality:

“There is a shortage of doctors gaining their [specialism] in child & adolescent psychiatry possibly because of the intensity of the work, the high stress levels known to be associated with the work, media coverage and bed shortages nationally”.

One respondent told us of the particular difficulties they had faced recruiting psychiatrists:

“Of the CAMHS consultant posts advertised in the last year one advert received no applications and the other advert received 1 application – the candidate declined the offer of appointment”.

As part of our research, the Education Policy Institute also spoke to the Chair of one CAMHS provider which had advertised for a consultant psychiatrist post four times with no success. The post remained vacant and was filled with locum staff, an expensive solution which undermined continuity of care¹⁵.

15 EPI interview with Chair of a mental health provider trust

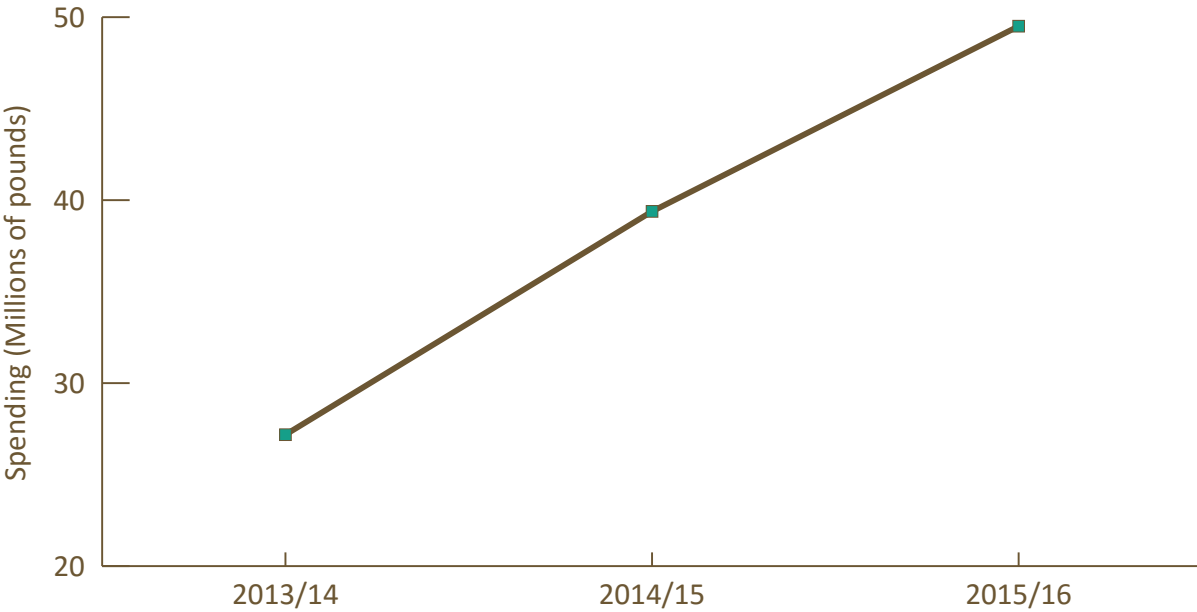
The government has introduced price capping on agency staffing, although evidence so far indicates that there has only been patchy success in enforcing these rules¹⁶. 85 per cent of acute trusts (hospital trusts) that responded to a Nursing Times Freedom of Information request had exceeded the nursing cap since it was introduced. More than 20 trusts had gone over the cap for more than 100 shifts a week.

A consultant psychiatrist is likely to work 48 hours per week and earn between £76,000 and £102,000 basic salary with additional pay for working unsociable hours¹⁷. A locum consultant psychiatrist could expect to earn between £70 to £100 per hour for unsociable hours¹⁸. This equates to around £200,000 per year, or double the cost of a permanent member of staff. With the addition of the cost of the agency’s fees (around 10 per cent¹⁹), this could rise to £220,000 per year.

Temporary staffing

32 trusts (78 per cent of those trusts which responded) were able to provide us with information on their spending on agency or locum staff over the last three years. The total expenditure by these trusts on temporary staffing increased from £27m in 2013-14 to nearly £50m in 2015-16, an 82 per cent increase.

Figure 13: Trust expenditure on temporary staffing



Reliance on agency staffing is expensive and can negatively impact on the quality and continuity of care. As one of our youth reference group members explained:

“They didn’t know what they were doing...giving out medication. Trust is such a huge thing. You open up at one appointment and then the next time it’s someone completely different”²⁰.

16 What has the impact been of recent caps on NHS agency staff spend?, Phoebe Dunn, Kings Fund, March 2016: <http://www.kingsfund.org.uk/blog/2016/03/nhs-agency-staff-spend-and> The use of temporary clinical staff in the NHS: An HSI investigation, December 2015: <http://www.hsj.co.uk/download?ac=3002770>
 17 <https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/psychiatrist.aspx>
 18 Taking the temperature: A review of NHS agency staff spending in 2014/15, Liaison, 2015: <http://www.liaisonfs.com/assets/user-uploads/downloads/Temperature-Annual-2014-15.pdf>
 19 Taking the temperature: A review of NHS agency staff spending in 2014/15, Liaison, 2015: <http://www.liaisonfs.com/assets/user-uploads/downloads/Temperature-Annual-2014-15.pdf>
 20 Member of EPI Mental Health Commission’s Youth Reference Group 2016

While it acknowledges that many locum doctors provide excellent care, the GMC has raised concerns over quality standards. The GMC's chief executive, Niall Dickson, told the BBC: *"locum work is risky in the sense that the doctor may not know enough about the hospital where he or she is working. It is risky in the sense that they may be brought in when the team is under considerable pressure, and it is risky in the sense that there may be some locum doctors who find it more difficult to find a permanent job."*²¹

Future challenges?

There are signs that recruitment difficulties will continue for the foreseeable future. Statistics from Health Education England show that in the August 2015 intake over half (51 per cent) of ST4 (specialist training post) trainee Child and Adolescent psychiatry posts were unfilled²². This means that there will continue to be significant shortages of consultant psychiatrists in future. According to Health Education England, providers' plans for the mental health workforce *"do not appear to represent the additional focus and resources we might anticipate in light of the policy around parity of esteem"*²³. This may reflect concerns over commissioning plans over the period, as described in the section on commissioning below.

Planned changes to the training of health professionals could impact on the numbers coming into the workforce and therefore make matters worse. The government has proposed that from 1 August 2017, all new nursing, midwifery and allied health professional students on pre-registration undergraduate and post-graduate courses will receive their tuition funding and financial support through the standard student support system, rather than NHS bursaries and tuition funded by Health Education England. According to the Government, under the loans system, students on nursing, midwifery and allied health courses will typically receive around 25 per cent more in the financial resources available to them for living costs than at present. This will, however, no longer be a grant but will be in the form of a loan which will need to be paid back after graduation in the same way as any other student loan²⁴.

These changes are expected to increase the provision of training places by 10,000²⁵ and therefore lead to a similar increase in the numbers of these professionals working in the NHS. The risk, however, is that the change from a grant to a loan will lead to a reduction in applications for these posts, further undermining the ability of providers to recruit for mental health nursing and allied health professional posts. This approach may in future be extended to clinical and educational psychologists. This would, according to the British Psychological Society, have a *"disastrous impact on the availability and diversity of the clinical psychology workforce as clinical psychology training is at postgraduate, doctorate level"*²⁶. It will be important to monitor the impact of this policy carefully during implementation.

