CHILDREN, YOUNG PEOPLE AND FAMILIES PARTNERSHIP

Venue: **Town Hall, Moorgate Street, Rotherham. S60 2TH**

Date: **Wednesday, 24th September, 2014**

Time: **2.00 p.m.**

A G E N D A

1. Apologies for Absence.

2. Minutes of the Previous Meeting (Pages 1 - 6)

3. Matters Arising.

4. Issues and Concerns
   Youth Cabinet

For Discussion

5. National Child Management Programme - Childhood Obesity Data (Pages 7 - 16)
   Ward Data Update 2012/13
   Catherine Homer

6. Families for Change Progress Report (Pages 17 - 22)
   Jenny Lingrell to report

7. CSE Update
   Joyce Thacker to report

8. Child Poverty Needs Analysis (Pages 23 - 32)
   Michael Holmes to report

9. Emotional Wellbeing and Mental Health Strategy (Pages 33 - 109)
   Paul Theaker to report

10. Young Carers (Pages 110 - 117)
    Paul Theaker to report

11. Key Stage 2/Key Stage 4 Indicative Outcomes (Pages 118 - 124)

Karen Borthwick to report

12. Partnership Arrangements to deliver School Improvement
Karen Borthwick to report

13. CYPS Self-Assessment (Page 125)
Sue Wilson to present

14. Transformation Challenge Award (MASH Bid) (Pages 126 - 160)
Sue Wilson to report

15. Budget Analysis across all Agencies
Joanne Robertson to present

16. Any Other Business.

17. Dates and Times of Future Meetings.
Wednesday, 19th November, 2014
14th January, 2015
18th March
27th May
15th July

All meetings will be held at 2.00 p.m. in the Town Hall

CHILDREN, YOUNG PEOPLE AND FAMILIES PARTNERSHIP
Wednesday, 16th July, 2014

Present:- Councillor Lakin (in the Chair); Councillors Roche and Rushforth; Joyce Thacker, Rachel Nicholls, Clair Pyper, Karen Etheridge, Chief Superintendent Jason Harwin, Julie Mott, Tracy Guest and Janet Wheatley.
Together with officers:- Paul Theaker, Sue Wilson RMBC), Emma Royle and Daniel C?? (Clinical Commissioning Group).
Mr. D. Pickering (member of the public).

Apologies for absence were received from Steve Ashley, Martin Kimber, Shona MacFarlane, Dr. John Radford, Sarah Whittle and from Dorothy Smith.

280. MINUTES OF THE PREVIOUS MEETING HELD ON 21ST MAY, 2014

Agreed:- That the minutes of the previous meeting, held on 21st May, 2014, be approved as a correct record.

281. ISSUES AND CONCERNS

(1) Elective Home Education

It was noted that the Council will shortly introduce a revised policy relating to the Elective Home Education of pupils. The cases of the two children now mentioned will be investigated by Children and Young People's Services.

(2) Foundation Years' Service for Young Children

It was noted that a report on this issue will be submitted to the next meeting of the Children, Young People and Families Partnership, to be held on 24th September 2014.

(3) Looked After Children's Council – Update

Consideration was given to a report, presented by Lisa Du-Valle (Integrated Youth Support Service), describing the participation of the Looked After Children's Council in Voice and Influence training and development sessions. The activities included:-

: sessions on team building, self-awareness and self-esteem;

: open evening with foster carers;

: residential event in Portugal and subsequent presentation to the Corporate Parenting Panel;

: training day with the Rotherham Youth Cabinet and the UK Youth

Parliament;

: various celebrations at Easter;

: Youth Voice Vehicle Training Day;

: Looked After Children's Council open evening event;

: annual Looked After Children's Council peer consultation and feedback;

: Youth Voice Vehicle – overnight residential at Habershon House on 23rd and 24th July, 2014.

(4) Rotherham Youth Cabinet – Launch of Manifesto

The Rotherham Youth Cabinet manifesto is to be launched at a meeting to be held on Thursday, 16th October, 2014, at the Town Hall.

Agreed:- That the report be received and the information noted.

282. CSE UPDATE

Joyce Thacker, Strategic Director, Children's and Young Peoples Services, informed the meeting of the following update:-

: a report on the progress of the review of the response to Child Sexual Exploitation in Rotherham will be submitted to the meeting of this Council's Cabinet to be held on Wednesday, 6th August, 2014;

: a training session about Child Sexual Exploitation will be held on 28th July 2014 for the recently elected Borough Councillors, as part of their induction to the Council;

: training about Child Sexual Exploitation for head teachers of secondary schools and special schools has taken place recently;

: during September 2014, there will be a training session on Child Sexual Exploitation for primary school head teachers.

In addition, the South Yorkshire Police monthly report (June 2014) on Child Sexual Exploitation in Rotherham was distributed and its contents discussed.

Agreed:- That the information be noted.

283. MULTI AGENCY THRESHOLDS

Clair Pyper, Interim Director of Safeguarding Children and Families, presented a report about the child sexual exploitation risk indicators. The

report stated that the indicators are a guide for all professionals to assist them in determining the level of risk of child sexual exploitation in a consistent manner. The assessment then allows the appropriate referral pathways to be progressed. This model is based on the Continuum of Need, but does not replace the wider safeguarding children multi-agency threshold descriptions.

Discussion took place on the application of the risk indicators, which will be very useful in respect of:-

: assisting staff involved in the multi-agency safeguarding hub co-location of services, scheduled to take place during the Autumn 2014; and

: enabling the Council's partner agencies to progress referrals of cases appropriately.

Agreed:- (1) That the information about the child sexual exploitation risk indicators, now submitted, be noted.

(2) That the following issues be considered at the next meeting of the Children, Young People and Families Partnership to be held on 24th September 2014:-

(a) examples of the application of the risk indicators to individual case studies; and

(b) the up-to-date protocol applicable to the use of the risk indicators.

284. NEGLECT - PREPARATION FOR SEPTEMBER PEER REVIEW

Consideration was given to a report, presented by Sue Wilson, Performance and Quality Manager (CYPS), concerning the proposed peer review due to take place during the week beginning Monday 8th September 2014, about the impact of childhood neglect in the Borough area. The report also described the current profile of childhood neglect cases in Rotherham. The peer review will be led by the Director of Children's Services, Doncaster, alongside social care professionals from North Lincolnshire and from York.

The focus of this peer review will be childhood neglect, the impact that it has on the lives of children and on what is happening in the Rotherham Borough area to combat childhood neglect. It is anticipated that the peer review will investigate the way in which the Council's partner organisations respond to this issue, as well as the role of schools.

Members of the Children, Young People and Families Partnership would have the opportunity to participate in the peer review, including attendance at focus group meetings. In addition, members were encouraged to study the Ofsetd report entitled "In the Child's Time : professional responses to neglect" (March 2014).

Discussion took place on some aspects of the way in which neglect may affect children, eg: brain development, educational attainment, diet, behavioural issues, deprivation of basic needs. There was also the impact on the family of low income and reliance upon benefit payments.

Agreed:- (1) That the report be received and its contents noted.

(2) That the arrangements for the forthcoming peer review of the impact of childhood neglect in Rotherham, as now reported, be noted.

285. REVIEW OF THE CHILDREN AND YOUNG PEOPLE'S ACTION PLAN 2013 - 2016

Further to Minute No. 251 of the meeting of the Children, Young People and Families Partnership held on 15h January, 2014, Sue Wilson, Performance and Quality Manager (CYPS) presented a report concerning the review of the Children and Young People's Action Plan 2013 – 2016. This Action Plan underpins the Plan on a Page, which was developed around six joint key priorities and is linked into the Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.

Currently there were 40 actions ranked on green, 103 on amber, 16 on red and none on blue.

An explanation was given for each of the red actions.

A further report was distributed describing Priority 7 "With parents and young people, we will transform how education, care and health partners ensure that children and young people with special educational needs or a disability are identified early and supported to achieve the best possible outcomes in adult life. We will focus on making the transition between different services as seamless as possible."

It was noted that the Action Plan is monitored each month by the Commissioning Group and that updates will continue to be submitted to meetings of this Partnerships as intervals of six months.

Agreed:- (1) That the update of the Children and Young People's Action Plan 2013 – 2016, as now submitted, be noted.

(2) That a further update of the Action Plan be submitted to the January, 2015, meeting of this Partnership.

(3) That a report on the progress of the Plan on a Page be submitted to the next meeting of the Children, Young People and Families Partnership.

286. MULTI AGENCY INSPECTION

Consideration was given to the joint consultation document on proposals

for the integrated inspection of services for children in need of help and protection, children looked after and care leavers and the joint inspections of Local Safeguarding Children Boards. This consultation document had been jointly published by, amongst others, the Care Quality Commission and the Office for Standards in Education (Ofsted).

The document stated that the consultation on the multi-agency arrangements for the protection of children focused on local authority and partnership arrangements for children and young people who are being harmed or who may be at risk of harm, including the provision and effectiveness of early help. In respect of the services for children and young people looked after and care leavers, Ofsted proposed to replace three separate inspection frameworks with a single inspection to focus on local authority performance of its statutory responsibilities for children looked after and care leavers. This was planned as a joint inspection with the Care Quality Commission.

The closing date for submission of responses to this consultation document was Friday 12th September, 2014.

Agreed:- That the contents of the consultation document be noted and members of this Partnership be provided with the template for responses to be submitted to Ofsted.

287. SEND

As part of items numbered 286 and 287 above, Sue Wilson, Performance and Quality Manager (CYPS) reported on issues concerning the Council's provision of Special Educational Needs and Disability (SEND) services.

288. YOUTH CABINET

The contents of the minutes of the meetings of the Rotherham Youth Cabinet held on (a) 15th May, 2014 and (b) 8th July, 2014, were noted. The Rotherham Youth Cabinet manifesto is to be launched at a meeting to be held on Thursday, 16th October, 2014, at the Town Hall.

289. ROTHERHAM LOCAL SAFEGUARDING CHILDREN BOARD

The contents of the minutes of the meeting of the Rotherham Local Safeguarding Children Board held on 5th June, 2014, were noted.

290. ANY OTHER BUSINESS

Copies of the Rotherham Local Safeguarding Children Board Business Plan 2014/2015 were distributed and members were invited to submit their comments to Joyce Thacker, Strategic Director for Children and Young People's Services.

291. DATE AND TIME OF FUTURE MEETINGS

Resolved:- That the next meeting of the Children, Young People and Families Partnership be held on Wednesday, 24th September, 2014, commencing at 2.00 p.m., at the Town Hall, Rotherham

Rotherham Public Health

National Child Measurement Programme Data
Rotherham Summary 2006/07 to 2012/13

Marcus Williamson, Catherine Homer & Joanna Saunders
Rotherham Public Health
September 2014

Rotherham Metropolitan Borough Council
Where Everyone Matters

Presentation will cover…..

- NCMP Participation rates
- Prevalence of overweight and obesity- reception & year 6
- Excess Weight prevalence by ward- reception & year 6
- Rotherham Healthy Weight Framework

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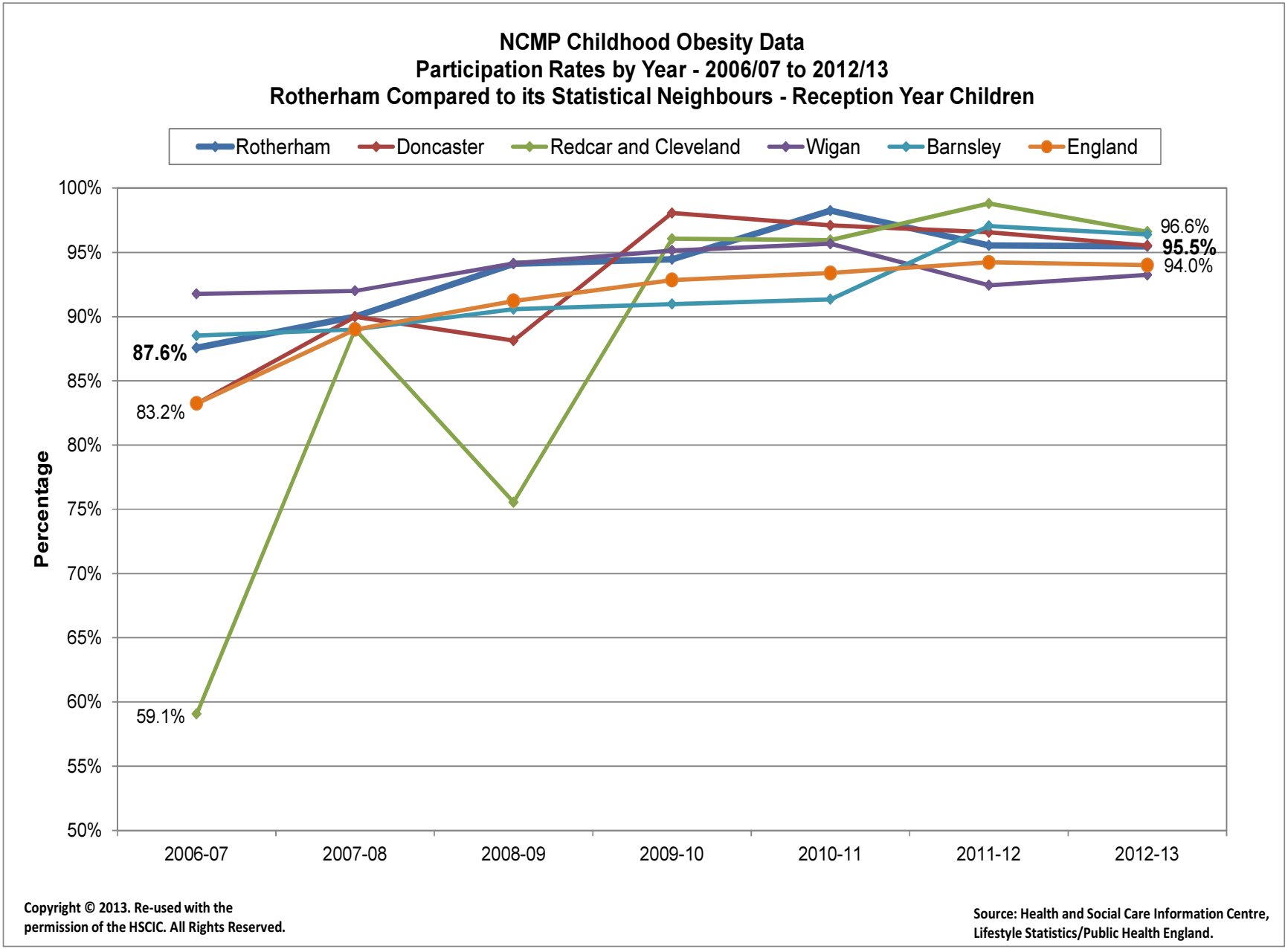
Participation - Reception



Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

Participation - Year 6

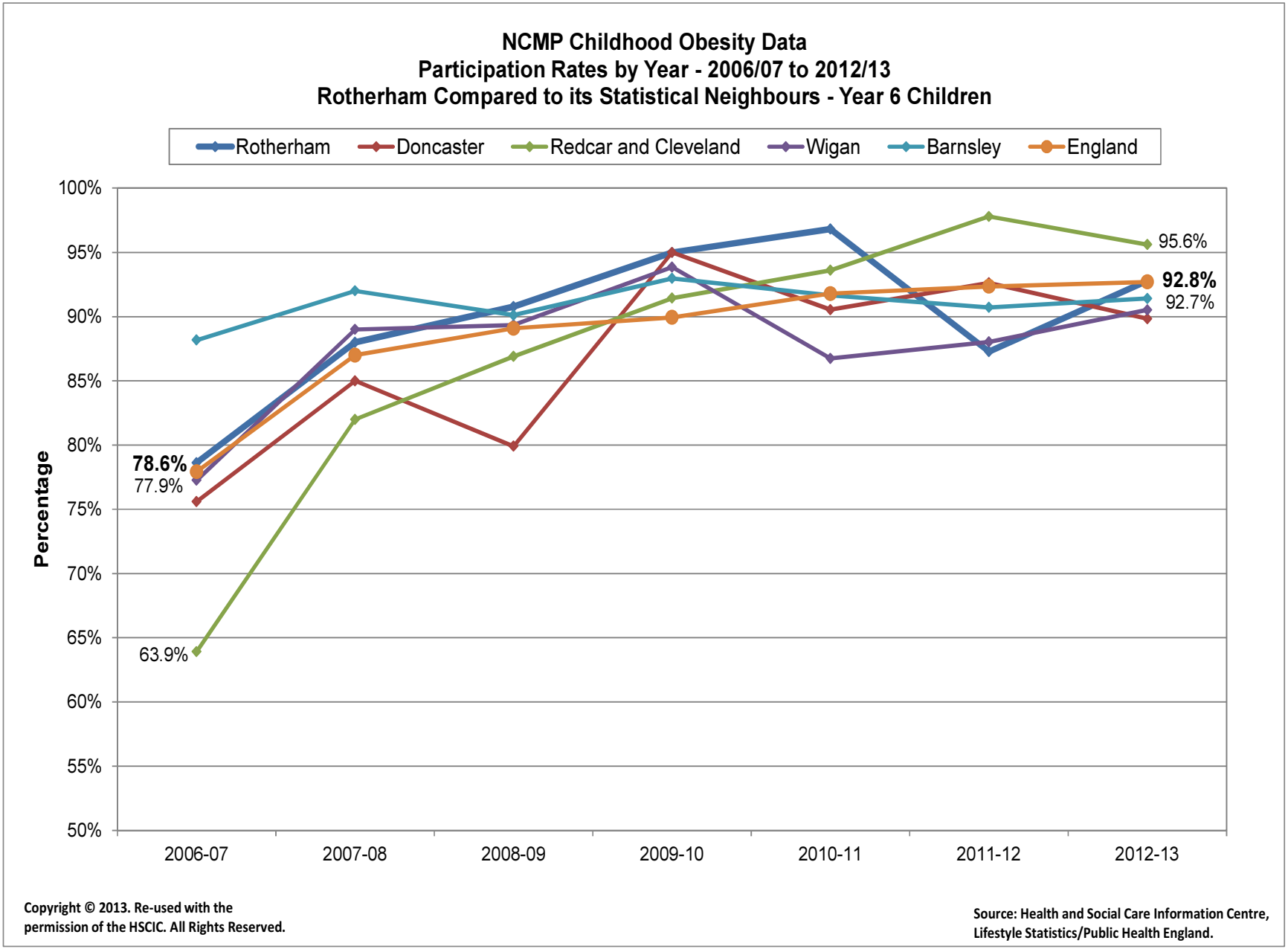
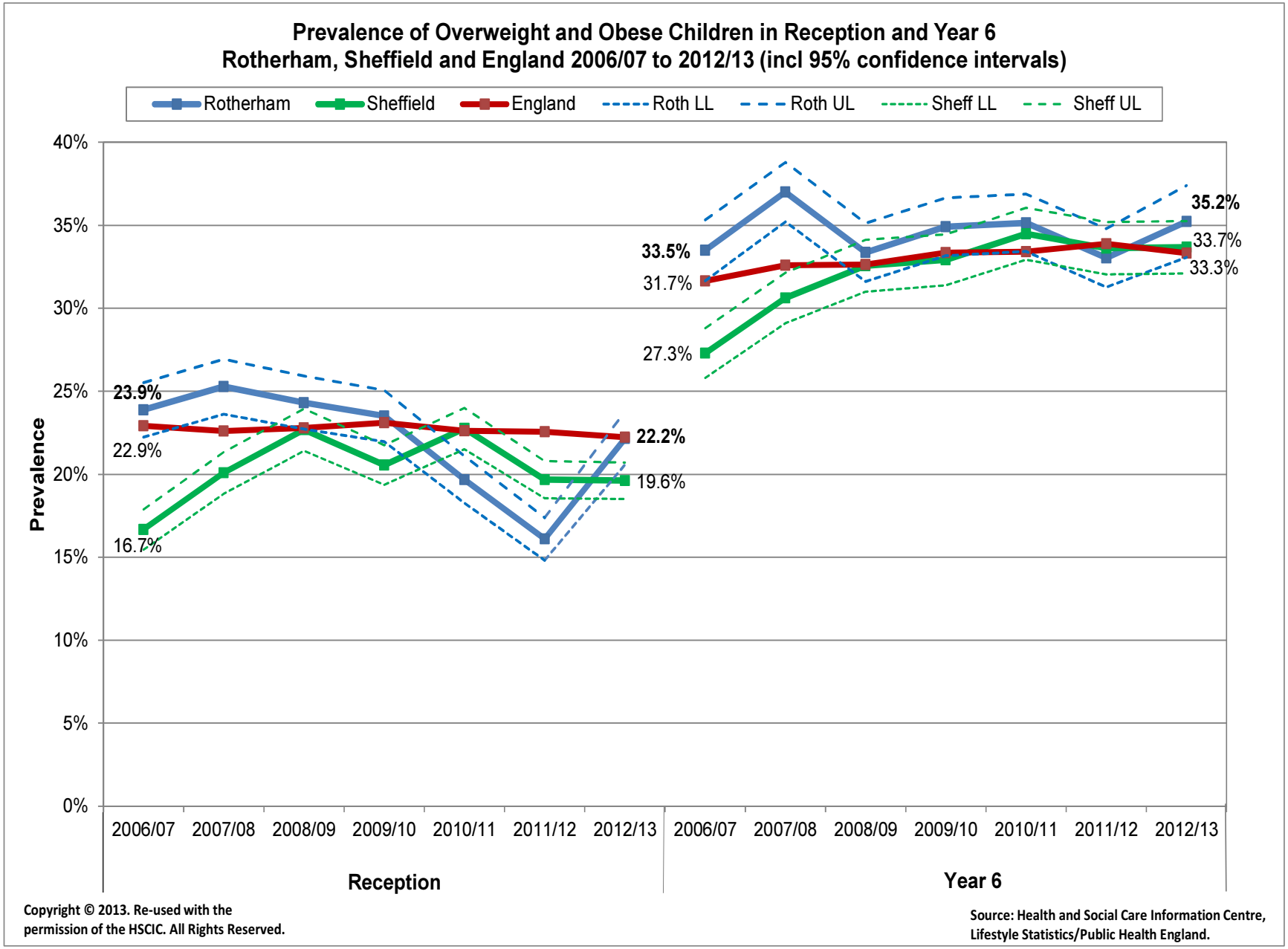
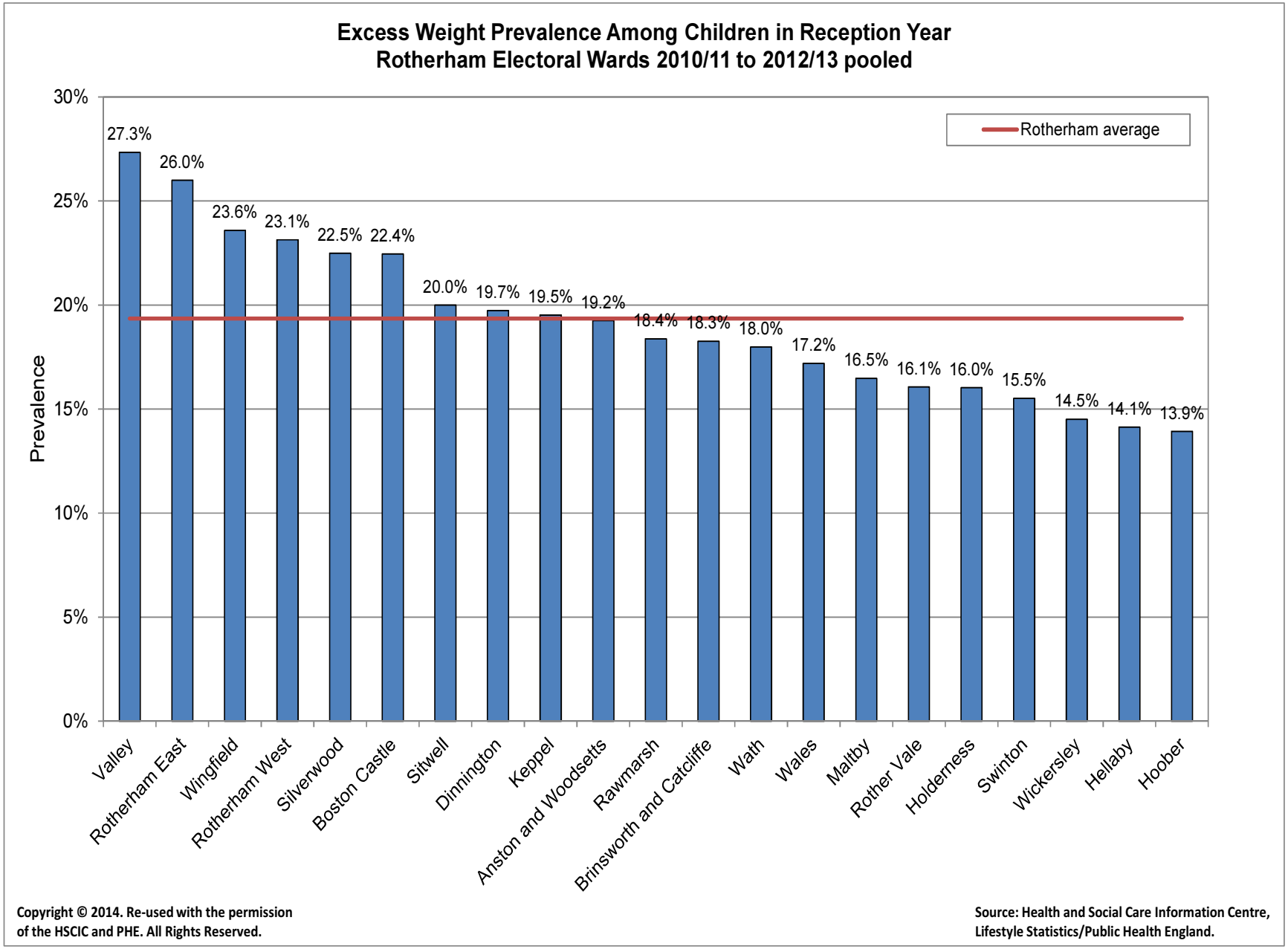


Chart 3



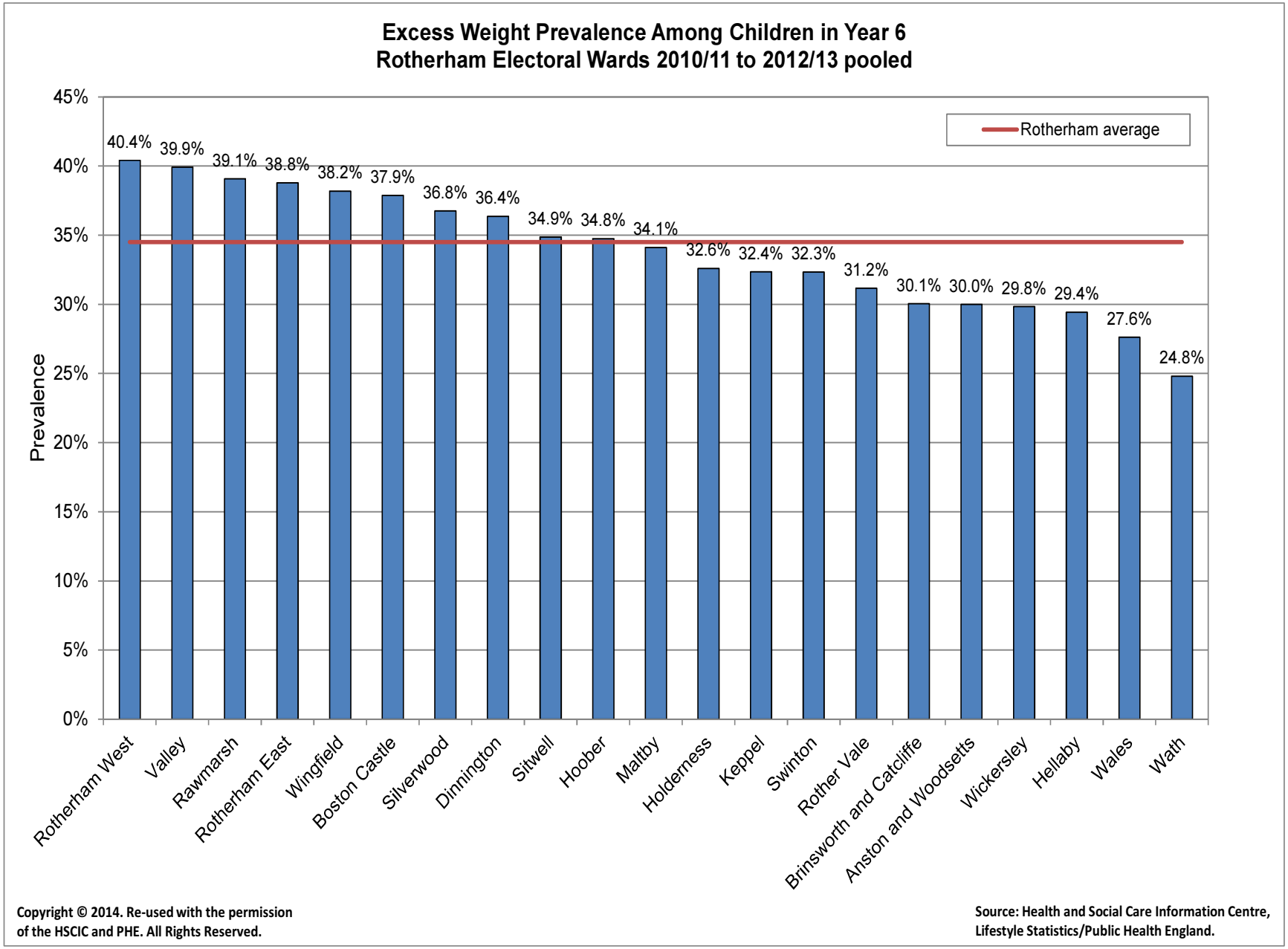
Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

Chart 6 - Reception



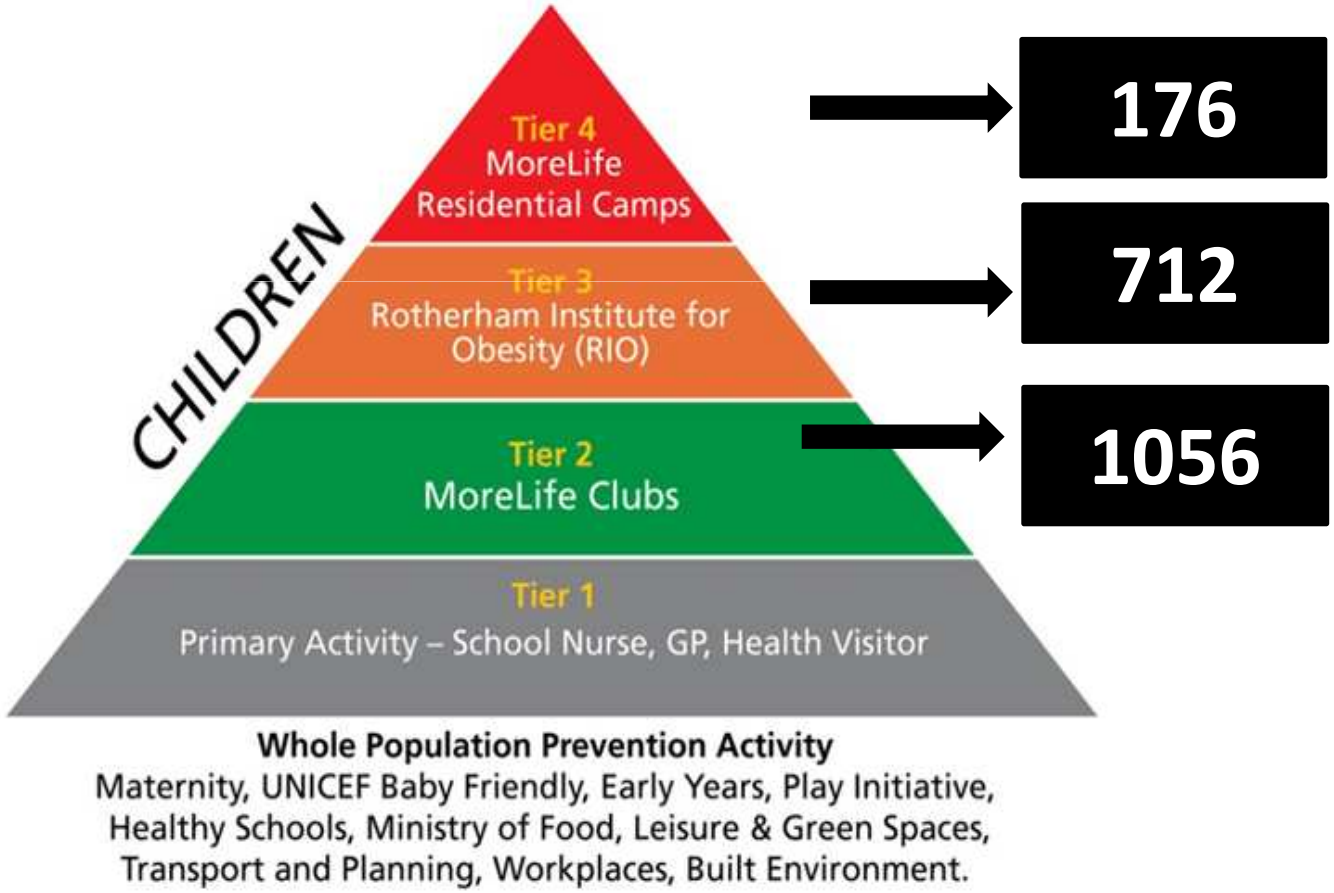
Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

Chart 6 - Year 6



Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

Rotherham Healthy Weight Framework



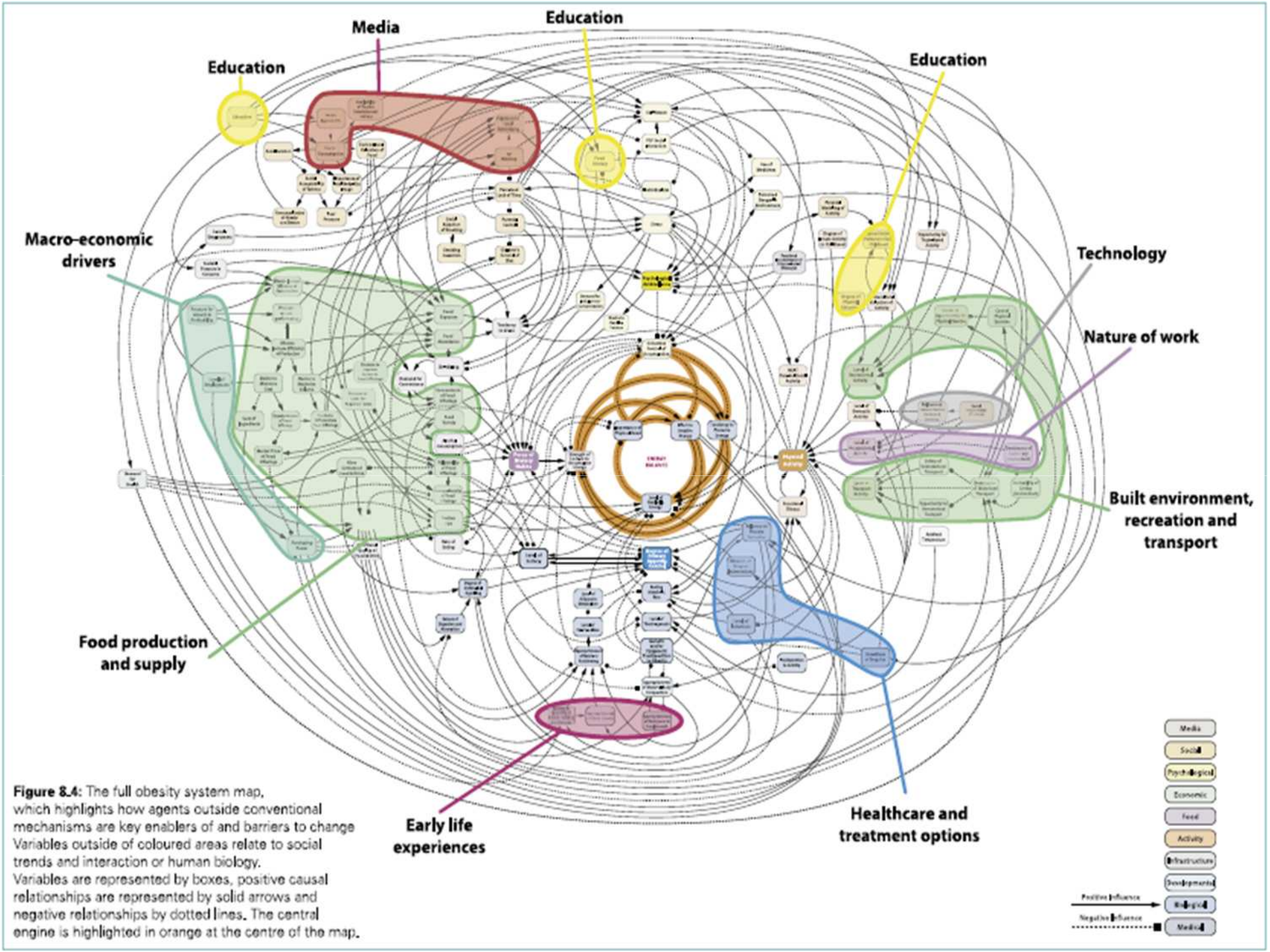


Figure 8.4: The full obesity system map, which highlights how agents outside conventional mechanisms are key enablers of and barriers to change Variables outside of coloured areas relate to social trends and interaction or human biology. Variables are represented by boxes, positive causal relationships are represented by solid arrows and negative relationships by dotted lines. The central engine is highlighted in orange at the centre of the map.

Thank you for listening

Any questions?

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CHILDREN, YOUNG PEOPLE & FAMILIES PARTNERSHIP

1.	**Meeting:**	**Children, Young People and Families Partnership**
2.	**Date:**	**24th September 2014**
3.	**Title:**	**Families for Change Progress Report**

4. **Summary**

The Children, Young People & Families Partnership received a report in May 2014 with details of the first two years of Families for Change delivery. Since then an additional payment by results claim has been submitted, and further information been published regarding the expansion of the programme.

This report provides a progress update in relation to payment by results and also identifies the strengths and vulnerabilities of current delivery. The available details regarding the expanded programme are outlined and the opportunities are highlighted for members of the partnership to provide input and feedback to inform the design and delivery of the programme.

5. **Recommendations**

The Children, Young People & Families Partnership is asked to:

- **Receive information about Rotherham's performance against the expectations of the current Troubled Families Financial Framework;**
- **Support the successful completion of phase 1 of the programme and commit to supporting delivery of the expanded programme, beginning in January 2015;**
- **Provide feedback to the Troubled Families Coordinator in relation to the local design of the expanded programme.**

6. **Proposals and Details**

Performance
Rotherham has submitted five payment by results claims (July and October 2013 and February, May and August 2014) for families who have achieved the outcomes set out in the Troubled Families Financial Framework.
An outcome is achieved if school attendance for all children in the family has increased to more than 85% and this has been sustained across three school terms. It is also possible to claim an outcome for school leavers. This improvement needs to have been achieved in conjunction with a sustained reduction in involvement in crime or anti-social behaviour.

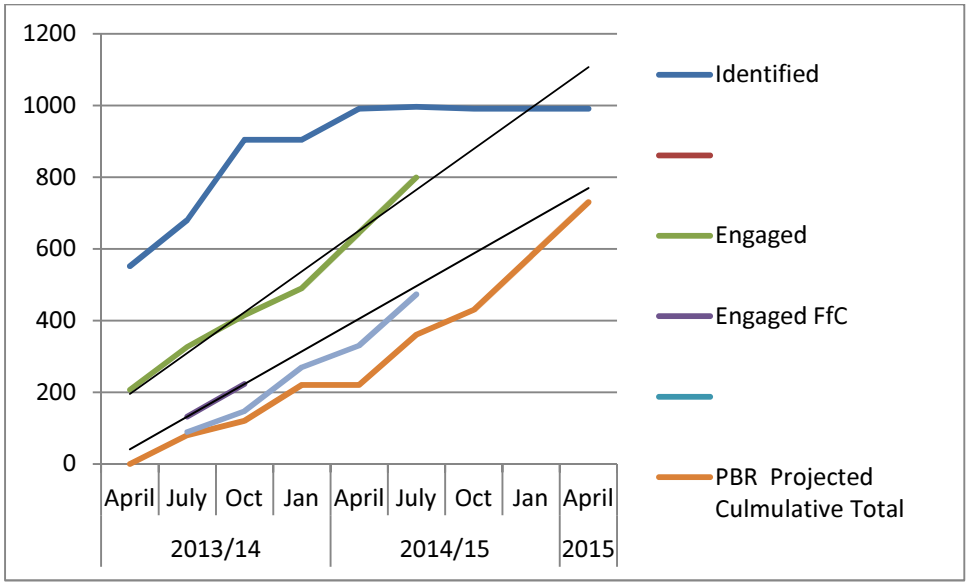
An additional payment is available where an adult family member has engaged with ESF Employment Support (Wiseability) or the Work Programme.

If an adult family member has entered and sustained employment for a period of 6 months it is possible to claim an outcome regardless of the progress in relation to attendance and anti-social behaviour.

The total outcomes achieved so far are as follows:

Outcome achieved	Number of families
Education & Crime / Anti-Social Behaviour	435
Progress to work	27
Continuous employment	38
Continuous employment (following previous claim for ASB / Education)	10
All adults remain in work throughout intervention	5

This performance represents 64.7% of the total cohort 'turned around'. The trajectory for Payment by Results claims remains above the projected outcomes and on target to claim 730 outcomes by May 2015, despite the complexities associated with families who have an inter-generational history of dysfunction.



Families for Change: Strengths
Partnership arrangements are working well, particularly with South Yorkshire Police. South Yorkshire Police share information with Families for Change on a six-monthly basis to inform the identification of families and support the Payment by Results process; a single point of contact has also been established to enable information sharing on a family by family basis where needed. The Troubled Families Coordinator meets regularly with the Chief Inspector of Safer Neighbourhoods and Partnerships, whilst Families for Change Coordinators attend Safer Neighbourhood Team meetings and have taken referrals of families that are causing concern through this route. A review of the role of Police and Young Peoples' Partnership Officers has been completed and new management arrangements became operational in September 2014; these arrangements will support the Families for Change work.

Families for Change Coordinators deliver an important role, by providing a key point of contact for other professionals and linking together services that work with families, for example, ensuring that schools are aware of the wider issues that might be facing a family such as a risk of eviction or significant debt. They are able to provide effective support and challenge, for example, a FfC Coordinator might be present when Anti-Social Behaviour Contracts are issued, or might work with a colleague in housing services to ensure that a formal letter includes reasonable expectations that are expressed in language that the family will understand.

Commissioned services provide valuable extra capacity, delivering family intervention services with families who are open to statutory services and by providing a dedicated lead worker role for complex families which prevents their problems from escalating, or re-emerging after a period of statutory intervention.

Families for Change: Challenges
Capacity to deliver the role of lead worker for the Family Common Assessment Framework (FCAF), a multi-agency tool to support the delivery of joined-up services to families, remains an issue. There is often reluctance to take on this role, particularly from some schools and health providers. There is a perception that the

process is onerous as well as genuine issues in terms of the capacity lead this work on top of managing a challenging caseload. However, as long as the lead worker role is delivered by a few individuals within a few organisations, the potential to realise the benefits of working more effectively together will never be realised.

A proposal to inject extra capacity to deliver the leadworker role, whilst modelling the potential of taking a whole family approach, supported by the FCAF tool, will be considered by Chief Officers at their next partnership meeting (October 2014).

Despite the significant effort that has been made by the Troubled Families Coordinator to join up employment support provision in the borough (for example, seeking to influence provision delivered by ESF and Work Programme providers as well as at Job Centre Plus), and the work of the FfC EA to deliver high quality support to individual family members, the number of families who are finding continuous employment is below expectations. The Troubled Families Unit target is for employment outcomes to represent 10% of total outcomes claimed; therefore, this must be an area of focus for future payment by results claims. Rotherham's performance was at 4% in May 2014 but has increased to 8% in August 2014. The ESF provision will end in March 2015 and the design of delivery of the new provision will be led by the Local Enterprise Partnership. This will potentially deliver better outcomes with this cohort of families, especially if the Ambition Project proves successful and expanded similar model is adopted to meet the needs of families with multiple problems.

Future Delivery Arrangements
The principles of the expanded programme are:

- Simplicity
- A 'whole family' programme
- That direct work with 'real families' will provide the grounding for service transformation BUT
- **That system change will be an expectation**.

The expanded programme will be based on a cluster of six headline problems, below which will sit a basket of indicators and referral routes. The six headline problems are:

- Parents and children involved in crime or antisocial behaviour
- Children who have not been attending school regularly
- Children who need help
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

Areas will have the opportunity to choose from a basket of indicators to identify the cohort. The draft financial framework for the expanded programme was published last week and is included as an appendix to this report. The document suggests datasets that might be used to identify the cohort.

Preliminary work will be led by the Troubled Families Coordinator to assess the most effective way to target the work in order to identify a cohort of approximately 2555

across a five year period. The work will review strategic plans and priorities alongside existing available data sets in order to make a recommendation about how best to deliver the programme.

Resources
The expanded programme will aim to work with 400k families nationally (120k families were targeted in the current programme), over a planned 5 year term. There will be funding of £1800 per family, with £1000 paid as an up-front attachment fee and a results payment of £800. Early indications are that Rotherham's cohort will be approximately 2555 families.

8. **Risks and Uncertainties**

Funding for the programme will be based on a payment by results framework, predicated on an assumption that the local authority and its partners will contribute to the investment (largely in kind) required to realise the results required. There is a risk that, in the current financial climate, it will not be possible to maintain the existing level of investment. If existing infrastructure is not sustained, the Families for Change Delivery Plan may become infeasible, placing future funding payments at risk.

The payment by results funding framework requires sustained change from families across the domains of school attendance, anti-social behaviour and employment. These may be difficult to achieve given the complex problems that many families are being supported to address.

9. **Policy and Performance Agenda Implications**

The Rotherham approach to the Troubled Families agenda is aligned to the operational delivery of the Early Help Strategy and the poverty workstream of the Health and Wellbeing Strategy, which aims to deliver targeted support to Rotherham's most deprived neighbourhoods.

10. **Equality and Diversity**

An Equality Impact Assessment has been completed for the Early Help Strategy and Implementation; this covers the Families for Change Delivery Plan.

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Troubled Families Coordinator

Telephone: 01709 254836
E-mail: jenny.lingrell@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL

1.	**Meeting:**	**Children, Young People and Families Partnership**
2.	**Date:**	**24th September 2014**
3.	**Title:**	**Poverty Needs Assessment**
4.	**Directorate:**	**Resources**

5. Summary:

The report sets out the approach and progress to date in refreshing the borough's 2011 child poverty needs assessment.

6. Recommendations:

That partners:

- **note the approach and provide comments to inform the ongoing development of the needs assessment**
- **Provide views, in particular, on whether the scope of the needs assessment should be widened beyond child and family poverty.**

7. Proposals and Details:

Background

As well as establishing targets to reduce child poverty, the 2010 Child Poverty Act requires local authorities to prepare and publish a child poverty needs assessment (CPNA) which should underpin the approach to tackling child poverty locally.

Rotherham's first CPNA was produced in 2011 and informed the Early Help strategy, which aims to "mitigate the effects of child poverty (including health inequalities) by supporting families to fulfil their potential".

Although there is no specific guidance indicating how regularly CPNAs should be updated, it is felt that – following the economic downturn and the introduction of a significant government reform programme, particularly welfare reform – an update is due.

Poverty needs assessment 2014

The initial approach to developing an updated needs assessment has considered whether:

- The assessment could be expanded to provide a more comprehensive analysis of poverty in the borough (i.e. to look at issues for people without dependent children)

There is a range of existing and emerging data indicating that large numbers of people without children are struggling to make ends meet. For example:

  - Two thirds of Rotherham CAB debt clients in 2013 did not have dependent children. Research suggests that a large proportion of payday loan borrowers are young men without children.
  - Data from DWP's discretionary social fund in 2011/12 shows that around 75% of crisis loans (for those in urgent need of financial assistance) went to people with no children under 16.
  - Recent analysis of local authority rent arrears shows that the vast majority (88%) of tenants owing £1,000 or more have no dependent children.
  - Information provided by local "food in crisis" organisations also suggest that large numbers of their customers don't have children, though further work is needed to quantify this

- Whilst still being underpinned by relevant statistics, the assessment should be short and succinct, centring on a small number of key areas and clearly drawing out the main issues. The suggested focus areas are:

  - Employment status (unemployed, l-t unemployed, p/t work, casual work, skills)
  - Family composition (lone parents, number of children)

- Household income (wage levels, benefit levels, pensions)
- Disability
- Health (including mental health and drug/alcohol dependency)
- Teenage pregnancy

Initial discussions have also been held with the chief executive of Age UK Rotherham to see how issues for struggling older people could be effectively captured in the needs assessment, with the emphasis probably more on qualitative information rather than statistics.

To try to provide a richer overall picture, the aim will be to include case studies or pen portraits to exemplify the key issues identified by the data and research.

The assessment will also highlight geographic and any other notable inequalities (e.g. between different ethnic groups), partly through an updated "500 babies" analysis.

Indicative timetable

- Draft needs assessment completed – December 2014
- Reports to CYP&F partnership, SLT, cabinet – January/February 15
- Final assessment completed – end March 2015

8. Finance:

There are no direct financial implications arising from this report.

9. Risks and Uncertainties:

Given continuing funding cuts and external economic and policy factors there is a concern that even by taking effective, coordinated action local partners can only have a marginal impact on poverty in the short term.

Updating our needs assessment will help to ensure that strategy is evidence-based and that partners target their resources effectively.

10. Policy and Performance Agenda Implications:

To effectively address poverty, including its causes and wider determinants and immediate and longer term symptoms, action is required across a range of policy areas. The following plans include actions to tackle poverty:

- Early help strategy - aims to understand and respond quickly to the needs of children, young people and families, mitigating the effects of child poverty by supporting families to fulfil their potential
- RMBC corporate plan - the new plan prioritises *helping people into work*, *improving health and wellbeing* and *reducing inequalities*. Specific commitments include:
    - We will focus on lifelong learning to improve the qualifications, skills and economic wellbeing of children, young people and their families

    - We will respond quickly to people's needs, mitigating the effects of poverty and helping them to thrive
  - Rotherham Partnership community strategy priority: *ensuring the best start in life for children and families*
  - Health and wellbeing strategy priority/outcome: *reduce poverty in disadvantaged areas*
  - *Economic growth plan (in development) theme: social inclusion and combating poverty*

In addition to these, a new "building resilience" strategy (in development) will be critical in coordinating anti-poverty efforts around a small number of headline objectives:

- Maximising access to sustainable, decently paid employment and relevant training
- Inclusive economic growth that benefits all of Rotherham's communities
- Helping people to thrive and fulfil their potential
- Building social capital and helping neighbourhoods to flourish

11. Background Papers and Consultation:

Rotherham child poverty needs assessment 2011

Contact Name: Michael Holmes, Policy and Partnership Officer, (01709) 254417, michael.holmes@rotherham.gov.uk

Rotherham's poverty needs assessment 2014

Introduction

In response to the 2010 Child Poverty Act, which set ambitious national targets working towards eradicating child poverty by 2020, Rotherham partners prepared and published the borough's first child poverty needs assessment (CPNA) in 2011. This needs assessment informed the development of *Early Help*, our strategy to reduce inequalities for families.

With various data sources and local intelligence revealing the impact of the economic downturn and policies such as welfare reform on hard-pressed local communities, the time is right to both update the assessment and broaden it to look at all aspects of poverty.

The 2014 needs assessment looks at the issues and evidence from three distinct, but overlapping perspectives: child poverty, working age poverty and pensioner poverty.

For this, our first attempt at an all-encompassing assessment, there is still a strong emphasis on and more detailed analysis of child poverty. This reflects our statutory duty to prepare a child poverty needs assessment, the wealth of available information – including updated statistics from the existing CPNA - and the general focus of intervening early to break the cycle of poverty.

In addition, our updated "500 babies" analysis, a statistical look at the life chances of hypothetical children born in different parts of the borough, highlights the continuing inequalities between Rotherham's most and least deprived neighbourhoods.

This assessment will inform and underpin a range of strategies geared towards reducing or mitigating the effects of poverty, helping partners to target their resources where they are most needed.

Overview

What is poverty and why is it an issue?
Poverty is a relative concept relating to people who are considerably poorer than the majority of the population and have resources well below those of the average individual or family in their society. This excludes people in poverty from ordinary aspects of life which are the norm for the majority.

The Joseph Rowntree Foundation's definition of poverty is:

'When a person's resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation).'

A lack of financial resources severely limits the opportunities available to people and the life outcomes they can expect. Social mobility is difficult and most children born into poverty remain there for their whole lives. Poverty limits the ability of people to participate in society, change their lifestyles and determine their own destiny. This

results in fuel poverty, poor diet, unhealthy lifestyles, low aspirations and dependency.

Lack of work or low pay for those in work are the most common causes of poverty. Such economic disadvantage is often a reflection of low skill levels and a lack of qualifications, but disability and ill health can also be significantly factors, as can caring responsibilities. These factors make it difficult for people to maximise their economic potential.

What is the local picture and how do we compare?
In the Indices of Deprivation 2010, 17.6% of Rotherham's population, or 45,400 people, were dependent on means tested benefits or other low income, including 11,600 children aged 0-15 (23.5%).

In Rotherham, 29,280 people or 18.7% of the working age population are in receipt of DWP benefits, compared with 13.5% in England (February 2014). 72% of Rotherham claimants have been claiming benefit for over a year and 42% have been claiming for over 5 years. Working age families claiming DWP benefits include 11,965 dependent children, of whom 7,933 (66%) live in families claiming for over a year and 3,028 (25%) live in families claiming for over five years.

5.7% of all people aged 18-64 are claiming JSA but youth unemployment (aged 18-24) is more than twice as high at 12.7%.

Rotherham has 20,610 people on Disability Living Allowance (8% of the population compared with 5% in England) and there are 12,710 people claiming long term sickness benefits, 7.8% of those aged 16-64, compared with 6% in England.

Child poverty in Rotherham at 22.6% (2011) is slightly below the South Yorkshire average of 23.5% but above the UK figure of 20.1%

What is the trend and what can we predict will happen over time?
The number of people unemployed in Rotherham increased by 126% between 2008 and 2013 (February) although is now reducing. Long term unemployment has increased from 380 in 2008 to 2,660 in 2013 (+600%).