Universal services

The children and young people's mental health 'system' is much broader than specialist CAMHS services, encompassing support offered by GPs, schools, community health centres and local hospitals. Thus any consideration of the CAMHS workforce needs to include an understanding of the appropriate role of universal staff such as teachers. All professionals who are in trusted roles of responsibility with young people require basic understanding of mental health needs and the local offer of support. This is currently not in place and many teachers, youth workers, GPs, social workers and NHS staff struggle to know how to identify and help the young people in their care with mental health needs. This leads to the high numbers of referrals into specialist services, many of which are considered by these services as 'inappropriate' and sent back to the referrer. There is often a disconnect between the attitudes of

21 <http://www.bbc.co.uk/news/health-34702933>

22 <https://www.nwpgmd.nhs.uk/sites/default/files/ST4%20Fill%20Rate%20Competition%20Ratios%202015.pdf>

23 <https://hee.nhs.uk/sites/default/files/documents/HEE%20commissioning%20and%20investment%20plan.pdf>

24 HEE commissioning and investment plan - 2016/17, Health Education England 2016: <https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform>

25 NHS bursary reform, Updated 7 April 2016: <https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform>

26 The British Psychological Society submission to the Education Policy Institute Call for Evidence 2016

staff within universal services and those within specialist CAMHS as to what constitutes an appropriate referral. This is due to the different languages, organisational cultures, training and perspectives of staff in these different parts of the system, (discussed in more detail in the fragmentation section below). Such barriers can get in the way of a smooth pathway for young people in need of support. *Future in Mind* called for joint training to be provided for teachers and CAMHS staff and this approach is being piloted in 22 areas. More widely, many local plans include ideas for training universal staff such as teachers in techniques such as mental health first aid. Nevertheless, this approach is not yet being adopted in every area.

Impact of 'Future in Mind'

Additional investment is fuelling recruitment pressures, as local areas compete to increase capacity and recruit CAMHS staff from the same limited pool. Several trusts commented in response to the EPI freedom of information request on the increased pressures caused by the expansion plans under *Future in Mind*:

“We believe that this recruitment difficulty is due to all CAMHS services nationally having to recruit and there being a shortage of suitable staff available”.

Responses to our Call for Evidence indicate that recruitment and retention of staff will remain a challenge for delivery of local transformation plans²⁷.

“With new monies being released in England and Wales, Trusts and Health Boards are struggling to fill posts. In addition, there are recent concerns over recruitment into specialist training in child and adolescent psychiatry”²⁸.

This risk was also mentioned in a number of local transformation plans:

“The greatest risk to the delivery of the LTP will undoubtedly be the recruitment of staff. Historically Barnsley has struggled to both attract and retain skilled workforce and as neighbouring CCG’s and Local Authorities are likely to be recruiting similarly skilled workforce within the same timeframe this will compound the difficulties”²⁹.

“Doncaster is one of more than 200 CCGs nationally that will all be looking to recruit staff to similar posts. This creates a real pull on an already under established workforce meaning that recruitment will be incredibly difficult. Doncaster due to its levels of deprivation, geography and social difficulties will face an even tougher challenge to recruit especially against the bigger city CCGs”³⁰.

27 Essex County Council submission to the Education Policy Institute Call for Evidence 2016

28 Royal College of Psychiatrists submission to the Education Policy Institute Call for Evidence 2016

29 Local Transformation Plan for Children and Young People’s Mental Health, Barnsley Clinical Commissioning Group, 2015 <http://www.barnsleyccg.nhs.uk/local-transformation-plan-for-children-and-young-peoples-mental-health.htm>

30 Doncaster Local Transformation Plan For Children and Young People’s Mental Health and Wellbeing, October 2015: <http://www.doncasterccg.nhs.uk/about-us/our-values-vision/five-year-commissioning-strategy/mental-health-and-well-being-local-transformation-plan/>

Training

Professionals currently employed within services are not always trained in the most up to date and evidence-based treatments. For example, the South Tyneside Local Transformation Plan states:

“The workforce analysis which has been undertaken by NHS England... highlighted concerns about the skill levels of staff who will deliver the therapies described in the NICE guidance. NHS England identified that this is a national issue and will take a number of years via a national training programme to enable the workforce to be appropriately skilled”³¹.

The Children and Young People’s Increasing Access to Psychological Therapies (CYP IAPT) programme³² has worked with services to improve this situation but a common frustration is that those that have been trained do not always remain within the service. There is, therefore, a mismatch between the supply of appropriately trained staff and the demands to increase capacity and adapt the services being provided.

Services need to be able to offer the right skill-mix to meet the needs of their redesigned services, including staff with the skills to engage young people, while retaining those with the specialist skills needed to deliver high quality, evidence-based interventions:

“Having the right mix of skills in the right places in CAMHS services is crucial to being able to meet the needs of children, young people and families. A mix of skilled professionals is required in order to meet different needs, and these will include (but is not limited to) clinical psychologists, mental health nurses, modality specific therapists, psychiatrists, child psychotherapists, etc. Services that do not include a mix of professional input may find it hard to meet the multitude of needs that children, young people and their families can present”³³.

A comprehensive CAMHS service requires a diverse range of interventions and skills to be available and this requires professionals with a range of competencies. NHS providers can feel limited to who they can appoint to a post because of the way that professionals are regulated by the Health and Care Professions Council. The workforce is currently very reliant on medical and nursing professionals; and qualified youth workers and counsellors are not always included in the workforce or offered good, well-remunerated positions, despite having suitable skills to offer early-intervention support so that young people may not need a medical intervention.

In some areas there are concerns that specialist posts are cut and replaced by generic mental health practitioner roles without the training or clinical governance oversight to deliver the necessary interventions. There is wide variation in the way in which services employ skilled professionals and how their time is allocated. For instance, employing a senior clinician ‘at the front door’ has been shown to help reduce referrals and improve the quality of care offered to young people and their families³⁴ The Education Policy Institute Commission will explore this further in our final report.

31 South Tyneside Transformation Plan for Children & Young People’s Mental Health and Wellbeing, 2015, <http://www.southtynesideccg.nhs.uk/wp-content/uploads/2016/02/South-tyneside-Transformation-plan-CAMHS.pdf>

32 The Children and Young People’s Increasing Access to Psychological Therapies Programme is an improvement programme run by NHS England which aims to increase access to evidence-based therapies and improve the quality of treatment offered through staff training and other support: <https://www.england.nhs.uk/mentalhealth/cyp/iapt/>

33 The British Psychological Society submission to the Education Policy Institute Call for Evidence 2016

34 Consultant psychiatrist interview with the Education Policy Institute 2016

Barriers to Transformation: Funding

The publication of *Future in Mind* was accompanied by announced investment of £1.25bn of new funding for child and adolescent mental health. With the addition of previous announcements of investment for eating disorders, this means a total of £1.4bn over the five years from 2015-16.

2015-16 investment

While campaigners expected £250m to be made available in 2015-16, the Department of Health stated in August that only £143m would be spent, as providers did not have the capacity to spend any more. A department spokeswoman said the allocation was reduced to ensure the money was properly invested, but that they were fully committed to spending the whole £1.25bn over the course of the Parliament³⁵. In December 2015, during a debate in the House of Commons, Mental Health Minister Alastair Burt reiterated this commitment: *“Will I commit to the £1.25 billion? Yes, I will”*³⁶.

Of the £143m for 2015-16, only £75m³⁷ was transferred to local Clinical Commissioning Groups to invest in frontline services. The rest was spent centrally on the following areas within child and adolescent mental health:

- £21m - Health Education England;
- £15m - Perinatal care (£11m underspend);
- £12m - Improving Access to Psychological Therapies programme;
- £10m - Hospital beds;
- £5m - Administrative costs for NHS England (£4m) and Department of Health (£1m);
- £2m - Improving care for young people in the justice system;
- £2m - Joint programme with Department for Education to improve services in schools;
- £1m - Support for children with learning disabilities in long-term care.

It is not yet clear how much of the £75m has reached service providers, or if any of the funding has been spent on other local priorities. According to the Mental Health Network of provider trusts some had seen *“no significant investment”* by March 2016³⁸. Stephen Dalton, the Network’s Chief Executive, said:

“It doesn’t seem to have turned into posts on the front line. We are not hearing any reports of any significant investment at a local level around children’s services. Indeed, some services are still experiencing cuts in services.”

The Education Policy Institute’s analysis of local transformation plans uncovered that the funding for 2015-16 was marked as non-recurrent. This means that local areas knew they might only get the funding for one year. This prevented services from investing in new sustainable services in case the money was not there for those services to continue in the following year. This undermined the ability of services to plan effectively for future investment. As one plan stated:

*“As we build our system capabilities, we will use the available funding **prior to recurrent commitment** to support the delivery of programmes to redefine and integrate a range of primary*

35 <http://www.bbc.co.uk/news/uk-33740709>

36 House of Commons adjournment debate, 3 December 2015, column 608

37 NHS England confirmed to Michael Buchanan, BBC News, 8 March 2016: <http://www.bbc.co.uk/news/health-35747167>

38 <http://www.bbc.co.uk/news/health-35747167>

*prevention activities into all our pathways*³⁹.

Another problem was that the investment did not reach local areas until late in the financial year (November/December 2015). This created difficulties for commissioners in planning how it could be best invested and prevented transformative action:

*“The ability to spend the full allocation of funding in 2015/16 is going to be difficult, due to the lateness in year that this will be received. In reality this means that we have approximately four to five months to spend a full year’s allocation. This forces us down a route of using existing providers on a short-term basis that may limit innovation.”*⁴⁰

Future funding

For 2016-17, £119m has been included in CCG baseline allocations as part of a total allocation to the Department of Health of £250m. A £30m fund for eating disorders will also be allocated⁴¹. NHS England has also now announced the breakdown in expenditure for each year until 2020-21. In the final year, £214m will be in CCG base allocations, with an additional £30m for eating disorders⁴².

This investment has, however, been included in the Clinical Commissioning Groups’ baseline allocations. This means that there is no ring-fence and Clinical Commissioning Groups have the freedom to invest it in other local priorities. Given that CCGs expected this to be a separate funding stream, many had not allowed for this expenditure as part of forward planning for their baseline allocations, which puts this investment further at risk. NHS England are planning to seek assurance of the level of expenditure from each CCG but there are unlikely to be severe consequences for CCGs that do not invest it all in children’s mental health, so there is a risk that extra funding could be used to backfill cuts made to other parts of the CAMHS system, rather than providing additional capacity.

Wider funding risks

It is also important to consider this additional investment in the wider context of funding for the whole system.

Children’s mental health services have been historically underfunded. In 2012-13 £704m was spent on CAMHS⁴³, the equivalent of about 6 per cent of the total mental health budget, or around 0.7 per cent of the total NHS budget⁴⁴.

39 North Lincolnshire Local Transformation Plan: <http://www.northlincolnshireccg.nhs.uk/data/uploads/north-lincolnshire-children-and-young-peoples-emotional-health-and-wellbeing-transformation-plan-master-031215-v3.pdf>

40 Doncaster Local Transformation Plan For Children and Young People’s Mental Health and Wellbeing, October 2015: <http://www.doncasterccg.nhs.uk/about-us/our-values-vision/five-year-commissioning-strategy/mental-health-and-well-being-local-transformation-plan/>

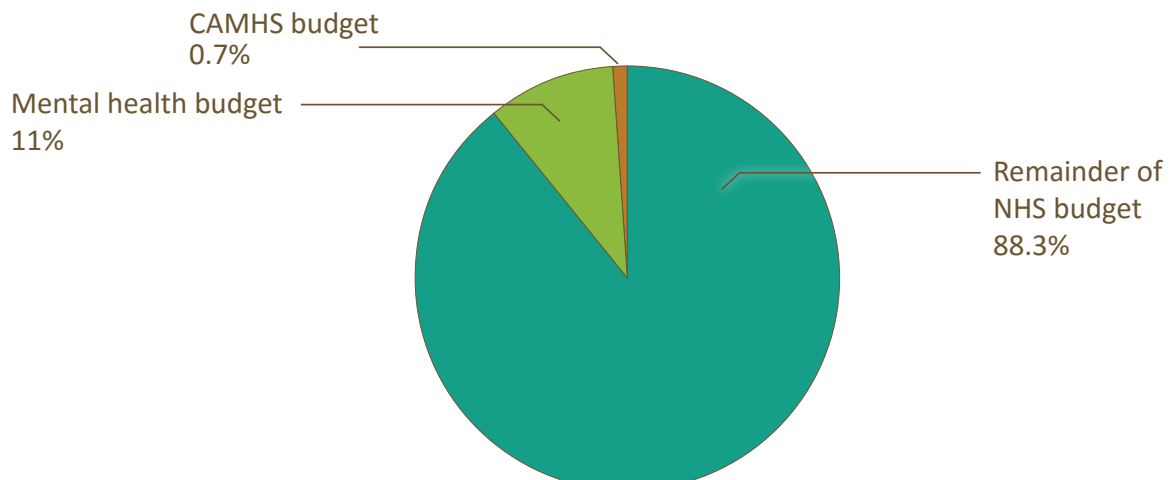
41 House of Commons written answer 7 March 2016 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-02-23/28160/>

42 Implementing the Five Year Forward View for Mental Health, NHS England, July 2016: <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

43 NB this does not include all investment in children’s mental health, such as through public health or schools budgets. Due to the move to a new system of data collection, figures will not be made available for 2013/14. Figures for 2014/15 will be made available at a later date

44 NHS England evidence to the Health Select Committee enquiry into children’s mental health, 2014 <http://data.parliament.uk/written-evidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-CAMHS/written/7703.pdf>

Figure 14: CAMHS expenditure as proportion of NHS Budget



It is very difficult to analyse trends in funding of CAMHS because there is no transparency in the way that data is collected. A parliamentary written answer appears to show a reduction in real terms funding from 2010-11 (£751m) to 2012-13 (£717m)⁴⁵ but this does not cover all expenditure and is not directly comparable across years. A freedom of information request by Young Minds in 2015 found that £35m had been cut from services over the previous year⁴⁶.

There is also widespread concern that reductions in local authority budgets have led to cuts in community mental health services (tier 2). Such reductions are hard to measure as there is little data collected on the availability of these early intervention services. However, the Children's Society and others found that between 2010-11 and 2015-16 spending by local authorities on early intervention services for children, young people and families has fallen by 31 per cent in real terms. They estimate that the early intervention grant will see a 71 per cent cut by the end of the decade⁴⁷. Essex County Council (ECC) has had to save over £520m in the last five years, and told us they anticipate needing to save at least another £300m by 2020⁴⁸. There have also been cuts to youth services, with severe cuts in some areas⁴⁹. These wider financial challenges facing local authorities, including specific pressures and uncertainties about public health and social care budgets, will impact on child and adolescent mental health because these specialist NHS services sit within a wider framework of local authority funded early intervention support. The Care Quality Commission has found that reductions in funding, including to non-NHS services, has contributed to increased waiting times⁵⁰.

Enfield's Local Transformation Plan illustrates this risk:

"Finance Investment in CAMHS has been relatively static over recent years, but this is in contrast to many areas where disinvestment of the previously ring fenced LA area based grant and NHS CAMH services has been significant. This strategy is being written at a time of financial challenge for both LBE (London Borough of Enfield) and the CCG... No decision has

45 Real terms 2013/14 prices, House of Commons Written Answer, 16 December 2014 <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-12-16/218865/>

46 Community Care Magazine, January 2015, <http://www.communitycare.co.uk/2015/01/09/real-terms-funding-cut-childrens-mental-health-services-revealed/>

47 Losing in the long run: Trends in early intervention funding, Children's Society, Action for Children and the National Children's Bureau, 2016

48 Essex County Council submission to the Education Policy Institute Call for Evidence 2016

49 Youth services in England: Changes and trends in the provision of services November 2014: <http://www.nya.org.uk/wp-content/uploads/2015/01/Youth-services-in-England-changes-and-trends.pdf>

50 Care Quality Commission submission to the Education Policy Institute Call for Evidence 2016

been taken about possible LBE disinvestment in CAMHS but this cannot be discounted”⁵¹.