The Government's welfare reforms (2011-2018) are expected to increase and intensify deprivation in Rotherham by reducing the incomes of the poorest households, particularly people who are disabled or long term sick and families with children.

Despite anticipated growth in jobs and earnings, the Institute for Fiscal Studies forecasts an increase in poverty, with one in three children and nearly one in four working-age adults in relative income poverty (after housing costs) by 2020.

Child and family poverty

Background

Childhood experiences lay the foundations for later life. Growing up in poverty can damage physical, cognitive, social and emotional development, which are all determinants of outcomes in adult life. While some children who grow up in low income households will go on to achieve their full potential, many others will not. Tackling child poverty will help improve children's lives and enhance their life chances; enabling them to make the most of their talents, achieve their full potential in life and pass on the benefits to their own children.

Child poverty means growing up in a household with low income. This results in a standard of living that is well below the average and which most people would consider unacceptable today. Income poverty and material deprivation is therefore at the heart of tackling child poverty, however this is just the core of a series of complex issues and outcomes which harm children's development.

Research shows that children who grow up in poverty have a greater risk of having poor health, being exposed to crime and failing to reach their full potential. As a result their education may suffer, making it difficult to get the qualifications they need to move onto well-paid employment. This limits their ability to earn enough money to support their own families in later life, creating the ongoing cycle of poverty.

However, poverty is not solely related to income. Poverty of ambition and aspiration are also key factors in determining a child's life chances.

Demographics and key stats

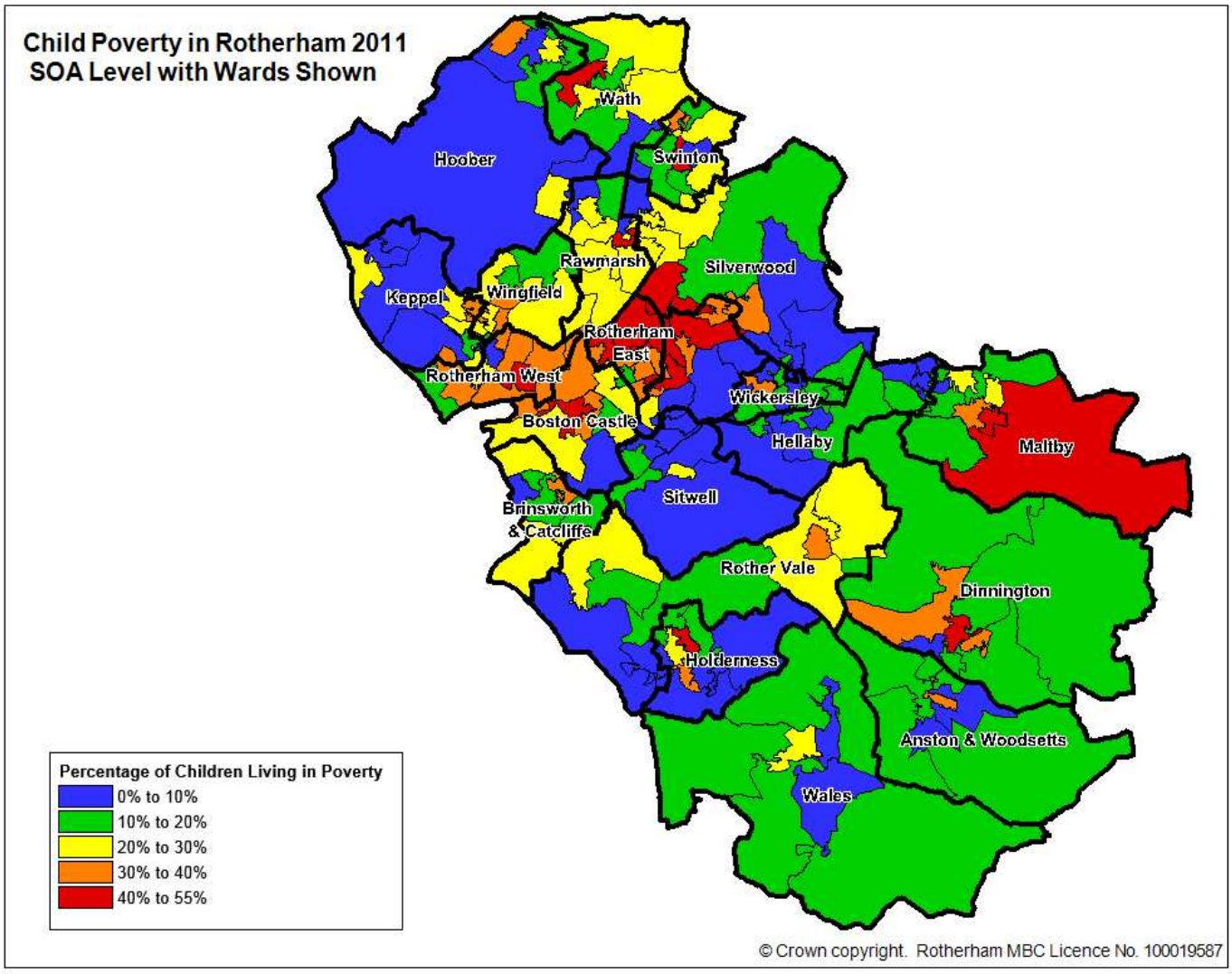
Rotherham has a population of 258,700 and the most recent population estimates (2013) show there were approximately 62,100 children and young people (aged 0-19) living in the borough representing 24% of the Borough's total population.

There are approximately 109,500 households in Rotherham (2013), 30% of which include dependent children. Lone parents with dependent children make up 7.3% of all households, which is slightly above the national average of 7.1% (2011 Census).

- Employment status (unemployed, l-t unemployed, p/t work, casual work, skills)
- Family composition (lone parents, number of children)
- Household income (wage levels, benefit levels, pensions?)
- Disability (of parents and children)
- Health (including mental health and drug/alcohol dependency)
- Teenage pregnancy

Rotherham's poverty needs assessment 2014

Map



Key messages

To be drawn from stats and lead into strategic context.

Strategic context

Early help, children's plan, HWB, resilience, economic growth.

Case study / pen portrait

Organisation or programme level data

Pupil premium, families for change (N.B. the focus needs to be on exemplifying or illuminating the situations of people living in poverty rather than evaluating the effectiveness of programmes)

Fuel poverty (SHU's Warm Well Families: Rotherham final report)
"Disconnection was something to be avoided at all costs. Most of the interviewees were on low income whether unemployed or on low wages. For all there was a

pervasive fear of debt 'not managing', of 'getting behind'. High bills were to be avoided. For that reason a pre-payment card was often the desired method of payment despite the knowledge that it may be more expensive than other payment methods.

Not facing a large unpredictable bill was important to participants in maintaining control when budgeting on a low income. Consequently disconnection by external agencies is avoided but self-disconnection becomes a regular feature of life, one to be managed in the same way as other life choices. The process can include degrees of self-disconnection, for example not heating particular rooms at all, not heating particular rooms at specific times and not heating the house at all. There would also be periods of total self-disconnection where the family had no cash left and were awaiting their next salary or benefit payment. The requirements of managing finances lead to competing priorities and consequences with self-disconnection a key management tool."

Working age poverty

- Background (include national context, how measured, broad trends: stagnant wages, growth of in-work poverty)
- Demographics and key stats (average pay, employment, benefits, cost of living/poverty)
- Key messages (low pay, insecure, need for mix of jobs and specific "poverty" targets as part of growth strategy, skills, addiction, mental health, housing)
- Local strategic context (growth strategy, HWB, resilience)
- Map
- Case study / pen portait (food in crisis, struggling working family)
- Organisation or programme level data (CAB/debt, food in crisis, fund for change)

Pensioner poverty

- Background (include national context, how measured, broad trends)
- Demographics and key stats (occupational pensions legacy/pension credits, specific BME issues?)
- Key messages (fuel poverty, cost of living, care costs, claiming benefits, transport)
- Local strategic context (HWB)
- Map
- Case study / pen portrait
- Organisation or programme level data (Rotherham Less Lonely, Age UK)

National stats (linked to "living on low income.." report on Age UK national website)

- 1 in 6 pensioners (1.8 million or 16% of pensioners in the UK) live in poverty, defined as 60% of median income after housing costs
- Pensioners are also the biggest group of people on the brink of poverty with 1.2 million on the edge

- Low income in retirement is often linked to earlier low pay, or time out of employment - for example, due to caring responsibilities, disability or unemployment
- Women, those aged 80 to 84, single people living alone, private tenants, and Pakistani and Bangladeshi people are at greater risk of pensioner poverty
- The numbers of people living on low income fell between 1997/98 and 2004/5; since then there has been little improvement

Key messages from Age UK Rotherham (meeting with Lesley Dabell 03/09/14)

- Though research shows that older people are particularly keen to avoid debt (Age UK, "living on low income in later life"), there is anecdotal evidence of increasing debt for older people, including credit card and utilities debt.
- Pension credit take up is lower than might be expected in Rotherham due to high number of occupational pensions from traditional industries. This is likely to change with next generation.
- Impact of caring (especially "younger old people") with people having to cut down or stop working leading to reduced income and pension
- Fuel poverty – access to advice/info on best deals as well as improving energy efficiency of homes
- Older people more likely to be asset rich / cash poor, but difficult to realise asset (i.e. sell house) as could mean moving away from friends/family
- Rural isolation – transport costs
- Look at attendance allowance stats as Rotherham has high proportion of older people with an illness/long-term condition
- See older people's forum consultation on priorities

ROTHERHAM BOROUGH COUNCIL – REPORT TO CHILDREN, YOUNG PEOPLE AND FAMILIES PARTNERSHIP

1.	**Meeting:**	**Children, Young People and Families Partnership**
2.	**Date:**	**24 September 2014**
3.	**Title:**	**Emotional Wellbeing & Mental Health Strategy**
4.	**Programme Area:**	**NAS**

5. Summary:

The draft Emotional Wellbeing and Mental Health Strategy 2014-19 has been produced to support Local Authority and Health Commissioners and service providers to improve the emotional health and wellbeing of children and young people in Rotherham.

The final draft of the Strategy and associated action plan, which has been widely consulted upon, is attached to this report and outlines the key recommendations and actions to be taken forward.

6. Recommendations:

That Children, Young People and Families Partnership:

6.1 Endorse the final draft of the Emotional Wellbeing & Mental Health Strategy 2014-19

7. Background

The draft Rotherham Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-19 has been produced by RCCG Commissioners, RMBC Commissioners and RMBC Public Health and draws on national and local guidance, local needs information, surveys of local emotional wellbeing and mental health services and information from key stakeholders.

The strategy includes sections on the scope of the strategy, the needs of children and young people, services in Rotherham, investment, challenges and risks and recommendations. The strategy and needs analysis are attached to this report.

The strategy went out for consultation to a wide range of stakeholders, including RMBC CYPS, schools, colleges, NHS providers and VCS providers, in June and July 2014. There have also been specific consultation sessions with parents/carers and with the Youth Cabinet.

The responses from consultation have been evaluated and the draft Emotional Wellbeing and Mental Health Strategy was substantially amended to take into account the comments that have been made. In addition, the Health Watch Rotherham report on Child and Adolescent Mental Health Services was reviewed to ensure that the key findings are addressed within the strategy.

The Rotherham CCG commissioned Attain, an independent sector consultancy organisation, to review CAMHs and their report was considered by the CCG and the Attain recommendations that the CGG agreed to take forward, have been included within the strategy.

The key recommendations outlined within the Strategy are as follows:

Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10 - Promote the prevention of mental ill-health.

Recommendation 11 - Reduce the stigma of mental illness.

Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

It should be noted that as the governance process progresses for final approval of the Strategy, the key recommendations and actions are already being acted upon. The development of multi-agency care pathways is a priority piece of work and will address a number of issues in relation to thresholds/access to services and pathways such as post diagnosis ASD. A workshop with stakeholders has been held and is informing the work of small time-limited working groups that have been established for each multi-agency pathway.

The Strategy, once considered by the Children, Young People and Families Partnership, will be submitted to the Health and Wellbeing Board for final approval at its meeting on 12 November 2014.

8. Finance

There are no financial implications at this stage. There may be financial implications arising from implementing the recommendations contained within the Emotional Wellbeing & Mental Health Strategy. Any such financial implications that arise will be fully outlined within future reports that are submitted through governance structures.

9. Risks and Uncertainties

- That the Emotional Wellbeing & Mental Health Strategy recommendations are not implemented within timescales.

10. Policy and Performance Agenda Implications

- Rotherham Health and Wellbeing Strategy 2012-2015
- Ofsted framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers

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Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

DRAFT

Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19

Version 3.1

Version Number	Revision date	Summary of Changes	Change By	Changes accepted
1.1	26.02.14	First draft following initial meeting	SM	Yes
1.2	27.02.14	Updated tier information with data from consultation	SM	Yes
1.3	04.03.14	Amendments & additions from PT & RFB	SM	Yes
1.4	04.03.14	Amendments following meeting with PT & RFB	SM	Yes
1.5	05.03.14	Format amendments	SM	Yes
1.6	05.03.14	Amendments & additions from NP	SM	Yes
1.7	06.03.14	Amendments & additions from NP Changes at Strategy Meeting	SM	Yes
1.8	10.03.14	Updated pyramid model & recommendations	SM	Yes
1.9	11.03.14	Updated with amendments from PT, RFB, NP & Miles Crompton	SM	Yes
1.10	12.03.14	Updates at CAMHS Strategy & Partnership Meeting	SM	Yes
1.11	19.03.14	Amendments from RFB, NP, BM and comments from Healthwatch	SM	Yes
1.12	24.03.14	Amendments following meeting	SM	Yes
1.13	07.04.14	Amendments following consultation	SM	Yes
1.14	08.04.14	Amendments from BM	SM	Yes
1.15	08.04.14	Meeting amendments	SM	Yes
1.16	09.04.14	Further additions following meeting	SM	Yes
1.17	06.05.14	Additions & amendments following meetings	SM	Yes
2.0	06.05.14	Ready for consultation	SM	Yes
2.1	19.05.14	Amendments regarding PRUs	SM	
2.2	28.05.14	Addition on page 28 on Family Nurse Partnership	SM	
2.3	10.07.14	Reductions	SM	
2.4	17.07.14	Amendments	SM	
2.5	01.08.14	Amendments following review by PT	SM	
2.6	28.08.14	References added	SM	
3	10.09.14	Final amendments made	SM	
3.1	11.09.14	Final draft following final amendments by RFB & NP	SM	

Approval Process			
Name/Meeting	**Date of Issue**	**Version Number**	**Approved**

Contents

Executive Summary

Traditionally mental health in the UK has had not had parity with physical health (Royal College of Psychiatrists, 2013). As a result there is a perception that children and young people with a mental health problems have not benefited from equitable treatment compared to those with physical conditions.

There has recently been a re-focus on mental health and a key policy initiative is to achieve 'parity of esteem' with physical health.

There is good reason why there must be this change in focus and particularly for children & young people when the following key facts are considered:

- One in ten children aged between 5 and 16 years has a clinically diagnosable mental health problem. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1–2% have severe ADHD;
- At any one time, around 1.2–1.3 million children will have a diagnosable mental health disorder;
- Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters before their mid-20s;
- The rates of disorder rise steeply in middle to late adolescence. By 11–15 it is 13% for boys and 10% for girls, and approaching adult rates of around 23% by age 18–20 years;
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed) but only a fraction of cases are seen in hospital settings;
- Although effective treatments are available only around 25% of those who need such treatment receive it;
- 11–16 year olds with an emotional disorder are more likely to smoke, drink and use drugs;
- Around 60% of Looked After Children and 72% of those in residential care have some level of emotional and mental health problem. A high proportion experience poor health, educational and social outcomes after leaving care;
- Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood;
- One third of all children and young people in contact with the youth justice system have been looked after. It is also important to note that a substantial majority of children and young people in care who commit offences had already started to offend before becoming looked after;
- Young people in prison are 18 times more likely to take their own lives than others of the same age;
- The costs of mental health problems for the English economy have recently been estimated at £105 billion per annum;
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing, poor physical and mental health, and have lower rates of economic activity in adult life; and
- Young people in prison are 18 times more likely to take their own lives than others of the same age.

It is also clear that focusing on the mental health issues of children and younger people can help to reduce the numbers of patients who continue to experience mental health issues into adulthood.

Key stakeholders in Rotherham (RCCG, RMBC and RDaSH) came together in March 2014 with the purpose of developing a strategy for the emotional wellbeing and mental health of children and young people in Rotherham. A thorough evaluation was undertaken of both national and local guidance around the mental health of children and young people in order to identify the key themes which would need to be addressed in a comprehensive strategy.

The next stage was to understand the specific mental health needs of children & young people in Rotherham, and information was collated from both national and local research initiatives. The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors and it is estimated that in Rotherham it is 14% above the UK average.

The development of the strategy has been informed by formal input from all key stakeholders, including parents/carers, young people and stakeholders in both the statutory and voluntary/community sectors.

Child and Adolescent Mental Health Services (CAMHS) in Rotherham are commissioned in 4 Tiers:

- Tier 1/Universal services are delivered by a range of providers including GPs, Health Visitors, School Nurses, Social Workers and voluntary services and offer general advice and identify mental health problems earlier in their development.
- Tier 2 services are delivered, usually on a 1:1 basis, by professionals with training in mental health, including RDaSH CAMHS, Integrated Youth Support Services (IYSS) and Rotherham & Barnsley MIND.
- Tier 3 provides specialist services for more severe, complex or persistent disorders, usually through multi-disciplinary teams. Providers include RDaSH, IYSS, Rotherham & Barnsley MIND and the Child Development Centre.
- Tier 4 provision is similar to Tier 3 in that it is provided by multi-disciplinary teams but in inpatient or highly specialised outpatient units.

Tier 1, 2 and 3 services are currently commissioned predominantly by RCCG and RMBC. Tier 4 services are commissioned by NHS England.

The strategy outlines examples of service provision in each of the 4 Tiers and highlights ‘additional required delivery’ in each area taking into consideration local needs and national guidance.

This additional service delivery has been condensed into 12 key themes or recommendations as follows:

Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations.

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Recommendation 11 - Reduce the stigma of mental illness.

Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

Whilst the above 12 recommendations are not exhaustive, it is felt that they are the basis of a robust emotional wellbeing and mental health strategy and will improve the mental health of the children and young people of Rotherham.

These recommendations have been incorporated into an Action Plan, as detailed in Appendix 6, and the stakeholders identified in that document will work together to implement the recommendations within the agreed timescales. It is important to see this action plan as a dynamic and long term document which will facilitate the implementation of the strategy over the next few years.

1. Introduction

Improved emotional health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse,
- reduced risk of suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- higher levels of social interaction and participation

Source - various including Annual Report of the Chief Medical Officer 2012

The emotional health and wellbeing of children and young people is nurtured primarily at home, however everyone delivering children and young people's services (particularly early years and schools) has a role in improving outcomes and reducing inequalities. This includes supporting the public to make healthier, informed choices to improve emotional health and wellbeing and to improve access to services where and when they are needed.

This Strategy has been produced to support Local Authority and health commissioners and service providers to improve the emotional health and wellbeing of children and young people (0 to 18 years) in the borough of Rotherham. It is the second strategy for emotional health and wellbeing of children and young people in Rotherham. The Strategy builds on the information provided by the Emotional Health and Wellbeing Analysis of Need 2014.

The Strategy has been developed in partnership with a range of organisations that work to deliver child and adolescent mental health services across the borough and is based on existing research and the results of various consultations undertaken by the Rotherham Metropolitan Borough Council (RMBC), NHS Rotherham CCG (RCCG) and other partners.

Actions and work resulting from the Strategy will be further informed by research and information, including the work of Healthwatch and other partners.

In addition, RCCG commissioned Attain Commissioning Services to undertake a comprehensive review of mental health services provided by Rotherham Doncaster and South Humber NHS FT (RDaSH). This was completed in May, 2014 and the results have contributed to the development of this Strategy.

Action to implement this strategy will only be effective if there is sustained partnership working across all sectors. To facilitate this partnership working a 'CAMHS' Strategy and Partnership Group (terms of reference can be found at Appendix 3) has been established, which will report into the Rotherham Health and Wellbeing Board.

2. Scope

2.1 Vision

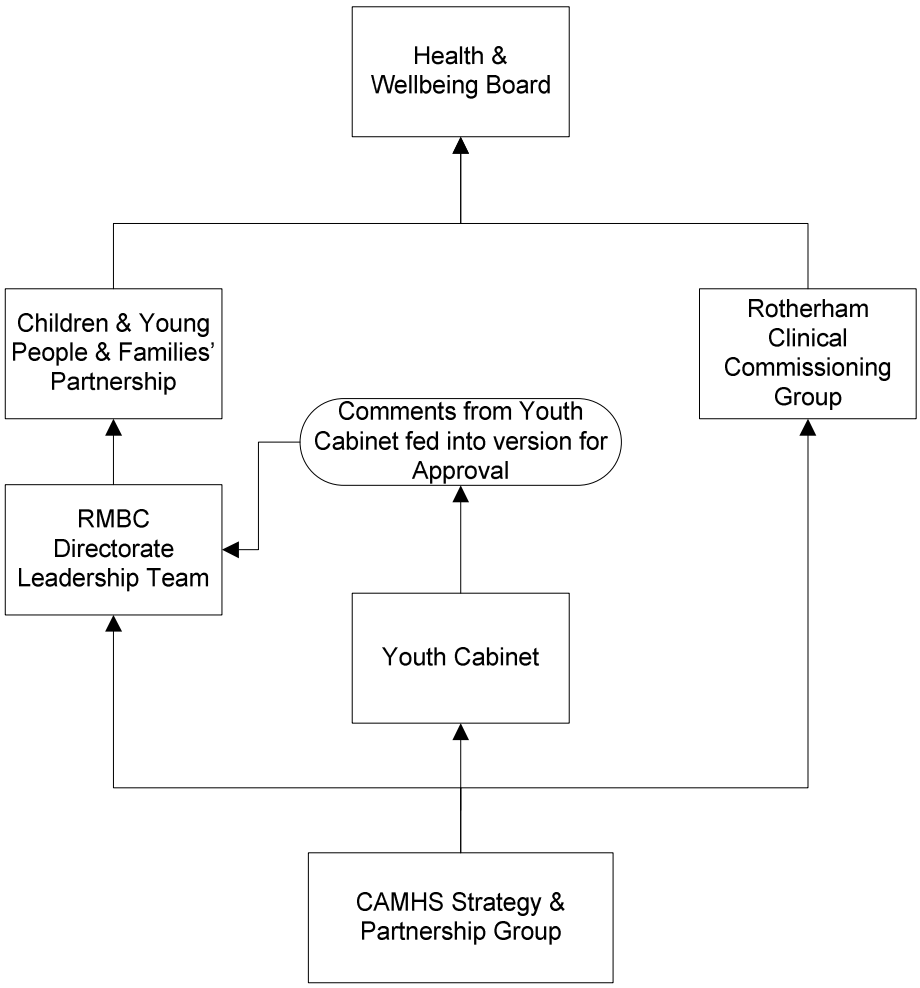
Our vision is for the children and young people of Rotherham to have the best possible emotional health and wellbeing, to build social and emotional resilience, promote good parenting skills and for our services to identify problems early and respond to them quickly.

2.2 Governance

The strategy will require approval from Rotherham Clinical Commissioning Group, RMBC's Directorate Leadership Team and Children and Young People and Families Partnership as well as being presented to young people via Youth Cabinet before final approval is granted by the Health and Wellbeing Board.

Once approved, ongoing monitoring will be undertaken by the CAMHS Strategy & Partnership Group and update reports will be fed into both RCCG and RMBC governance procedures, as well as ensuring that children and young people are kept up to date with progress and have an opportunity to feed in their views and comments. Figure 1 below sets out the approval and reporting processes.

Figure 1 Approval & Reporting Process



2.3 Tiered Approach to Services

A wide range of services play an important role in the promotion and support of children and young people's emotional health and wellbeing. They work together to deliver a four tier model of Child and Adolescent Mental Health Services (CAMHS) as outlined in *Together We Stand* (Health Advisory Service, 1995). This model is illustrated in Figure 2.

The following is a definition of child and adolescent mental health services:

> *Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone*
>
> Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Appendix 5 contains a diagram which combines the conventional 'Tiered' model with a Social Services 'Windscreen' model. This maps specific local Rotherham services across the different levels of service provision and demonstrates that a majority of services can be found in Tier 1 which supports an early intervention and prevention approach.

Table 1 shows the different levels of the tiered approach, together with information on the types of service to be found at each level.

2.4 Commissioning

Commissioning is the process through which the needs of people are assessed, potential resources available to meet those needs are identified and decisions are taken about how best to use resources to maximise outcomes.

In the area of emotional health and wellbeing, responsibility for commissioning and providing services at each of the tiers shown in Figure 2 lies with a number of agencies.

Tier 1 services are wide ranging, open access provision. Some Tier 1 services are commissioned via the Local Authority and Health, whilst others are non-commissioned services, such as those in the wider voluntary sector.

In terms of Tier 2 and 3 child and adolescent mental health services, commissioning is led by RCCG on a regional basis from Rotherham, Doncaster and South Humber NHS Foundation Mental Health Care Trust (RDaSH). RMBC's Children and Young People's Services (CYPS) are a partner in this commissioning model which is led by RCCG.

Services for children and young people commissioned by RMBC are commissioned in line with the Children and Young People's Commissioning Strategy. Services commissioned by RCCG are commissioned in line with the NHS Rotherham CCG Commissioning Plan. A small amount of child and adolescent mental health services activity is also commissioned by RCCG from other local providers where Rotherham patients access services which are

geographically more convenient. These providers include; Sheffield Health and Social Care, Nottinghamshire Healthcare, and South West Yorkshire NHS FT.

Tier 4 services are commissioned by NHS England from specialist providers.

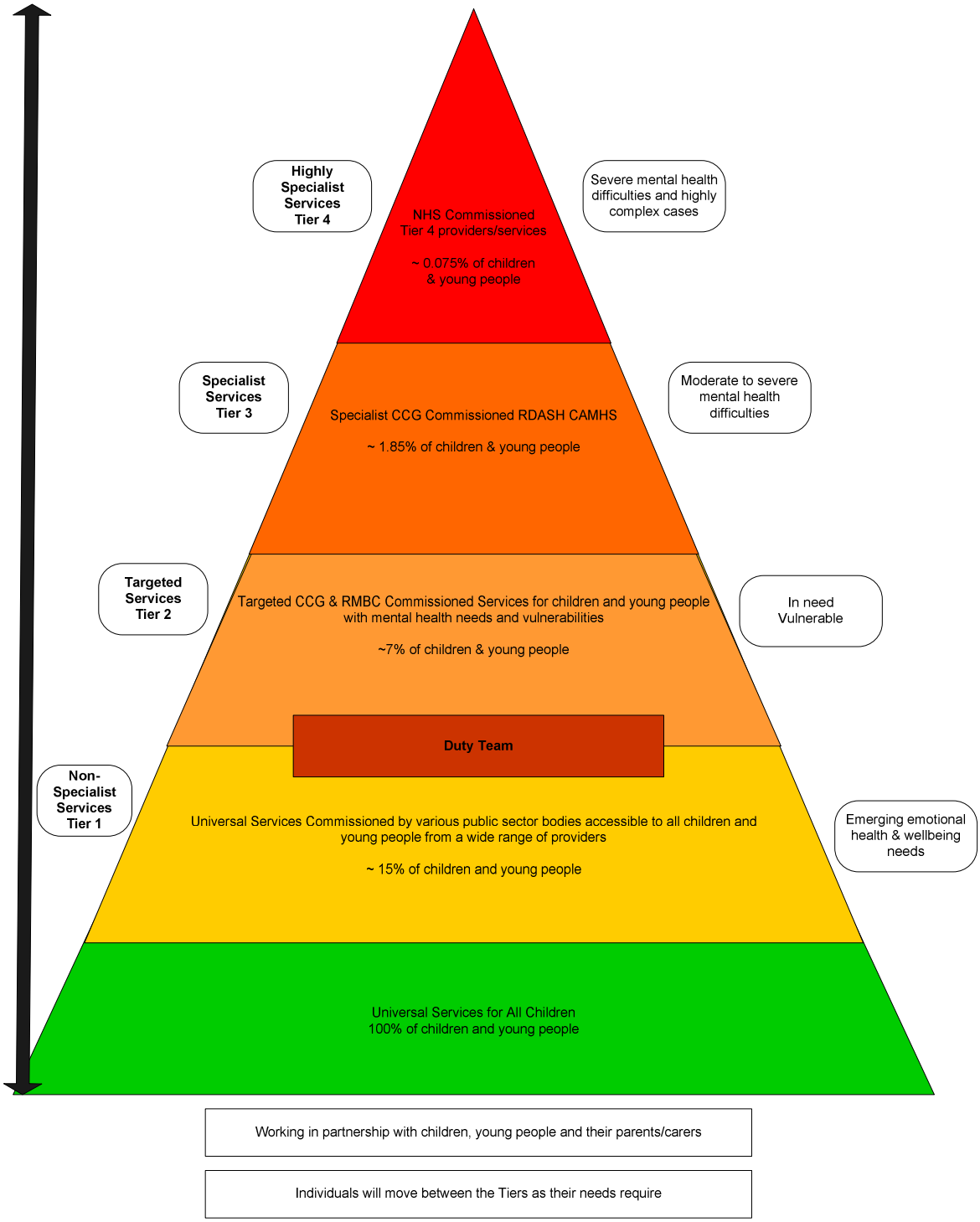
2.5 Analysis Of Need

A separate report - Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People 2014 sets out the various national guidance, such as 'No health without mental health' and 'Closing the Gap' which has informed this Strategy. In addition, the report also references local guidance and details the results of a needs analysis for Rotherham both of which have also been taken into account when formulating recommendations and subsequent action plans.

This strategy and its recommendations will inform commissioning activity for both the CCG and RMBC for 2014-19 as we endeavour to deliver additional value for money, achieving 'more for less'.

Figure 2

Comprehensive Child & Adolescent Mental Health Services in Rotherham (CAMHS)



Kurtz Z,1996.

NB Figures and percentages in each Tier are estimates based on national prevalence numbers

Table 1

Tier	Description	Professionals providing the service include but are not limited to	Function/Service
4	Essential tertiary level services such as day services, highly specialised out-patient teams and in-patient units	Services provided by professionals, usually on the basis of a multi-disciplinary team approach • Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community or inpatient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists Family Therapists	• Child and adolescent inpatient units • Secure forensic units • Eating disorder units • Specialist teams (e.g. for sexual abuse) • Specialist teams for neuro–psychiatric problems
3	Specialised services for more severe, complex or persistent disorders such as depression & eating disorders		Services offered by multi-disciplinary teams: • Assessment and treatment • Assessment for referral to T4 • Contributions to the services, consultation and training at T1 and T2
2	Services provided by professionals with training in mental health	Services provided by professionals, usually on a 1:1 basis • RDaSH CAMHS workers eg social workers, therapists, nurses, doctors, psychologists • IYSS Youth Start • Rotherham & Barnsley Mind • Education psychologists	Child and adolescent mental health services professionals should be able to offer: • Training and consultation to other professionals (who might be in T1) • Consultation to professionals and families • Outreach • Assessment • Therapeutic interventions
1	Services provided by a wide range of commissioned and non-commissioned providers	Services provided by professionals, usually on a 1:1 basis • GPs • Midwives • Health visitors • School nurses • Social workers • Teachers & pastoral support • Integrated Youth Support workers • Education psychologists • Paediatricians • Voluntary services	Child and adolescent mental health services at this level are provided by professionals working in universal services who are in a position to: • Identify mental health problems earlier in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention

3. Services in Rotherham

3.1 Tier 1

Services in Tier 1 are provided by practitioners working in universal services which can be accessed by any child or young person and are not necessarily mental health specialists. Services within this Tier are predominately open referral and are delivered in a variety of settings which are regularly accessed by children and young people, such as children's centres, schools, youth centres, GP practices etc. See Appendix 5 for examples of Tier 1 services.

In addition to the services included in Appendix 5, there are also a variety of support services which support schools at very early levels of intervention. These include; The Autism Communication Team, Behaviour Support Service and Learning Support Service.

Tier 1 services provide the following:

- General advice
- Promote mental health and wellbeing
- Focus on early support around reducing risk taking
- Offer practical support
- Offer listening services
- Support parents
- Help identify, refer on and support children and young people who may require targeted or specialist services

A Common Assessment Framework (CAF) may be required where referral is needed.

3.1.2 Work to Support Tier 1 Activity

3.1.2.1 Targeted Mental Health in Schools (TaMHS) (Wolpert et al. 2011)

Targeted Mental Health in Schools (TaMHS) was a 3 year national project established in 2008 and supported by Department for Children, Schools and Families and the National Child and Adolescent Mental Health Services Support Service. Following the success of the TaMHS work in Rotherham there has been a conference for schools held in the borough for the last 3 years, focusing on mental health and emotional well-being. The conference last year focused on the wider determinants which can impact on a families' mental and emotional well-being; a seminar is planned for 2014 with a focus on loss and bereavement. it is anticipated that the conferences will be ongoing.

3.1.2.2 Mental Health Training for Tier 1/Universal Workers

Both Rotherham Public Health and Rotherham and Barnsley Mind have been providers of training for universal workers on a variety of mental health issues. These include Youth Mental Health First Aid Training and Self-Harm training.

RDaSH CAMHS are commissioned by RCCG to provide training and support to Tier 1 services.

3.1.2.3 Rotherham Healthy Schools Programme

The Healthy Schools consultant raises awareness of local and national issues, resources and opportunities relating to wellbeing with schools via a variety of methods, in order to support schools to address issues relating to wellbeing. Issues mentioned by the schools are also raised in appropriate forums to raise awareness of upcoming need. Partnership working is key.

Examples of activity relating to wellbeing support for schools are:

- Local Rotherham Healthy Schools Programme devised to reflect local priorities and school needs.
- PSHEe curriculum work supported relating to Relationships and Sexual Health, including Child Sexual Exploitation, Domestic Abuse and positive teenage relationships.
- Update of the Rotherham Healthy Schools Scheme of Work for Personal, Social, Health and Citizenship Education – Primary phase, to include current issues in an age appropriate way. This includes domestic abuse, anti-homophobic bullying and an enhancement of e-safety which therefore supports prevention work on child sexual exploitation.
- Rotherham Healthy Schools Wellbeing Roadshow devised and piloted. External agencies have the opportunity to interact with parents/carers from the school communities to promote their services and support the wider school community at an existing school event.
- Promotion of the Childline input 'This is Abuse' to primary phase schools for Y5&6.
- In conjunction with Public Health, developing and disseminating a drug education resource on MCAT for staff working with Rotherham Young People
- Working with key partners, updated the LA Anti-Bullying Guidance for schools.

3.1.3 Additional Required Delivery Based on Evidence in Analysis of Need

3.1.3.1 All services in Tier 1 to recognise their role in focusing on prevention and strengthening resilience in young people *(Recommendation 10)*

Prevention of mental ill health and promotion of good mental health is the responsibility of all Tiers within CAMHS .The development of the pathways will include a focus on best practice for building resilience amongst young people. Preventative and resilience messages and healthy lifestyle advise, for example; Connect, Be Active, Be Creative and Play, Learning and Take Notice (The Children's Society 2013) will be incorporated into Tier 1 training. In addition the development of a Public Mental Health Strategy, as recommended in the Rotherham Director of Public Health Annual Report (2013/14),will focus on a local commitment to promote mental health and build emotional resilience across the whole of the population in Rotherham.

3.1.3.2 Improved & quicker access to services *(Recommendation 12)*

Work will be undertaken to improve access to Tier 2 services and Tier 2 and 3 RDaSH CAMHS. Work will include:

- Developing a Tier 1 screening tool with clear onward referral criteria
- Enhanced monitoring of the young person's journey and experience
- Improved links across all tiers
- Mechanism to raise service issues ('Issues Log')
- Improved understanding of access and referral processes
- Further development of self-referral into Tiers 2 and 3 child and adolescent mental health services
- Prompt access including out of hours support
- Developing clear care pathways
- Scoping of a 24/7 service

3.1.3.3 Continue to foster good working relationships between workers in Tiers 1, 2 and 3

This work will include, for example, looking at relationships between schools, GPs and IYSS so that these services are assisted and supported in identifying mental health problems as soon as possible.