School based counselling is often funded from schools’ own budgets, including through the Pupil Premium. The decision not to increase school budgets in real terms per pupil over the next five years, coupled with additional employment costs, such as the cost of pension changes, means that this funding stream could also be subject to reductions, adding further pressure to the wider CAMHS system. An Education Policy Institute analysis has found that schools may be left with a funding gap of 10.7 per cent in 2020-21, or £4.8bn in 2015-16 prices⁵².

There have also been reductions in the availability of grant funding for the voluntary sector to address gaps in mainstream service provision. This further undermines the ability of services to support young people at an earlier stage. Given the pressures on budgets, there are often perverse incentives for commissioners to disinvest in early intervention support and adopt a risk-based approach with high thresholds for accessing care, as evidenced in our first report (see section below, on ‘Intervening too late’).

Payment mechanisms

The majority of CAMHS services are currently funded via block contracts. This has historically led to funding problems as block contracts are easy to top slice and often investment does not keep pace with demand. Locally, commissioners and providers have autonomy to decide on the most appropriate payment approaches. Providers and commissioners are gradually moving away from block contracts for adult mental health, and this move is likely to be extended to CAMHS services over the next few years. The development of new payment approaches in child and adolescent services has, however, lagged behind that in adult mental health and these approaches are now being tested over a two-year period⁵³. Acute hospitals (those that deal with physical health problems) are funded by a system of payment for results, where they are paid for the activity they undertake. There are no plans to introduce such a national pricing mechanism for mental health, and therefore concerns remain that in the context of a limited overall NHS budget and rising cost pressures, funding will continue to be drawn towards the acute hospital sector and away from mental health.

Rising demand

In our first report, the Education Policy Institute’s Commission found that referrals to specialist CAMHS services have risen by 64 per cent between 2012-13 and 2014-15. If this trend continues then commissioners will need to invest heavily simply to keep pace with rising demand unless the transformation process can release enough capacity to match the increased level of need. Local transformation activity to raise awareness and reduce stigma around mental health could further increase the pressure on services, at least in the short term. Local commissioners will need to use available data to track carefully how well investment is matched to local demand.

Barriers to Transformation: Commissioning

As funding for service transformation has been added to the baseline allocation for local CCGs, so the process of transformation is now firmly in the hands of local commissioners. There is, however, wide variation in the quality of commissioning in different areas of the country. This is evidenced by the different levels of current service provision. Less than half (48 per cent) of children and young people’s services have a crisis intervention team⁵⁴. The Royal College of Psychiatrists found that people who

51 Joint Commissioning Strategy for Emotional Well-being & Child and Adolescent Mental Health for 0-18 year olds in Enfield 2015 – 2020

52 The Education White Paper & Budget 2016: Financial Implications for Schools, April 2016, Peter Sellen, Education Policy Institute: <http://epi.org.uk/analysis/education-white-paper-budget-2016-financial-implications-schools/>

53 <https://www.england.nhs.uk/resources/pay-syst/eoi-camhs/>

54 NHS England, Five Year Forward View, October 2014, <https://www.england.nhs.uk/ourwork/futurenhs/>

live outside of cities with eating disorder services often have to travel long distances from home for treatment because appropriate services are not commissioned locally⁵⁵.

Mental health experts have told us that local commissioners do not always have the specialist expertise in mental health services or in children's services that is needed to commission services effectively. As one psychiatrist told us: *"In cancer you wouldn't dream of not including the specialist experts in designing services but this is often the case for mental health"*⁵⁶.

One reason why this is problematic is that commissioners could set key performance indicators for service providers based on unrealistic expectations of what could be achieved by services given the current evidence base of effective services. A psychologist explained:

*"We do an outcomes measure at the start and end of every case. This gives a clinician's view of the young person's difficulties in a number of domains, e.g. emotional difficulties, family problems, peers etc. The commissioners have asked for 75 per cent of cases to improve on this score. On the surface this seems fair enough. Except the vast majority of studies do not show success rates anything close to this mark, and that is not for cases of the complexity that we deal with. The commissioners are clearly putting pressure on our managers regarding the (high) expectation rate of 'success' – it is unhelpful and unrealistic, in my opinion"*⁵⁷.

This lack of expertise also often means that commissioners are not able to hold providers to account fully and so poor practice and vested interests are not always challenged effectively.

Short-term funding

Another element of poor commissioning is short-term funding arrangements. In many areas providers are faced by a constant churn of annual retendering processes:

*"Currently CAMHS contracts are very short with an annual re-negotiation which consumes vast amounts of staff resources, both for providers and commissioners. New service specifications and performance frameworks barely have time to be constructed before they are subject to review and further change. We have a floor of people endlessly going round this contracting round... It is important to get it right, but you end up being a contracting person rather than somebody commissioning services for children who have mental health problems. They should run for two or three years and then you might have some chance to see what works."*⁵⁸

Short term budgets prevent providers from planning effectively over the medium term. This can lead to insecurity for the workforce and further exacerbate recruitment difficulties. Fixed term contract positions, in services which are subject to annual recommissioning, are not very attractive for staff with a wealth of alternative employment options. The King's Fund⁵⁹ recently identified commissioning

55 Eating disorders in the UK: service distribution, service development and training Report from the Royal College of Psychiatrists' Section of Eating Disorders March 2012

56 Education Policy Institute interview with a child and adolescent psychiatrist based in Manchester

57 Education Policy Institute interview with a child and adolescent psychologist based in London

58 North West London Commissioning Support Unit Evidence to Health Select Committee Inquiry into Children's and Adolescent's Mental Health, 2014

59 Workforce planning in the NHS, Rachael Addicott David Maguire Matthew Honeyman Joni Jabbal, Kings Fund, April 2015: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

decisions as a key driver affecting providers' decision-making on workforce numbers. It found that Health Education England has reported a very small increase in demand from providers for nurses in 2014-15, followed by a sustained predicted fall every year after to 2019. The King's Fund noted:

“Providers can only employ staff for services paid for by commissioners; the pattern up until 2014 and provider forecasts to 2019 suggest that the greater strategic priority given to mental health may not be translating into extra funding for staff numbers on the ground. This represents another major disconnect between policy and workforce planning”.

As a national workforce expert told us: *“Everything hinges off”* the local commissioning process.

Barriers to Transformation: Data

Child and adolescent mental health services have been described as working in a ‘fog’ due to the lack of up to date and reliable data⁶⁰ on everything from prevalence of mental health problems to the outcomes services achieve. There is very little information at a national level on access and waiting times or on investment and workforce within services. This means it is difficult to assess whether overall funding has increased or decreased. It makes comparison between service performance challenging and inhibits the setting of goals or targets for the system as a whole.

From March 2016, new data has begun to flow from the Health and Social Care Information Centre's minimum dataset. This will eventually include information on everything from referral rates to waiting times and outcomes of treatment. It will, however, be a number of years before it is possible to view robust statistics on these areas.

Similarly, data on prevalence is in the process of being updated and will be available in 2018. Until that point, commissioners are reliant on a study that is over a decade old⁶¹. In addition, that study covered children and young people between the ages of 5 and 16 and therefore does not provide a complete picture of the needs of children and young people in CAMHS services, which usually provide support from the early years up to the age of 18, or even 25 in some areas. Given that around 25 per cent of mental health problems become apparent during the ages of 14 and 18⁶², and that referrals to CAMHS services have increased by 64 per cent over the two years to 2014-15⁶³, this means that local areas are likely to be significantly under-estimating the level of need.

Commissioners are hindered in the development of local transformation plans because of this and because they often also lack baseline data on numbers of referrals, waiting times or investment across the whole pathway of support in their area. 9 of the 50 CAMHS providers which responded to the Education Policy Institute's research on referrals (18 per cent) did not have easily accessible information about referrals made to them⁶⁴.