3.1.3.4 Development of a self-harm pathway *(Recommendation 2)*

A pathway and guidance for use by universal workers will be produced in conjunction with children's mental health services and universal services. The Youth Cabinet will be consulted and involved in the content.

3.1.3.5 Tier 1 workforce development *(Recommendation 6)*

To have a borough wide training plan for Tier 1 workers to include minimum requirements for staff. This will inform the future commissioned training programmes that will be provided by RDaSH CAMHS, RMBC and the voluntary and community sector.

3.1.3.6 Access to good, safe and accurate information *(Recommendations 1 and 3)*

Involve young people to develop user-friendly information/media messages. Ensuring that children, parent/carers and professionals have access to good information resources in order to promote children's emotional wellbeing through a variety of media ie print, telephone and internet, including new technology and social media.

RDaSH is currently developing the use of technology through the 'Digital First' and '3 Million Lives' initiatives.

3.1.3.7 Continued mapping of Tier 1 provision *(Recommendation 6)*

To continue to map Tier 1 activity through revisiting the directory of services and ensuring that this information is available to other Tier 1, 2 and 3 workers, parents/carers and young people. Mapping of Tier 1 services will ensure that future commissioning considers any changes within the wider child and adolescent mental health services provision. This includes mapping changes in capacity and/or resource.

A directory of services has been developed and is regularly updated and shared with relevant key stakeholders.

3.1.3.8 Develop Self-help and Peer Support *(Recommendation 3)*

Develop consistent self-help messages to be promoted by Tier 1 services for use by children, young people, parents and carers. Develop peer support and 'expert by experience' to support young people to develop coping strategies and promote wellness principles.

3.1.3.9 Take action to reduce the stigma and discrimination associated with mental health problems *(Recommendation 11)*

To work across the Tiers, in partnership with young people, to tackle stigma and discrimination associated with mental health problems. This will be through coordinated action at a borough wide level, as specified in the action plan. Individual services/organisations will be encouraged to consider this in their day to day work.

3.1.3.10 Rotherham Healthy Schools Programme *(Recommendation 10)*

To refine the Programme's Wellbeing Road Show and raise awareness of the programme with key partners together with planning a roll out across Rotherham Schools and Early Years settings.

Distribute updated Rotherham Healthy Schools scheme of work for personal, social, health and citizenship education – delivering primary phase resource to remaining Rotherham Schools.

Continue to promote the Childline input 'This is Abuse' to primary phase schools for years 5 and 6 so that all schools are involved by 2017.

Continue to support curriculum development relating to local and national priorities, including the understanding of 'consent' and work around bereavement.

Promote Samaritans guidance for schools "Help when we needed it most" and the pathway for self harm/suicide in schools.

3.1.3.11 Access for patients from vulnerable groups *(Recommendation 3)*

Carry out equality impact analyses of services to ensure that patients from vulnerable groups have equality of access to emotional wellbeing and mental health

services in Rotherham. From the information gathered an action plan should be developed to address areas where vulnerable groups are not accessing services at predicted rates.

3.1.3.12 Special Educational Needs and Disability (Children & Families Bill 2013) *(Recommendation 3)*

Ensure that future service provision reflects the changes called for in respect of children with special educational needs and disability. Specifically the need to reflect an extended age range to 25 years, to undertake joint 'Health & Care' plans, to be able to offer personal budgets to families and ensure that they are involved in reviewing and developing service provision. Work is ongoing across partner organisations to deliver the requirements of the Bill.

3.2 Tier 2

Tier 2 services offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 2 services are more targeted services and are frequently accessed by referral from other professionals. Services within this Tier include IYSS Youth Start, Rotherham and Barnsley Mind, Education Psychology and RDaSH CAMHS Tier 2.

Provision at Tier 2 is provided by an individual mental health practitioner and includes assessment and intervention. This could include improving emotional resilience, promoting positive behaviours, developing coping strategies and improving the self esteem of children and young people and the use of specific psychological therapy or medication. See Appendix 5 for examples of Tier 2 services.

3.2.1 Current Delivery

3.2.1.1 IYSS Youth Start

The service provides open access/self-referral for young people aged 11 years and above in order that young people can access when they feel they need the service.

The service now operates from the IYSS Youth Hub which houses a wide range of children and young people's services on an open access basis, where the holistic needs of the young person can be addressed.

3.2.1.2 Joint Youth Start/RDaSH CAMHS Mental Health Clinic

A joint Youth Start/RDaSH CAMHS Mental Health Clinic has been developed and is in operation at the IYSS Youth Hub at the Eric Manns Building in the centre of Rotherham. The Clinic provides for joint assessment and referral into child and adolescent mental health services to the service which best meets the needs of the young person (Youth Start, RDaSH or alternative services ie Mind etc).

The RDaSH CAMHS service has worked alongside the Youth Start service to develop an opportunity for young people aged 14 years and above to self refer into RDaSH CAMHS.

3.2.1.3 Rotherham and Barnsley Mind

Rotherham and Barnsley Mind contribute to the delivery of Tier 2 child and adolescent mental health services within Rotherham by use of a multi-agency team offering mental health support to children and young people up to the age of 18 years. The service is provided in a range of schools and community settings across the borough where children and young people are able to access 1:1 support from a trained professional through delivery of 1:1 mental health support clinics. The service offers a range of consultation opportunities including telephone and face-to-face advice.

The service has also provided of a range of Tier 1 multi-agency mental health training and provided support to Tier 1 staff working directly with children and young people in universal services.

3.2.1.4 RDaSH CAMHS

The service provides a range of Tier 2 targeted services and links with universal services, attending locality meetings with GPs and surgery visits, IYSS, LAAC, Heads of Schools meetings, Primary and Secondary School SENCOs support meetings, Supervision and support to the Family Recovery Programme and the Rowan Centre, engagement with South Yorkshire Fire and Rescue services and engagement with secondary schools/ academies. RDaSH has also delivered presentations to school nurses, health visitors and Child Development Centre staff at the Additional Needs training event. RDaSH also supports and liaises with Public Health, addressing issues around suicide and self-harm and delivering self-harm seminars at local conferences.

The clinical lead has attended the Key working 'train the trainer' to address the Children and Families Act (2014) (the SEND agenda) and takes an active role in the SEND strategy group.

3.2.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.2.2.1 Define Tier 2 interventions *(Recommendation 1)*

Define the level of intervention at Tier 2 and interactions with other Tiers as part of multi-agency pathway developments.

3.2.2.2 Tier 2 workforce skills and competencies *(Recommendation 4)*

To have a borough wide minimum requirement for skills and competencies for Tier 2 staff.

3.2.2.3 RDaSH CAMHS locality workers model of provision *(Recommendation 3)*

To ensure that a locality model of provision is developed, which includes RDaSH CAMHS locality workers working directly with IYSS locality teams and provide specialist support to a range of services in that locality, eg schools, colleges and GPs.

3.2.2.4 Transitions between young people's services and adult services *(Recommendation 7)*

The RDaSH CAMHS service has employed Peer Support Workers (PSWs) who assist in the transition of young people who require on-going mental health support beyond their 18th birthday. Transition work commences at 17½ years. Further work to improve the transition between services is required, particularly within the ADHD pathway and in relation to young people who are first identified around the transition point of age 17 years approaching 18 years.

There are additional challenges where patients also have Learning Disabilities and will need to transfer to specialist Adult LD services.

3.2.2.5 Development of interfaces between services *(Recommendation 2)*

Development of clear interfaces between services across a range of interventions, including within tiers and inter-tier for step-up and step-down support.

3.3 Tier 3

Services in Tier 3 are usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

The RDaSH CAMHS team provides an integrated tier 2 and tier 3 approach to service delivery in order to support a smooth journey for the young person and their family. Tier 3 aspects of service delivery are focussed on more multi-disciplinary interventions and complex cases. The team employs specialist staff, including child and adolescent psychiatrists and a broad range of other staff who provide a range of therapies including art therapy, cognitive behaviour therapy, family therapy and psychotherapy. See section 3.3.1 for further details.

The RDaSH CAMHS team also provides an integrated service for patients with Learning Disabilities (LD). A specialist team provides support to LD patients with specific interventions as required. There are also a number of LD patients with associated conditions such as ASD and challenging behaviour and these require specific individual treatment. There are cases where such patients require Tier 4 services. This can be challenging when such patients step-down from Tier 4 to Tier 3.

Other providers of Tier 3 services include the Child Development Centre (CDC), The Rotherham Foundation Trust (TRFT) Paediatrics, Youthstart, The Looked After and Adopted Children Children's (LAAC) Support and Therapeutic Team, Educational Psychologists and Rotherham & Barnsley MIND.

3.3.1 Current Delivery

3.3.1.1 RDaSH CAMHS Duty Team

Introduction of the duty team within RDaSH CAMHS which allows anyone to contact the service between 9am and 5pm Monday to Friday for advice and consultation on referrals and support. This service is provided by a range of child and adolescent mental health services practitioners from the team.

3.3.1.2 RDaSH CAMHS Integrated Managerial and Clinical Leadership Team

There has been an improved and strengthened integrated leadership team, which incorporates generic tier 2 and 3 child and adolescent mental health services, Learning Disability services and Know the Score (young people's substance misuse service).

3.3.1.3 RDaSH Clinical Supervision Group

Introduction of group clinical supervision to support clinicians with complex cases. The group includes a range of professional backgrounds, including psychiatry, nursing, family therapy, occupational therapy and social work.

3.3.1.4 RDaSH Clinical Pathway Reviews

Review of pathways, particularly the ASD and ADHD pathways within the RDaSH services in order to streamline assessments and diagnostic procedures and minimise delays in assessment which have been previously identified. There are future plans to align this further with CDC.

3.3.1.5 Improved RDaSH CAMHS Reporting

Improved performance reporting information and progress towards meeting waiting time key performance indicators (KPIs). All referrals are triaged for urgency within 24 hours and urgent referrals assessed within 24 hours of receipt of referral currently. RDaSH CAMHS are working towards a referral to routine assessment target of 15 working days.

3.3.1.6 RDaSH Outcome Measures

Introduction of routine outcome measures across the service, including 'impact' and 'symptom' trackers, with options of session-by-session feedback available to be collected to review progress.

3.3.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.3.2.1 Improved access to advice and support *(Recommendation 3)*

Improved access to advice and support from specialist RDaSH child and adolescent mental health services workers.

3.3.2.2 Routine Outcome Measures*(Recommendation 9)*

Further development by RDaSH and Rotherham & Barnsley MIND of the Children & Young Peoples Improving Access to Psychological Therapies (CYP IAPT) work which developed the use of routine outcome measures

3.3.2.3 Improved links with other tiers (*Recommendations 2 & 3)*

Improved links with other tiers through further development of the RDaSH Locality Worker role.

3.3.2.4 Improved understanding of access and referral processes for Universal/Tier 1 services *(Recommendations 6 & 8)*

Undertake work to improve the access & referral processes for Tier 1/Universal Services when accessing Tier 3 services.

3.3.2.5 Further development and establishment of self-referral *(Recommendation 3)*

RDaSH and the RMBC IYSS services to work together to further develop the self-referral services which have been implemented.

3.3.2.6 Out of hours support when in crisis *(Recommendation 5)*

Further development work to be undertaken to clarify and improve the RDaSH CAMHS Out of Hours service, particularly in respect of the impact on other stakeholders such as TRFT.

3.3.2.7 Develop clear multi-agency care pathways *(Recommendation 2)*

3.3.2.8 Improved access to Tier 4 in-patient beds. *(Recommendation 2)*

The specific Tier 3/Tier 4 interface is important and discussions, which have already started, need to be further developed to ensure that the transition of patients to an inpatient facility is seamless and efficient at what is already a difficult time for the patient and their family.

3.3.2.9 Improved transition to adult mental health services from child and adolescent mental health services *(Recommendation 7)*

RDaSH has already developed the use of Peer Support Workers to aid this process but further work needs to be undertaken.

3.4 Tier 4

Tier 4 child and adolescent mental health services are specialised services, commissioned by NHS England, with a primary purpose of the assessment and treatment of severe and complex mental health disorders in children and young people. Tier 4 services are part of a comprehensive pathway and provide for a level of complexity that cannot be provided for by comprehensive secondary, Tier 3 community services.

The purpose of treatment in these specialist services is to reduce risk using a variety of evidence-based therapies, whilst increasing the young person's psychological wellbeing and enabling discharge from the Tier 4 service at the earliest possible opportunity with the support of community services.

Where possible all children and young people should be treated as close as possible to their home area and in the least restrictive environment.

Further information is available on the NHS England website using the following link:-
http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-c/

NHS England and CAMHs Mental Health Case Managers (MHCM) work collaboratively with local services and Tier 4 providers. A national review of child and adolescent mental health services Tier 4 provision commenced in December 2013 to consider the use and capacity of Tier 4 provision, the final report was published in July 2014. NHS England has recently outlined the intention to undertake a procurement exercise for child and adolescent mental health services Tier 4.

3.4.1 Current Activity

Mental Health Case Managers work closely with the local RDaSH CAMHS service during the admission of patients to Tier 4 in-patient units, whilst young people are in and also to facilitate discharge from hospital in a planned and collaborative way.

3.4.2 Additional Required Delivery Based on Evidence in Analysis of Need

3.4.2.1 Availability of Tier 4 Inpatient places *(Recommendation 2)*

Future actions will depend on the outcome of the national Tier 4 review; the aim will be to ensure that children and young people access Tier 4 beds when absolutely necessary. The appropriate range of Tier 4 provision should be available for all children and young people as locally as us possible and feasible.

3.4.2.2 Improved Tier3/Tier 4 Interface *(Recommendation 2)*

Further work to improve the Tier 3/Tier 4 interface and to ensure that all stakeholders work well together to provide the best outcome for the patient.

3.4.2.3. Scoping Tier 3+ Service *(Recommendation 3)*

Work to explore potential provision for young people requiring more intensive input than currently available at Tier 3 but who would not necessarily be best placed in a Tier 4 bed. This can be referred to as Tier 3+.

3.5 Child and Adolescent Mental Health Services Strategy & Partnership Group

A Child and Adolescent Mental Health Services Strategy and Partnership Group has been established with the following objectives:

- To support the development of local strategic plans to reflect the Child and Adolescent Mental Health Services agenda at a local level by continuously working towards understanding need.
- To co-ordinate and monitor the implementation of the Local and National the Child and Adolescent Mental Health Services Strategies.
- To promote quality standards and best practice and oversee national target implementation at a local level.
- To receive information from relevant sub groups and be notified of any performance issues.

The group meets on a quarterly basis and has representation from all areas of commissioning and service provision across all Tiers of the Child and Adolescent Mental Health Services.

A child and adolescent mental health services 'Top Tips' document has been developed through the group, to provide referral guidance to GPs and partners for young people who need child and adolescent mental health services in order to aid referrals to the appropriate service.

A directory of services has also been developed for GPs and partners which outlines emotional health and wellbeing provision and at which tier they operate.

3.6 Key Messages

Information from the Analysis of Needs demonstrates a requirement for delivering improved access and flexibility to services with a view to providing help and support before a young person reaches crisis point. Work is also needed to support transitions between services, step up and step down and transition to adult services.

Workforce development and improved working relationships between services and tiers will also support a culture of delivering interventions at the lowest levels possible and therefore at the earliest possibility, which will in turn deliver financial efficiencies. Similarly self-help and peer support are key areas to supporting young people to improve their resilience and to support one another.

Developing pathways for grouped conditions would provide information to young people, parents, carers and professionals as well as creating an opportunity to undertake mapping of the range of services and interventions available and defining the thresholds of access to services.

4. Investment

The following table outlines the current investments by RMBC and RCCG within each tier of CAMHS provision.

Tier	Service	Commissioned By	Cost Per Annum
1	Families for Change Intensive Family Support	RMBC	112,946
2	IYSS Youth Start	RMBC	128,000
2	Rotherham & Barnsley Mind	RMBC	60,000
2	LAAC Support & Therapy Team	RMBC	229,000
2	RDaSH CAMHS	RCCG	2,345,058
3		RMBC	139,000

5. Recommendations

The recommendations outlined below have been developed from key findings in the previous sections within this document and the Analysis of Need.

5.1 Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers

The involvement of service users and their families is key to developing services which deliver equality of access and provide the right interventions and support at the right time. Service user involvement will also help to highlight existing barriers to services and inform when, where and how services most need to be accessed by children and young people.

5.2 Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Multi agency pathways will clearly define the routes that patients will take for particular pathways, how they are referred in and what interventions are undertaken at various points. Service providers will also benefit from a better understanding of their role in the pathway. Post diagnosis support is also critical to ensure that patients and Parents/Carers don't feel abandoned once the diagnosis element of the pathway has concluded.

5.3 Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations

This will include ensuring that services are delivered on a local basis and through a variety of mediums including telephone & web-based support. Services will also facilitate self-referral as appropriate and ensure that the most vulnerable families are not missed. This recommendation will also support the SEND agenda through better joint working between Health, Social Care and Education.

5.4 Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham

From the Analysis of Need there is clearly a high level of need for mental health and emotional wellbeing services in Rotherham. We also know that most mental health issues in adults arise before the age of 18 years. Prevention and early intervention will therefore benefit not just the budgets set aside for children and young people, but also those for adults in the longer term. Services also need to take account of the physical health needs of patients.

5.5 Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours

Service provision is moving towards being delivered 7 days a week and 24 hours a day through the needs of patients and improvements in technology. Working with children and young people and their families we need to align, wherever possible, the times of service to the requirements of service users and their parents and carers.

5.6 Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision

Appropriately trained staff and support for them is essential to delivering wider access to services. Aligning with prevention and early intervention, having appropriately trained universal staff will deliver early help as well as identifying and satisfying patient's needs prior to crisis.

5.7 Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services

As noted above, we know that most mental health conditions for adults begin when they are young people; supporting the transition from children and young people's services to adult services will be a key way to reduce distress and crises for those concerned – improving their lives and reducing costs.

5.8 Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed

A single point of access would improve the speed of access by preventing delays in locating the relevant service and access point, again supporting the Health and Wellbeing Board's early intervention priority. There are multi-agency working benefits to be achieved by a single point of access which require further investigation.

5.9 Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services

The key measure of whether or not a mental health service is achieving is whether or not it is delivering better outcomes for patients and also able to record that.

5.10 Recommendation 10 - Promote the prevention of mental ill-health

A key theme of current national guidance is 'parity of esteem' and the need to see mental health on a par with physical health. Clearly a key factor in achieving that parity is promoting good mental health in the same way that good physical health is promoted. Services at all Tiers need to consider how they promote good mental health and build resilience amongst young people along the themes of Connect, Be Active, Be Creative and Play, Learning and Take Notice.

5.11 Recommendation 11 - Reduce the stigma of mental illness

Mental ill-health remains an area of both actual and perceived discrimination. Providing good quality information, promoting success stories and peer support will all work towards normalising and reducing stigma. Services at all Tiers should develop their own actions to tackle stigma and discrimination and look to work with others across the borough as part a wider initiative.

5.12 Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery

Inappropriate delays in service access improve the likelihood of patients reaching crisis point and additional interventions being required. Improved use of resources, through early intervention and prevention, times and locations of access and improved transitions and cross tier/service working will work towards reducing delays and delivering appropriate, accessible services when needed.

6.0 Summary and Next Steps

Whilst the above 12 recommendations are not exhaustive, it is felt that, in considering the key national and local policy drivers and the particular needs of Rotherham patients, they are the basis of a robust emotional wellbeing and mental health strategy and will improve the mental health of the children and young people of Rotherham.

These recommendations have been incorporated into an Action Plan, as detailed in Appendix 6. The various stakeholders identified in that document will work together to implement the recommendations within the agreed timescales.

It is important to see this action plan as a dynamic and long term document which will facilitate the implementation of the recommendations contained in this strategy, but also develop over time as priorities change.

Appendix 1

Glossary of Terms

ACE	Adverse Childhood Experiences
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black & Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	Child Development Centre
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
CYPS	Children and Young People's Services
DCSF	Department for Children, Schools & Families
DLA	Disability Living Allowance
EHWB	Emotional Health & Wellbeing
EHWBB	Emotional Health & Wellbeing Board
FT	Foundation Trust
GIFT	Great Involvement, Future Thinking
GPs	General Practitioners
IYSS	Integrated Youth Support Service
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAAC	Looked After & Adopted Children
LGBT	Lesbian, Gay, Bisexual & Transgender
NFER	National Foundation for Educational Research
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NSF	National Service Framework
ONS	Office of National Statistics
PICU	Psychiatric Intensive Care Unit
PSW	Personal Support Worker
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster & South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SEN	Special Education Needs
TaMHS	Targeted Mental Health in Schools
TRFT	The Rotherham Foundation Trust

Appendix 2

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Appendix 3

NHS Rotherham Clinical Commissioning Group | Rotherham Metropolitan Borough Council Where Everyone Matters | Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust | mind For better mental health

Revised TERMS OF REFERENCE
CAMHS Strategy and Partnership Group

NAME OF GROUP:	CAMHS Strategy and Partnership Group
ACCOUNTABLE TO:	RMBC Children and Young People Services Directorate Leadership Team (CYPSD), NHS Rotherham CCG Management Executive (OE)
REPORTING THROUGH:	CCG OE, RMBC C&YPD, RDASH CAMHS business division
PRIMARY PURPOSE:	To drive forward and oversee developments through the TRFT implementation of the CAMHS Strategy Action Plan within the area of Child and Adolescent Mental Health Services across Rotherham
COMPOSITION OF GROUP:	Multi-professional, see membership list
SERVICES IN ATTENDANCE:	Rotherham Borough Council Children and Young People Services and Public Health, NHS Rotherham CCG Commissioners, Rotherham Foundation Trust Community Services, Rotherham Doncaster and South Humber Mental Health Trust, Rotherham MIND, Healthwatch
Chair GP Commissioner	NHS Rotherham CCG
Quorate	Representatives from RMBC, RDASH, RCCG, TRFT
Attendance	All members will attend a minimum of 75% of the meetings. If a member is unable to attend they will send a nominated deputy
Objectives	• To support the development of local strategic plans to reflect the CAMHS agenda at a local level by continuously working towards understanding need. • To co-ordinate and monitor the implementation of the Local CAMHS Strategy Action Plan and National CAMHS Strategies. • To promote quality standards and best practice and oversee national target implementation at a local level • To receive financial information on the local CAMHS grant and support the commissioning decision with regard to the allocation. • To receive information from relevant sub groups and be notified of any performance issues • To receive patient, carers and key stakeholders who will feed into service commissioning through the organisations represented above.
SERVICED BY:	NHS Rotherham CCG
FREQUENCY OF MEETINGS:	Quarterly
REPORTING MECHANISM:	NHSR CCG; RMBC Business Division, RMBC C&YP Services, TRFT, RDaSH CAMHS,
MINUTES CIRCULATED TO:	Membership
REVIEW DATE:	12 Months from organisational sign up

MEMBERSHIP

NHSR CCG GP Commissioner
NHSR CCG CAMHS Commissioning Manager
RMBC, Public Health Lead Mental Health
RDASH CAMHS Assistant Director/ Service Manager
RDASH, Consultant Psychiatrist
RMBC Children's and Young People's Commissioner
RMBC, Service Manager
Rotherham MIND Service Manager (On behalf of VSC)
RFT Children's Lead
Clinical Lead Looked After Children's Mental Health Support Team
Youth Start, Emotional Coordinator
Service Manager Education Psychology
YOS Representative

Appendix 4

NICE guidance

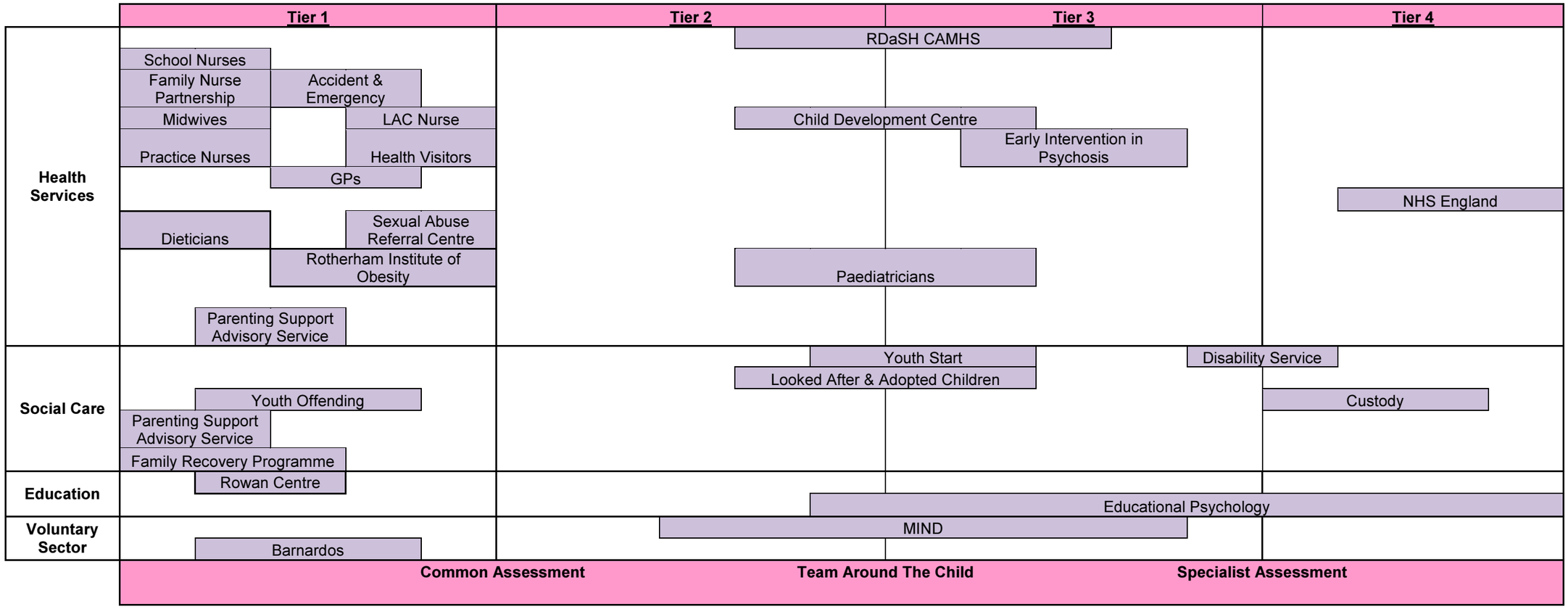
The National Institute for Health and Care Excellence has produced evidence based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice.

The following list is correct as of September 2013.

Eating disorders (CG9)
Self-harm (CG16)
Anxiety (CG22)
Violence (CG25)
Post-traumatic stress disorder (PTSD) (CG26)
Depression in children and young people (CG28)
Obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
Bipolar disorder (CG38)
Antenatal and postnatal mental health (CG45)
Drug misuse: psychosocial interventions (CG51)
Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
Attention-deficit hyperactivity disorder (ADHD) (CG72)
Antisocial personality disorder (CG77)
Borderline personality disorder (BPD) (CG78)
Schizophrenia (update) (CG82)
When to suspect child maltreatment (CG89)
Depression with a chronic physical health problem (CG91)
Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
Alcohol dependence and harmful alcohol use (CG115)
Psychosis with coexisting substance misuse (CG120)
Autism in children and young people (CG128)
Self-harm (longer-term management) (CG133)
Conduct disorders in children and young people (CG158)
Social anxiety disorder (CG159)
Four commonly used methods to increase physical activity (PH2)
Interventions to reduce substance misuse among vulnerable young people (PH4)
School-based interventions on alcohol (PH7)
Physical activity and the environment (PH8)
Maternal and child nutrition (PH11)
Social and emotional well-being in primary education (PH12)
Social and emotional well-being in secondary education (PH20)
School-based interventions to prevent smoking (PH23)
Alcohol-use disorders: preventing harmful drinking (PH24)
Health and well-being of looked after children and young people (QS31)
Insomnia – newer hypnotic drugs (TA77)
Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
Structural neuroimaging in first-episode psychosis (TA136)
Domestic violence and abuse – identification and prevention (in progress)

Appendix 5

Mental Health Services for Children in Rotherham - Tiered Model



Appendix 6

Strategy Action Plan

Ref	Sub-Action	Strategy Priority Reference	Detail	Resource Required	Action Owner(s)	Target start date	Target end date	Comment/Update	Date	RAG Status
1	**Ensure that services are developed which benefit from input by young people and parents/carers**									
1.1	Develop voice and influence mechanisms for children and young people		Ensure clauses around voice and influence in all contracts	Lisa Duvall Young People's rep Parent rep Helen Wyatt	Nigel Parkes Paul Theaker	01.04.14	ongoing			
			Work with children and young people to find out how they would like to input into services & feedback							
			Work with children and young people to provide friendly documentation							
			Involve children and young people in service design							
1.2	Implementation		Implement agreed mechanisms							
			Monitor outcomes							
1.3	Develop voice and influence mechanisms for parents/carers		Ensure clauses around voice and influence in all contracts	Lisa Duvall Young People's rep Parent rep Helen Wyatt	Nigel Parkes Paul Theaker	01.04.14	ongoing			
			Work with children and young people to find out how they would like to input into services & feedback							
			Work with children and young people to provide friendly documentation							
			Involve children and young people in service design							
1.4	Implementation		Implement agreed mechanisms							
			Monitor outcomes							
2	**Develop multi-agency care pathways which move service users appropriately through services towards recovery**									
2.1	Pathways (step up/step down/transition) to be further developed for ASD	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Healthwatch, Parent/Carer reps, young people's rep and VCS	Nigel Parkes	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.2	Pathways (step up/step down/transition) to be further developed forADHD	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Russell Brynes Nigel Parkes	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							

			Review and update pathway as appropriate			01.04.15	ongoing			
2.3	Pathways (step up/step down/transition) to be further developed for behavioural issues	4.2.2.6 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Paul Theaker	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.4	Pathways (step up/step down/transition) to be further developed for emotional health & wellbeing issues (including self-harm)	4.1.3.4 4.2.2.6 4.3.2.4 4.3.2.7 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Ruth Fletcher-Brown	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.5	Pathways (step up/step down/transition) to be further developed for substance misuse	4.3.2.4 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Debbie Stovin & Neil Power	01.06.14	30.11.14			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.6	Develop and agree a model for post abused trauma incluginds pathway (step up/step down/transition)	4.3.2.4 4.6.4	Establish working group	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Paul Theaker	01.09.14	31.03.15			
			Establish pathway							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.7	Protocol (step up/step down/transition)between Tier 2 services (Youth Start, LAAC Team, Rotherham & Barnsley	4.1.3.3 4.2.2.2 4.2.2.6	Draft protocol	Officer Time - CCG, RMBC, RDaSH etc	Paul Theaker & Ruth Fletcher-Brown	01.08.14	01.10.14			
			Agree protocol							
			Prioritise pathway							

	Mind)		Test out pathway	plus input from Parent/Carer reps, young people's rep and VCS						
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.8	Protocol (step up/step down/transition) between Tier 3 & Tier 4 provision	4.4.2.2	Draft protocol	Officer Time - CCG, RMBC, RDaSH etc plus input from Parent/Carer reps, young people's rep and VCS	Nigel Parkes	01.08.14	01.10.14			
			Agree protocol							
			Prioritise pathway							
			Test out pathway							
			Undertake impact assessment for vulnerable groups							
			Develop family friendly presentation							
			Consult with stakeholders							
			Launch pathway							
			Review and update pathway as appropriate			01.04.15	ongoing			
2.90	Other clinical pathway development	4.2.2.6 4.3.2.7 4.6.4	Ongoing review to establish gaps in pathways and address as appropriate	Officer Time	Barbara Murray	ongoing	ongoing			
3	**Develop family focussed services which are easily accessible and delivered in appropriate locations**									
3.1	Develop toolkit for families and friends to support children and young people including self help and continued development of the self-referral facility	4.3.2.5	Research best practice & innovation; link to existing resources; where do parents access help & information; develop FAQs; develop toolkit; test with parents; ensure parent representation	Young people's rep Parent rep Potential funding	Nigel Parkes Ruth Fletcher-Brown Barbara Murray	01.06.14	01.01.15 + ongoing review			
			Research where parents access help & information							
			Link to existing resources							
			Develop FAQs							
			Develop toolkit							
			Test with patients, parents and carers							
3.2	User, parent and carer involvement in service development	4.6.5	Map current participation		All partners	01.05.14	31.03.15			
			Hold consultation events				Ongoing			
			Build involvement into future activities							
			Develop innovative range of participation mechanisms							
3.3	Access to pathways for families	4.3.2.5	Publish pathways as part of toolkit	Parent rep	Paul Theaker Barbara Murray	01.09.14	01.12.14			
3.4	Locality based workers delivering services in community, school and home settings	4.2.2.4 4.3.2.3	Research and map where parents & young people access services		Nigel Parkes Barbara Murray Paul Theaker	01.04.14	31.03.15			
			Consult with young people and families on choice and best locations to access services							
			RDaSH CAMHS workers to provide locality based consultations & interventions							
			Workers allocated to specific schools & GP practices and/or locality areas							

			Publish allocations							
			Deliver rolling programme of visits by allocated workers							
			Ensure all service locations are family friendly, including reviewing reception arrangements at Kimberworth Place							
3.5	Develop flexibility of appointment times to meet need		Families, children & young people to be offered a choice of location and times for service access eg school, home, GP		Nigel Parkes Barbara Murray	01.05.14	ongoing			
3.6	Ensure that services reflect the SEND element of the Children & Families Bill 2013	4.1.3.12	Work with SEND Commissioning group to ensure all CAMHS workers contribute to EHC Plans		All partners	01.05.14	ongoing			
3.7	Ensure that services take account of vulnerable groups	4.1.2.11	Ongoing dialogue and attendance at forums. Use of census information, JSNA data etc		All partners	01.05.14	ongoing			
3.8	Explore potential provision of a Tier 3+ service	4.4.2.3	Research best practice & innovation elsewhere		Nigel Parkes	01.09.14	31.03.15			
			Develop draft model for provision							
			Consult with stakeholders on draft model & practicality of implementation							
			Develop financial plan for implementation including efficiency savings							
			Agree if option is viable							
			Seek approval to progress							
			Develop implmentation plan and implement							
4	**Ensure that the services being delivered represent the best value for money for the people of Rotherham.**									
4.1	Use the conclusions of the Attain report to review any areas of service provision which could be more economically delivered, eg recovery college approach	4.2.2.1			Nigel Parkes	01.06.14	01.03.15			
4.2	Reduce inappropriate referrals & incorrect referrals		Delivered through workforce development and training plans, development of pathways and referral mechanisms		Barbara Murray Nigel Parkes Paul Theaker Ruth Fletcher-Brown	01.04.14	ongoing			
4.3	Reduce need by improving resilience of young people and families at lower tiers		Revisit directory to be suitable for universal services		Ruth Fletcher-Brown	01.04.14	01.12.14			
			Review top tips document to be suitable for universal services							
			Develop screening tool							
			Develop minimum training requirements for each Tier							
			Promotion of RDaSH duty time phone number							
			Investigate potential to share care plans across each young person's support network							
4.4	Ensure coping mechanisms are built into all care plans to reduce need for young people to revisit services		Delivered through care plans and the Public Mental Health Strategy	Tier 2 providers	Paul Boyden Barbara Murray Ruth	01.04.14	31.03.15			

					Fletcher-Brown					
4.5	Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers				Ruth Fletcher-Brown					
5	**Ensure that the services being provided are deilvered at the appropriate time as required and not restricted to normal working hours**									
5.1	Investigate options for provision of web-based support for parents & young people		Investigate existing information provision Investigate existing information provision Consult with young people and families Explore platforms for delivery Agree options for implementation Obtain funding to implement Develop implementation plan Implement	Youth Cabinet RDaSH All partners Creative Media Service	Ruth Fletcher-Brown	01.06.14	31.12.14			
5.2	Investigate provision for e-platforms (e-clinic), email and text based support		Investigate existing information provision Consult with young people and families Explore platforms for delivery Agree options for implementation Obtain funding to implement Develop implementation plan Implement		RDaSH All Partners	01.06.14	31.12.14			
5.3	Investigate options for provision of a 24/7 service including telephone and crisis support	4.1.3.2 4.3.2.6	Investigate existing information provision Consult with young people and families Explore platforms for delivery Undertake options appraisal Revisit duty/on call service Agree options for implementation Obtain funding to implement Develop implementation plan Implement		RDaSH All partners	01.06.14	31.12.14			
6	**Ensure that services across all tiers of provision are delivered by appropirately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision**									
6.1	Collate training & development needs from consultation		Add in information/gap analysis from pathway development		Nigel Parkes Paul Theaker Ruth Fletcher-Brown	01.04.14	01.10.14			