This lack of data was regularly raised as a problem within transformation plans⁶⁵. Lancashire's local transformation plan states:

“There is currently very limited contract monitoring of the main provider for Lancashire CAMHS. It is included within the contract arrangements for all age mental health; however there

60 Children's and adolescents' mental health and CAMHS, Health Select Committee, October 2014

61 Mental health of children and young people in Great Britain, Green et al, Office of National Statistics, 2004 <http://www.hscic.gov.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf>

62 Murphy M and Fonagy P (2012). Mental health problems in children and young people. In: Annual Report of the Chief Medical Officer 2012. London: Department of Health.

63 NHS CAMHS benchmarking review for 2014/15 published in November 2015

64 Children and Young People's Mental Health: State of the Nation, Emily Frith, Education Policy Institute, 2016

65 Essex Local Transformation Plan, 2015 https://www.essex.gov.uk/Documents/Full_version_Open_up_Reach_out_v17.pdf

has been no specific focus on this part of the service and the performance data provided has not been fit for purpose nor is there a mechanism to report the data through the appropriate governance systems”⁶⁶.

The lack of data additionally makes it more difficult for providers to negotiate for increased funding.

Inadequate IT systems

There are few information technology products which are tailored to CAMHS; this makes it difficult to capture patient records appropriately⁶⁷. Services are often forced to use packages which were designed for adult treatment, and so do not have the facility to enter relevant details, for example of parents or schools. Staff may have to use duplicate records on two or even three IT systems because their main system is not designed to gather information on outcome measures. This bureaucracy can lead to delays and mistakes and is a drain on staff time⁶⁸. This has an impact on the quality and consistency of data collected because it is heavily reliant on clinician engagement. There is not a strong market for the development of appropriate IT systems because CAMHS services often sit as a small subset of adult providers or wider paediatric services, so there is little incentive for better systems to be developed.

Another key challenge for services working across the wider youth mental health system is that sharing data is fraught with complications over confidentiality and data protection rules. As services are split between universal support in GP surgeries and schools, early intervention counselling, specialist community provision and inpatient settings, this causes serious barriers to the continuity of care.

Barriers to Transformation: Fragmentation

CAMHS services are highly complex. Within specialist services there are a large number of different conditions and pathways of treatment, ranging from depression to autistic spectrum disorder. This creates challenges for service improvement, such as standardised assessment, the development of effective technology and outcomes monitoring to cover such a wide variety of conditions. These services often also cater for a wide age range, from early years up to 25, and so service transformation programmes are covering an array of different issues.

CAMHS is also made more complex by its multi-disciplinary nature, with psychiatrists, psychologists, therapists, nurses and other specialist CAMHS staff all having had different training. Outside of the specialist services, other players include social workers, education colleagues, the police, commissioners, parents and young people themselves. This creates further challenges in agreeing strategies for change. For example, there can be different perspectives on what constitutes a good outcome of treatment and how far an individual young person has moved on such an outcome measure between the young person themselves, their parents and the clinicians involved in their treatment⁶⁹.

Another problem is the fragmentation of current commissioning arrangements. Child and adolescent mental health support is currently commissioned by a range of different organisations, including: individual schools, local authorities (including social care, education and public health departments), clinical commissioning groups, commissioning support units, some GP practices and by NHS England. There are various models of joint commissioning in place across the country and there are often overlapping boundaries between local authorities and a large number of local CCGs. This makes the commissioning process highly complicated, creating gaps in provision or waste as services overlap. As the British Psychological Society told us:

⁶⁶ Lancashire Local Transformation Plan, 2015: <http://blackpoolccg.nhs.uk/wp-content/uploads/2015/10/Item-14-Lancashire-CAMHS-transformation-Plan-061015-New-Plan-v1.pdf>

⁶⁷ Education Policy Institute interviews with Miranda Wolpert, Anna Freud Centre and Dr Duncan Law, Anna Freud Centre. Discussion at NHS England Conference on CAMHS Transformation, March 2016.

⁶⁸ Education Policy Institute interview with London CAMHS psychologist

⁶⁹ Warren et al, 2010

“The way that CAMHS services are commissioned can lead... to the same NHS service offering different services to families living in different part of the local area. This can be confusing for families, referrers, and for schools where different children in a school might have access to very different CAMHS services because of where they live”⁷⁰.

The interface between locally commissioned community services and centrally managed inpatient care was raised by many respondents to our Call for Evidence. The British Psychological Society⁷¹ told us that where excellent community services were successfully preventing admissions to hospital, it was NHS England and not the CCGs who had commissioned them that received the financial benefit. This has caused concerns over the perverse incentive on CCGs to seek an inpatient place because budget responsibility then moves to NHS England. This division also often makes it difficult for local commissioners to find a bed and causes delayed discharges from inpatient settings back to the community. Further integration between the national management of inpatient services and local provision would enable more coordinated care⁷².

Physical and mental health

CAMHS services also need to be more integrated into the wider NHS, including community health clinics, GP surgeries and hospitals. Children often have a range of physical and mental health needs which can be inter-related and it is important that these are considered together. Between 10 and 30 per cent of children and young people in the UK have a chronic illness or physical health need⁷³. These children experience four times more psychological distress than their healthy peers⁷⁴. This increases the risk of developing psychological and behavioural difficulties which impact on their emotional, social and educational development and future job prospects⁷⁵.

Similarly, those with mental health conditions may have consequent physical health needs. A young person with anorexia may present to hospital with physical symptoms caused by their eating disorder. Young people who have self-harmed or attempted suicide will often be taken to an A&E department or be seen by paramedics. A youth reference group member said of non-mental health specialist NHS staff: *“People don’t regard them as having anything to do with mental health but they have everything to do with it”*.

The Care Quality Commission reported in 2015 that *“Less than half of parents ... with children with mental health needs or a learning disability felt that staff definitely knew how to care for their child’s individual needs. This compares to 72 per cent of parents and carers of children without these conditions.”*⁷⁶ This is in spite of national guidance on the importance of this approach⁷⁷.

Children with mental health problems often have a range of health and social problems, for example behavioural issues in school or increased risk taking, such as substance misuse. In many local areas there are a significant number of different services for young people, all commissioned with different guidelines and to meet different needs, many of which overlap. It is often not easy to identify where the overlaps and gaps in provision can occur. Children and young people often bounce between

70 British Psychological Society submission to Education Policy Institute Call for Evidence, 2016

71 British Psychological Society submission to Education Policy Institute Call for Evidence, 2016

72 Essex County Council submission to Education Policy Institute Call for Evidence

73 Kush & Campo, 1998

74 Hysing et al., 2007

75 Glazebrook et al., 2003; Meltzer et al., 2000. All references cited in the British Psychological Society submission to EPI Mental Health Call for Evidence

76 Children and Young People inpatient and day case survey 2014, key findings July 2015, p3 <http://www.cqc.org.uk/content/children-and-young-peoples-survey-2014>

77 “Child liaison psychiatry services should be an essential component of any acute hospital providing paediatric care.” Liaison psychiatry for every acute hospital: integrated mental and physical healthcare, Royal College of Psychiatrists, report CR183, 20135

different services, telling their story again and again without a holistic solution for their needs. Health services need to work more effectively with each other, with the social care system and with schools and colleges.

Funding pressures on all community services can make integration more difficult, with providers losing the capacity to make better connections with other organisations. Nevertheless, it is even more important during times of austerity that there is better coordination, for instance between health and social care services, so that resources are not wasted. For example, some CAMHS services adopt a policy of not treating a young person until their safeguarding issues are first addressed by social services. This can cause the child to be caught between two organisations shifting responsibilities and therefore waiting longer for treatment⁷⁸.

Education

The distinct training and cultures of different teams can hinder communication between services. Specialist children's mental health services are often led by psychiatrists with medical training, focused on diagnosis and evidence-based treatment. Teachers and other school staff have a different culture and set of priorities, and conflict and confusion can often emerge at the interface between the two systems. Social care teams have still another programme of training and experience. The three services speak different languages and have different priorities. Children's mental health support is therefore managed across a wide range of busy teams interacting for the most part through written or faxed communications with incomplete information. Mistakes and inefficiencies often develop as a result of the friction between these systems. Professionals are naturally nervous about dealing with situations which are out of their sphere of knowledge or experience. This can mean the young person is 'referred on' to another service where their needs could have been met in a more coordinated way. This can create delays and affect the quality of support the young person receives⁷⁹:

*"CAMHS don't accept our referrals. Many schools have stopped referring. They don't see the point"*⁸⁰.

Schools and colleges are on the frontline of dealing with young people with mental health problems:

*"We are the constant factor for that young person. My staff are holding things that they shouldn't have to because there is no one else to hold it. We feel at the moment that we are in the eye of the storm... having experienced a huge spike in the number of students with mental health problems. We are often running around late into the evenings trying to find somewhere to help them"*⁸¹.

The education sector has become more fragmented under recent reforms, which creates a challenge for mental health services that need to engage with a range of multi-academy trusts. Schools often commission their own support, which creates further complexity in the local system. Many head teachers do not have the right expertise to commission these services, which can mean that support provided in schools is not always evidence-based or under appropriate clinical governance.

Teachers and other key adults in education settings do not always have the training or time to identify young people with mental health problems and to provide them with the right support.

"Teachers do not know how to look for the warning signs".

78 Children's Society submission to Education Policy Institute Call for Evidence

79 Interview with Helen Pye, Social Worker of the Year 2015, South West Yorkshire NHS Partnership Foundation Trust

80 Education Policy Institute meeting with the Association of State Girls' Schools 2016.

81 Further Education College leader at meeting of the Association of Colleges with the Education Policy Institute, 2016.

“I had no idea where the (in-school) counselling service was and neither did my teachers”⁸².

Teachers are also often not aware of the services available to help, particularly early-intervention services in the community. The current performance framework for schools does not include recognition of the role of education as a first point of contact with the wider system of state support for young people in distress. As one head teacher explained: *“We know that an awareness of our pupils’ mental health is part of our job, but this needs to be recognized externally”⁸³.*

The government has taken steps to improve the support and guidance offered to schools, as outlined in our first report. One example of this is the MindEd resource, which provides online advice for families and professionals on managing a wide range of mental health issues in children and teens.⁸⁴ Nevertheless, our research has uncovered that many schools are not aware of the guidance and materials that are already available⁸⁵.

The majority of local transformation plans aim to build stronger relationships with local schools but they are health-led plans, the vast majority of which were not co-designed with school leaders.

The Education Policy Institute’s Commission will investigate what further measures are needed to ensure that schools can provide the right support to young people with mental health problems.

Barriers to Transformation: Intervening too late

“You have to fit into categories to get help...they should treat everyone as an individual”⁸⁶

As previously noted, in our first report we identified that, on average, services are turning away nearly a quarter (23 per cent) of the young people referred to them for treatment⁸⁷. This is often due to the high eligibility thresholds that are set by services to manage demand. These thresholds are based on the signs and symptoms of diagnosable disorders or conditions, such as depression, anorexia nervosa or psychosis. This means that those experiencing less acute or difficult to diagnose problems are often not eligible for treatment⁸⁸.

For example, a child who has faced bereavement, abuse or another traumatic event may not be automatically eligible for treatment until such time as this experience reaches a certain diagnostic threshold:

“Our experience in Essex is that there are also significant numbers of children and young people who do not have a diagnosable mental health problem, but would benefit from therapeutic interventions on issues like loss and attachment, including children in our care and on the edge of care. Thresholds exclusively based on mental health diagnosis may be incompatible with a commitment to early intervention, and result in longer-term costs”⁸⁹.

This can even be the case where the child is showing signs of mental distress, such as self-harm:

82 Members of Education Policy Institute Commission’s Youth Reference Group.

83 Education Policy Institute meeting with the Association of State Girls’ Schools 2016.

84 Minded.org.uk

85 Education Policy Institute meeting with the Association of State Girls’ Schools 2016 and individual discussions with other teachers.

86 Member of Education Policy Institute Mental Health Commission’s Youth Reference Group

87 Children and Young People’s Mental Health: State of the Nation, CentreForum, April 2016: <http://epi.org.uk/report/children-young-peoples-mental-health-state-nation/>

88 Children and Young People’s Mental Health Coalition submission to Education Policy Institute Call for Evidence 2016.

89 Essex County Council submission to Education Policy Institute Call for Evidence 2016.

“It is frequently almost impossible for bereaved children to access support unless they have very severe co-morbid difficulties. It is particularly difficult to gain access for young people exhibiting distress through self-harming behaviour”⁹⁰.

Recognising that children can have more than one diagnosis is also important:

“Diagnosis based services can be hugely problematic for young people and families for a number of reasons. The difficulties faced by children and young people may not fit into clear diagnostic boxes and this means they can find themselves not meeting service criteria; as an example, a child or young person with neurodevelopmental difficulties is likely to meet the diagnostic criteria for more than one neurodevelopmental condition (Gillberg, 2010; Lundstrom et al., 2015), leading to them not fitting into either ADHD or autism specific services because they have both sets of difficulties. Condition specific commissioning can, therefore, leave some of the neediest children without access to any specialist CAMHS provision, despite their needs being very high”⁹¹.

If a referral is considered inappropriate, a child may then be referred back to their GP or school for support. In many areas early intervention services have been cut and social care services are facing budget reductions so are not often able to provide this early-intervention support. As discussed above, this can leave teachers in a position of responsibility to support a young person, but feeling that they do not have the right training or guidance to offer this.

In some areas, there are also voluntary sector early-intervention services which do not have such high thresholds for care. These are, however, vulnerable to cuts and often not well-integrated with the specialist services, so that there is not a smooth transition between specialist and early intervention support and there is not a clear route for young people to access these services. As Catch 22, a voluntary sector service provider, explains:

“Traditionally mainstream NHS led services are highly clinically focussed, and as a result clinically diagnose a mental health illness, treat the symptoms, stabilise the person, ensure risk to themselves and others is managed, support the person to become ‘well’ and then either discharge from hospital or discharge from service.... Current services do not (on the whole) take a holistic approach and do not support young people with wider areas of their life, for example money, housing, benefits, employment, education, primary care.... The issue is that for many children and young people, these areas are interlinked. They don’t have single problems, but multiple needs... To respond to these needs requires an innovative and multi-faceted service response, which includes mental and emotional health and well-being as part of a wider holistic support offer”⁹².

One barrier to integrating support across specialist and early-intervention services is the need for appropriate clinical standards and supervision of staff within the latter. Newcastle’s local transformation plan highlights this:

90 Child Bereavement UK submission to Education Policy Institute Call for Evidence 2016.

91 British Psychological Society submission to Education Policy Institute Call for Evidence 2016.

92 Catch 22 submission to Education Policy Institute Call for Evidence 2016.

“In Newcastle there is huge concern regarding the ongoing supervision of staff trained within community and voluntary sector organisations who are members of the partnership. During the training the supervision is paid for through the University. Small community and voluntary sector organisations are at a disadvantage as they will have to find these costs for the supervision out of their charitable funds, often through independent supervisors who charge a premium rate. In comparison specialist mental health providers have robust supervision in place in their infrastructure through the very nature of their work. We need to consider a financial package to support this supervision need.”⁹³

Young people with the highest levels of need are often not willing to engage with clinical services based in NHS buildings. They may not seek a referral or may simply not turn up for their appointment. This demonstrates the need for services to deliver effective outreach into the community. There are real barriers to adopting this approach, however, including operational policies on risk, data collection, guidelines on clinical eligibility and inflexible IT requirements. Voluntary sector providers often have more flexibility to provide this outreach approach, and within the public sector it requires strong leadership to create new operational policies at board level.

Youth Access is a membership organisation for Youth Information, Advice and Counselling services provided by the voluntary sector. They undertook research with their members on how far they felt engaged with the local transformation process. On the positive side, most were involved in the process and 60 per cent of respondents felt their local transformation plan signalled an enhanced role for the voluntary sector. More worryingly, one in five reported that their local transformation plan signalled increased protectionism in statutory services (some felt that the local NHS would simply attempt to copy, rather than fund, the voluntary sector services)⁹⁴.

Stigma

The stigma associated with mental health problems can prevent people accessing services quickly⁹⁵.

“My parents would have never thought of mental health [as being the problem]. As much as there was nothing for me, there was absolutely nothing for them [in terms of advice and support for them as parents]”⁹⁶

There is an average delay of ten years between the time that young people first experience the symptoms of a mental health problem and when they receive help⁹⁷. Only a small proportion of this time is after referral to services. Therefore, in order to reduce this delay, there must be a focus on tackling stigma and raising awareness of mental health problems, not just improving waiting times within services.

93 Newcastle Local Transformation Plan 2015: <http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2015/11/Local-Transformation-Plan-published-30.11.2015-with-appendices.pdf>

94 A foot in the door? VCS providers' view of CAMHS transformation, Youth Access and the Young People's Health Partnership, June 2016

95 Stewart et al., 2006

96 Member, Education Policy Institute Mental Health Commission's Youth Reference Group

97 Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication, Philip S. Wang, MD, DrPH; Patricia Berglund, MBA; Mark Olfson, MD, MPH; Harold A. Pincus, MD; Kenneth B. Wells, MD, MPH; Ronald C. Kessler, PhD, 2005: <http://archpsyc.jamanetwork.com/article.aspx?articleid=208684>

The Time to Change initiative has made strides to tackle stigma. Since the start of the campaign in 2007 there has been an 8.3 per cent improvement in public attitudes towards mental health⁹⁸. An Institute of Psychiatry evaluation of the campaign⁹⁹ found a clear and consistent link between awareness of the campaign and changes in attitude.

Nevertheless, stigma associated with mental health, and accessing mental health services remains a significant barrier to the identification and early treatment of young people with mental health problems.

98 Time to Change annual survey measures the number of people in England saying they would be willing to live, work and have a relationship with someone who has experience of a mental health problem. <http://www.time-to-change.org.uk/news/latest-survey-shows-public-are-less-likely-discriminate-against-people-mental-health-problems>

99 Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: an analysis of survey data, Dr Sara Evans-Lacko, Elizabeth Corker, MSc, Paul Williams, MPH, Claire Henderson, PhD, Prof Graham Thornicroft, PhD, The Lancet Psychiatry, 2014

3. National policy progress since *Future in Mind*

At a national level, the policy focus has widened with the publication of the *Five Year Forward View for Mental Health*¹⁰⁰. This adopted a ‘life course’ approach, looking at the whole of the mental health system from birth to retirement. This report was wide-ranging and ambitious. On children and young people’s services, it endorsed the direction of travel set out in *Future in Mind*. There is, however, a risk that the national focus on transformation of the CAMHS services may be lost as other policy priorities overtake it. Both reports were widely welcomed but they did not include clear, measurable goals by which progress can be assessed and monitored over the next five years. In July 2016, Mental Health Minister Alastair Burt said:

“There are no plans to publish information in relation to the monitoring and governance that is in place to support the delivery of the vision set out in Future in Mind. The care delivery mechanism in making this happen is the system-wide publicly available, Local Transformation Plans (LTPs), that should cover the full spectrum of need for children and young people who have existing or emerging mental health problems”¹⁰¹.

The *Mandate to NHS England 2016/17*, published in December 2015¹⁰², sets out the government’s main objectives for the NHS. The most relevant objectives in relation to child and adolescent mental health are:

- Consistent improvement on the mental health aspects of the CCG assurance framework;
- Oversee implementation of the local transformation plans;
- Be on track to deliver coverage of the CYP IAPT programme across the country by 2018;
- Implement agreed actions from the Mental Health Taskforce. Given the lack of available data in CAMHS it has been difficult to identify specific performance measures. The implementation of the plans assurance measure includes indicators on funding, workforce and eating disorders¹⁰³. These are welcome but there are many aspects of the process that are not included in these areas and that need a stronger focus.

The detailed *Planning Guidance to the NHS*,¹⁰⁴ published at the same time as the mandate, set out proposals for each local health area to develop their own Sustainability and Transformation Plans for the period up to 2020-21. These will be published in summer 2016 and the extent to which they cover child and adolescent mental health, and the way in which they are assured on this issue, will be a crucial factor. In the meantime, local areas are focused on the delivery of core targets and financial sustainability. The guidance states that commissioners must “continue to increase investment in mental health services each year at a level which matches their overall expenditure increase”. This was also the case in 2015-16 but there is no national data available on CCG expenditure on mental health in 2015-16, so it is impossible to say whether this objective has been met.

In July 2016, NHS England published an implementation plan for the *Five Year Forward View*. This contains a welcome focus on some of the key barriers identified in this report. For example:

¹⁰⁰ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

¹⁰¹ House of Commons Deb, 14 July 2016, cW <https://www.theyworkforyou.com/wrans/?id=2016-07-12.42540.h&s=Mental+Health+Services+Young+People#g42540.r0>

¹⁰² Mandate to NHS England 2016/17, Department of Health 2015, <https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017>

¹⁰³ CCG Assurance Framework 2016/17 Technical Annex, NHS England, 2016: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf>

¹⁰⁴ Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, NHS England, NHS Improvement (the new body which will bring together [Monitor](#) and the [NHS Trust Development Authority](#)), the [Care Quality Commission](#), [Public Health England](#), [Health Education England](#) and [NICE](#), December 2015

- Local transformation plans will be refreshed this year and annually as part of business planning cycles.
- NHS England is moving towards collaborative commissioning of inpatient services with localities.
- Health Education England will develop a comprehensive all-age mental health workforce development strategy by December 2016.
- NHS England and partners will develop a five year data plan.
- A dashboard for mental health is in development and will be published this year, containing a set of standard indicators to articulate progress in mental health services at a national level and allow benchmarking of services across the country. This will form the basis of the CCG Improvement and Assessment Framework in subsequent years.
- NHS England will be working with partners to develop evidence-based treatment pathways and the supporting infrastructure required to enable their implementation, including expectations regarding referral to treatment waiting times, interventions provided and outcomes measured. Children and young people's mental health will be covered in 2016-17.
- NHS England will deliver a national commissioning development programme for children and young people's mental health in 2017 by NHS England.

These developments are to be welcomed. NHS England has identified some critical elements of transformation which need to be addressed. In our third report, we will explore what additional measures are necessary to ensure that the vision of *Future in Mind* is delivered.

Conclusion

The Education Policy Institute Commission's first report identified a serious treatment gap facing children and young people, with services turning away on average 23 per cent of the children and young people referred to them for support, and a postcode lottery of waiting times. These problems are too serious to rely simply on local health leaders to resolve them, especially given the wide variation in the quality of local plans and the significant barriers to progress identified in this report.

Our analysis of local transformation plans found that only 18 areas (15 per cent) have 'good' plans. 58 plans (48 per cent) 'require improvement' and 45 plans (37 per cent) 'require substantial improvement'.

There was regional variation, with the Eastern region and the West Midlands scoring highest and the South East and the East Midlands having the lowest scoring plans.

The key challenges to transformation we have identified are:

- Significant challenges in recruiting the right **workforce**, particularly consultant psychiatrists and mental health nurses. There are also challenges in ensuring existing staff have up to date training in evidence-based practice.
- Robust assurance is needed to ensure the additional announced **funding** is invested in frontline services and not replaced with cuts in early intervention support.
- Local health and care leaders do not always have the right **skills and expertise** to commission services effectively.
- The system is still operating in a fog, without accurate **data** on the level of need and the quality and availability of services in each area.
- Services are **fragmented**, with gaps and inconsistencies between specialist and community care, health, social care and education, and physical and mental health.
- The current system **prevents early-intervention**, meaning that young people often only access support when they have reached a crisis.

This autumn, the Education Policy Institute Commission will make detailed policy recommendations for national and local health and care leaders to address the barriers that we have identified above. It is clear, however, from our research so far, that the following actions are urgently needed:

- i. Health Education England should work with provider trusts and local health and care commissioners to ensure that the **workforce strategy** to support CAMHS transformation covers recruitment and retention of key staff, improving the skill-mix between the different professions and covering training needs for specialist and universal staff such as GPs, health visitors and teachers.
- ii. There must continue to be a rigorous process of assurance of how local areas are planning to spend the **additional investment** and the development of local plans as part of the business planning process for the second year of implementation, particularly given the risk that the transition to baseline funding and 'mainstreaming' the plans will shift the focus away from children and young people's mental health.
- iii. At a national level, there should a stronger focus on where action is needed across departments such as with schools and children's social care.

Unless improving CAMHS services remain a top priority for the Government, with annual clear implementation plans and access standards at a national level for which the Department of Health as well as NHS England can be held to account, there is a risk that levels of access will remain the same, or even deteriorate. Our aim is to ensure the implementation of *Future in Mind* is as effective as possible in order to tackle the treatment gap outlined in our first report.

Appendix A: Local Transformation Plans

Plans rated 'Good'

Local Area	Transparency	Ambition	CYP Involvement	Early Intervention	Governance	Overall Rating
Barnet	Good	Good	Good	Good	Good	Good
Birmingham	Good	Good	Good	Good	Good	Good
Buckinghamshire	Good	Good	Good	Good	Good	Good
Camden	Good	Good	Good	Good	Good	Good
Dudley	Good	Good	Good	Good	Good	Good
Essex	Good	Good	Good	Good	Good	Good
Herefordshire	Good	Good	Good	Good	Good	Good
Kirklees (Huddersfield & Kirklees CCG)	Good	Good	Good	Good	Good	Good
Liverpool CCG	Good	Good	Good	Good	Good	Good
North Somerset	Good	Good	Good	Good	Good	Good
Oxfordshire	Good	Good	Good	Good	Good	Good
Sheffield	Good	Good	Good	Good	Good	Good
Shropshire	Good	Good	Good	Good	Good	Good
South Tyneside	Good	Good	Good	Good	Good	Good
Stockport	Good	Good	Good	Good	Good	Good
Tower Hamlets	Good	Good	Good	Good	Good	Good
Trafford	Good	Good	Good	Good	Good	Good
West Sussex	Good	Good	Good	Good	Good	Good

Plans rated 'Requires Improvement'

Area	Transparency	Ambition	CYP Involvement	Early Intervention	Governance	Total Score (50)
Barking & Dagenham	Green	Green	Red	Orange	Orange	Orange
Bedfordshire	Green	Orange	Green	Orange	Orange	Orange
Bexley	Green	Green	Orange	Green	Orange	Orange
Bournemouth, Dorset & Poole	Orange	Orange	Green	Green	Orange	Orange
Brighton & Hove	Green	Red	Red	Orange	Orange	Orange
Cambridgeshire & Peterborough	Orange	Orange	Orange	Orange	Red	Orange
City & Hackney	Green	Red	Orange	Orange	Green	Orange
Coventry & Warwickshire	Orange	Orange	Green	Orange	Orange	Orange
Croydon	Green	Green	Orange	Green	Orange	Orange
Derbyshire County & Derby City	Orange	Orange	Green	Orange	Orange	Orange
Doncaster	Green	Orange	Orange	Orange	Red	Orange
East Sussex	Orange	Orange	Orange	Orange	Red	Orange
Eastern Cheshire & South Cheshire	Orange	Orange	Orange	Orange	Red	Orange
Gloucestershire	Green	Orange	Orange	Orange	Orange	Orange
Hambleton, Richmondshire & Whitby	Orange	Orange	Red	Orange	Orange	Orange
Harrogate & Rural District	Orange	Orange	Red	Orange	Orange	Orange
Havering	Green	Green	Red	Orange	Orange	Orange
Hertfordshire	Orange	Orange	Orange	Orange	Orange	Orange
Heywood, Middleton & Rochdale CCG	Orange	Red	Green	Orange	Orange	Orange
Hull	Green	Orange	Orange	Orange	Red	Orange
Islington	Orange	Green	Red	Green	Red	Orange
Kent	Green	Green	Red	Orange	Orange	Orange
Kingston	Green	Orange	Orange	Green	Green	Orange
Lancashire	Green	Green	Red	Green	Orange	Orange
Leeds CCGs	Orange	Orange	Red	Orange	Green	Orange
Manchester	Orange	Green	Orange	Green	Red	Orange
Medway	Orange	Orange	Orange	Orange	Orange	Orange
Merton	Orange	Orange	Red	Orange	Orange	Orange
Milton Keynes	Orange	Orange	Red	Orange	Orange	Orange
Newcastle Gateshead	Green	Green	Green	Orange	Red	Orange
Newham	Orange	Green	Orange	Green	Orange	Orange
North East Lincolnshire	Orange	Orange	Red	Orange	Green	Orange
North Tyneside	Green	Orange	Red	Orange	Green	Orange
North West London	Orange	Orange	Orange	Orange	Green	Orange
Northern, Eastern & Western Devon	Orange	Orange	Green	Green	Orange	Orange
Northumberland	Green	Green	Orange	Orange	Orange	Orange
Nottinghamshire	Green	Orange	Orange	Red	Orange	Orange
Oldham CCG	Green	Orange	Green	Orange	Orange	Orange
Redbridge	Green	Green	Red	Orange	Orange	Orange
Richmond	Green	Orange	Orange	Orange	Green	Orange
Rotherham	Orange	Red	Orange	Red	Orange	Orange
Salford	Green	Orange	Orange	Orange	Orange	Orange
Scarborough & Ryedale	Orange	Orange	Red	Orange	Orange	Orange

Plans rated 'Requires Improvement' (continued)

Solihull	Red	Orange	Orange	Orange	Orange	Orange
Somerset	Green	Red	Orange	Orange	Orange	Orange
St Helens	Green	Orange	Orange	Orange	Orange	Orange
Suffolk	Green	Orange	Orange	Orange	Orange	Orange
Sunderland	Orange	Orange	Red	Orange	Orange	Orange
Surrey	Orange	Orange	Orange	Orange	Orange	Orange
Swindon	Green	Red	Orange	Red	Orange	Orange
Vale of York	Orange	Orange	Red	Orange	Orange	Orange
Wakefield	Green	Orange	Red	Orange	Orange	Orange
Walsall	Orange	Orange	Orange	Orange	Orange	Orange
Waltham Forest	Orange	Orange	Orange	Orange	Green	Orange
Wandsworth	Green	Orange	Orange	Orange	Green	Orange
Warrington	Orange	Orange	Orange	Orange	Orange	Orange
Wiltshire	Orange	Orange	Orange	Orange	Orange	Orange
Worcestershire	Orange	Orange	Orange	Orange	Orange	Orange

Plans rated as 'Requires Substantial Improvement'

Area	Transparency	Ambition	CYP Involvement	Early Intervention	Governance	Total Score (50)
Barnsley CCG						
Bath and NE Somerset						
Bolton						
Bradford District & Craven						
Bristol CCG						
Bromley						
Bury CCG						
Calderdale						
County Durham						
Cumbria						
Darlington						
East Berkshire						
East Riding of Yorkshire						
Enfield						
Halton						
Hampshire (all five CCGs)						
Haringey						
Hartlepool and Stockton on Tees						
Isle of Wight						
Kernow						
Knowsley						
Lambeth						
Leicester, Leicestershire & Rutland						
Lewisham						
Lincolnshire						
Norfolk						
North Lincolnshire						
Northamptonshire						
Nottingham City						
Portsmouth						
Sandwell						
South Devon and Torbay						
South Gloucestershire						
South Sefton & Southport & Formby						
South Tees						
Southampton CCG						
Southwark						
Staffordshire						
Sutton						
Tameside & Glossop						

Plans rated as 'Requires Substantial Improvement' (continued)

Vale Royal & West Cheshire						
West Berkshire						
Wigan						
Wirral						
Wolverhampton						