6.2	Develop and implement training plan using electronic training, skills transfer & knowledge sharing	4.1.3.3 4.1.3.5 4.1.3.7 4.2.2.3 4.3.2.1 4.6.3		RMBC & CCG Learning & Development	Nigel Parkes Paul Theaker Ruth Fletcher-Brown Barbara Murray	01.10.14	31.12.14			
6.3	Develop screening tool		Develop model for expected level of training for each tier/service and training resource		Ruth Fletcher-Brown Barbara Murray	01.04.14	01.11.14			
7	**Ensure well planned and supported transition from child and adolescent mental health services to adult services**									
7.1	Links to action 1 – ensure all pathways include paths to exit service with reducing support, transition to adult services or information on how to return to service	4.2.2.5 4.3.2.9	Improve coordination of services between CAMHS and Adult Mental Health, including transitions to adult LD services.		Barbara Murray Nigel Parkes	01.04.14	31.12.14			
8	**Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed**									
8.1	Explore single access point for triage and referral to relevant provider	4.1.3.2 4.1.3.3	Links to pathways & screening tool; Identify current points of access, how they work and how to improve Establish actions to implement if appropriate		Nigel Parkes Russell Brynes	01.06.14	31.03.15			
9	**Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services**									
9.1	Implement appropriate quality outcome monitoring tool (CIAPT and others)	4.1.3.6 4.3.2.2	Scope current measures Develop actions by service and organisation	All partners	Nigel Parkes	01.09.14	31.03.15			
9.2	Long term tracking of data showing admission to adults services of those who accessed CAMHS as young people		Undertake scoping Develop mechanisms to monitor	All partners	Barbara Murray	01.04.15	ongoing			
10	**Promote the prevention of mental ill-health**									
10.1	Development of a Rotherham Mental Health Strategy	4.1.3.1 4.1.3.3 4.1.3.6 4.1.3.8 4.1.3.10 4.6.2	To be delivered through separate action plan	All partners	Ruth Fletcher-Brown	01.09.14	ongoing			
11	**Reduce stigma of mental illness**									
11.1	How to achieve a cultural change around mental illness	4.1.3.6 4.1.3.9 4.6.1	Link to national strategies & initiatives, Public Mental Health Strategy etc Develop a time table of key points each year to raise mental health awareness	All partners Communica-tion leads Youth Cabinet	Ruth Fletcher-Brown	01.06.14	ongoing			
12	**Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversley affect their recovery**									
12.1	Delivered through clearer pathways, better referral mechanisms and 24/7 service	4.3.2.8 4.4.2.1 4.4.2.2	Develop charter for Emotional Wellbeing and Mental Health services	All partners	Nigel Parkes Paul Theaker	01.06.14	01.04.15			

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People 2014

Version 2

Version Number	Revision date	Summary of Changes	Change By	Changes accepted
1.0	10.07.14	First draft following discussion with PT	SM	
1.1	01.08.14	Amendments from NP	SM	
1.2	28.08.14	References added	SM	
2	11.09.14	Final version following final amendments by RFB & NP	SM	

Approval Process			
Name/Meeting	**Date of Issue**	**Version Number**	**Approved**

Contents

1. Introduction

Improved emotional health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse,
- reduced risk of suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- higher levels of social interaction and participation

Source - various including Annual Report of the Chief Medical Officer 2012

The emotional health and wellbeing of children and young people is nurtured primarily at home, however everyone delivering children and young people's services (particularly early years and schools) has a role in improving outcomes and reducing inequalities. This includes supporting the public to make healthier, informed choices to improve emotional health and wellbeing and to improve access to services where and when they are needed.

This Analysis of Need has been produced to inform Rotherham's Emotional Wellbeing and Mental Health Strategy for Children and Young People.

2. National Guidance

This Strategy is informed by a wide range of current guidance the most relevant of which is detailed below.

2.1 National CAMHS Review – 2008

The review made a number of recommendations as follows.

2.2.1. All parents, carers, children and young people throughout the country should have:

- a more positive understanding of mental health and psychological well-being as a result of national media activity
- up-to-date information, in a range of formats, about mental health and psychological well-being and what services are available locally to help them
- good telephone and web-based help and advice
- confidence that staff in the services they use every day:
    - understand child development and mental health
    - actively promote strong mental health and psychological well-being
    - use language that they understand
    - take them seriously

- can identify needs early
- can help their child and can draw on support from others to make sure needs are addressed.

2.1.2 Children and young people who need more specialised support, and their parents and carers, should have:

- a high-quality and purposeful assessment, which informs a clear plan of action and which includes, at the appropriate time, arrangements for support when more specialised input is no longer needed
- a lead person to be their main point of contact, making sure other sources of help play their part, and co-ordinating that support
- clearly signposted routes to specialist help and timely access to this, with help available during any wait
- clear information about what to do if things don't go according to plan.

2.1.3 Children and young people and their families who are vulnerable (such as children in care, children with disabilities and children with behavioural, emotional and social difficulties) should be confident that, in addition to the above:

- their mental health needs will be
- assessed alongside all their other needs,
- no matter where the need is initially identified
- an individualised package of care will be available to them so that their personal
- circumstances, and the particular settings in which they receive their primary support
- appropriately influence the care and support they receive

For those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children's Trust and delivered, where possible, in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.

2.1.4. Young adults who are approaching 18 years of age and who are being supported by CAMHS should, along with their parents and carers:

- know well in advance what the arrangements will be for transfer to adult services of any type, following a planning meeting at least six months before their 18th birthday
- be able to access services that are based on best evidence of what works for young adults, and which have been informed by their views
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan

- have confidence that services will focus on need, rather than age, and will be flexible.

2.2.1. National Service Framework (NSF) for Children, Young People and Maternity Services.

Standard 9 of the NSF specifically deals with '*The Mental Health and Psychological Well-being of Children and Young People*'. This proposed three elements of a 'Vision' as follows:

2.2.1 An improvement in the mental health of all children and young people.
2.2.2 That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.
2.2.3 That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

It also outlined the following standard:

> '*All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families*.'

2.3 National Institute for Health & Care Excellence (NICE)

Various NICE clinical guidance deals with areas of relevance to child and adolescent mental health services provision. An up to date list of guidance is included in Appendix 3.

2.4 No Health without Mental Health (Centre for Mental Health et al. 2012)

The guidance contains the following priorities:

2.4.1 More children and young people will have good mental health.
2.4.2 More children and young people with mental health problems will recover.
2.4.3 More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health.
2.4.4 More children and young people will have a positive experience of care and support.
2.4.5 Fewer children and young people will suffer avoidable harm.
2.4.6 Fewer children and young people and families will experience stigma and discrimination.

2.5 Children & Young People's Health Outcomes Strategy (Lewis & Lenehan, 2007)

The Public Health Group of the Children and Young People's Health Outcomes Forum focused on developing suggestions and recommendations for how the new health system could improve the life chances of children and young people by promoting good health and acting early where problems are developing.

Highlighted within the document are the views of children and young people in relation to health promotion and illness prevention. They found children and young people generally:

- understand that peer pressure and advertising can work against healthy choices;
- need better information and advice about healthy lifestyles;
- believe that too many public health campaigns are aimed at adults;
- connect being healthy with 'things to do' in their area and access to public transport and sports facilities;
- want involvement in the design, development and evaluation of child friendly campaigns and services;
- recognise and value the role of the school in encouraging healthy behaviour;
- recognise there is a place for social media and want a trusted internet source of accurate health information.

For further information visit:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf

2.6 Everyone Counts – Planning for Patients 2014-15 to 2018-19

This planning guidance specifically outlines the need for Parity of Esteem between physical and mental health. It specifically states:

> '*We are absolutely committed to moving towards parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems'.*

The guidance specifically calls for commissioners to be clear about the resources they are allocating to mental health to achieve parity of esteem and that there is specific identification and support for young people with mental health problems. They should also be clear on plans to reduce the 20 year gap in life expectancy for people with severe mental illness.

2.7 Closing the Gap: Priorities for Essential Change in Mental Health (Department of Health, 2014)

Closing the Gap supports the measures in the national mental health strategy '*No Health without Mental Health*', the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the following 25 priorities for action.

2.7.1 High quality mental health services with an emphasis on recovery and meeting local need.
2.7.2 An information revolution around mental health.
2.7.3 Waiting time limits for mental health services.
2.7.4 Tackling inequalities in access.
2.7.5 Increasing the uptake of psychological therapies for children and young people.
2.7.6 Extend access to psychological therapies for children and young people.
2.7.7 The most effective services will get the most funding.
2.7.8 More choice.
2.7.9 Reduce all restrictive practices and end the use of high risk restraint.
2.7.10 Friends and family test.
2.7.11 Poor quality services identified sooner and action taken.
2.7.12 Better support and involvement for carers.
2.7.13 Better integration of mental and physical health.
2.7.14 Front-line services respond more effectively to self-harm.
2.7.15 No one in mental health crisis should be refused a service.
2.7.16 Better support for postnatal depression.
2.7.17 Schools supported to identify mental health problems sooner.
2.7.18 End the cliff-edge of lost support at age-18.
2.7.19 People with mental health problems will live healthier and longer lives.
2.7.20 More people will live in homes that support recovery.
2.7.21 A national liaison and diversion service.
2.7.22 Enhanced support to victims of crime.
2.7.23 Support employers to help more people with mental health problems stay in or enter employment.
2.7.24 New approaches to help people with mental health problems move into work and support them when unable to work.
2.7.25 Stamping out discrimination.

2.8 Children and Families Bill 2013

The Government is transforming the system for children and young people with special educational needs and disability (SEND), including those who are disabled, so that services consistently support the best outcomes for them. The Bill will extend the SEND system from birth to 25 years, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme set out in '*Support and Aspiration: A new approach to special educational needs and disability* progress and next steps' (Department for Education, 2012) by:

- Replacing statements and learning difficulty assessments with new birth to 25 years Education, Health and Care Plans, extending rights and protections to young people in further education and training and offering families personal budgets so that they have more control over the support they need.
- Improving cooperation between all the services that support children and their families and particularly requiring local authorities and health authorities to work together.
- Requiring local authorities to involve children, young people and parents in reviewing and developing provision for those with special educational needs and to publish a 'local offer' of support.

These changes will clearly impact on the future direction of emotional wellbeing and mental health services for children in Rotherham in a number of key areas:

- Extending the age range to 25 years, which may mean that transition to adult services from children's mental health services becomes even more important.
- Requiring a joint 'Health & Care' plan and the associated co-operation between health and social care services necessary to achieve that.
- Requiring the offering of personal budgets to families.
- Requiring the involvement of children, young people and their families in reviewing and developing service provision and the publication of a 'Local Offer'.

3. Local Guidance

3.1 Rotherham Health and Wellbeing Board

There are six identified high level priorities for the Health and Wellbeing Board (HWBB):

3.1.1 Prevention and Early Intervention - Rotherham people will get help early to stay healthy and increase their independence.

3.1.2 Expectations and Aspirations - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality. services in their community, tailored to their personal circumstances

3.1.3 Dependence to Independence - Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.

3.1.4 Healthy Lifestyles - People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

3.1.5 Long-term Conditions - Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

3.1.6 Poverty - Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

All these are across the Life Course Framework adapted from the Marmot Life Course.

3.2 Rotherham Director of Public Health's Annual Report

The Director of Public Health's Annual Report (2013-14) recommends the development of a Rotherham Mental Health Strategy which will outline local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems in Rotherham. This strategy will have a lifespan focus and therefore will support the vision of this Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19 in supporting good mental health in children, young people and families.

3.3 Children's Plan

RCCG has some key areas of work relating to Children's and Maternity services. These are:

- Implementation of the SEND reforms resulting from the new Children's Act 2014.
- A review of the community midwifery service looking at issues such as choice, accessibility and continuity.
- Production of a Rotherham Maternity Services Strategy and service specification.
- A South Yorkshire and Bassetlaw review of children's continuing care service.
- Continuation of the Care Closer to Home workstream looking at pathways of care for children.
- A review of children's therapy services.

4. Tiered Approach to Services

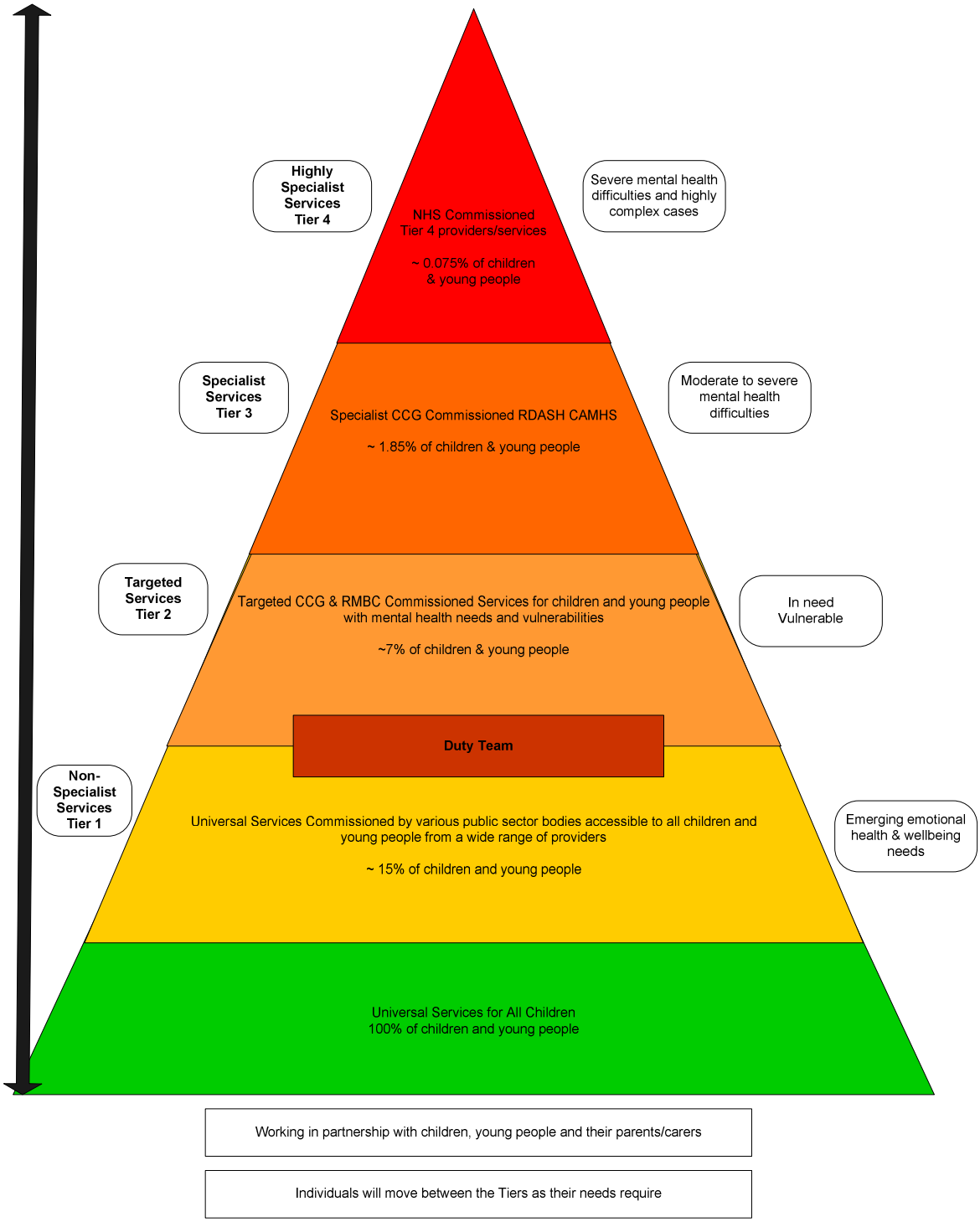
A wide range of services play an important role in the promotion and support of children and young people's emotional health and wellbeing. They work together to deliver a four tier model of Child and Adolescent Mental Health Services (CAMHS) as outlined in *Together We Stand* (Health Advisory Service, 1995). This model is illustrated in Figure 2.

The following is a definition of child and adolescent mental health services:

> *Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone*
>
> Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Figure 2

Comprehensive Child & Adolescent Mental Health Services in Rotherham (CAMHS)



Kurtz Z, 1996.

NB Figures and percentages in each Tier are estimates based on national prevalence numbers

Table 1 shows the different levels of the tiered approach, together with information on the types of service to be found at each level.

Table 1

Tier	Description	Professionals providing the service include but are not limited to	Function/Service
4	Essential tertiary level services such as day services, highly specialised out-patient teams and in-patient units	Services provided by professionals, usually on the basis of a multi-disciplinary team approach • Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community or inpatient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists Family Therapists	• Child and adolescent inpatient units • Secure forensic units • Eating disorder units • Specialist teams (e.g. for sexual abuse) • Specialist teams for neuro–psychiatric problems
3	Specialised services for more severe, complex or persistent disorders such as depression & eating disorders		Services offered by multi-disciplinary teams: • Assessment and treatment • Assessment for referral to T4 • Contributions to the services, consultation and training at T1 and T2
2	Services provided by professionals with training in mental health	Services provided by professionals, usually on a 1:1 basis • RDaSH CAMHS workers eg social workers, therapists, nurses, doctors, psychologists • IYSS Youth Start • Rotherham & Barnsley Mind • Education psychologists	Child and adolescent mental health services professionals should be able to offer: • Training and consultation to other professionals (who might be in T1) • Consultation to professionals and families • Outreach • Assessment • Therapeutic interventions
1	Services provided by a wide range of commissioned and non-commissioned providers	Services provided by professionals, usually on a 1:1 basis • GPs • Midwives • Health visitors • School nurses • Social workers • Teachers & pastoral support • Integrated Youth Support workers • Education psychologists • Paediatricians • Voluntary services	Child and adolescent mental health services at this level are provided by professionals working in universal services who are in a position to: • Identify mental health problems earlier in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention

5. The Needs of Young People in Rotherham

5.1 Self Reported Emotional Health & Wellbeing

In October 2008 the Department for Children, Schools and Families (DCSF) commissioned the National Foundation for Educational Research (NFER) to develop and deliver the Tellus4 survey. The purpose of this national survey was to gather children and young people's views on their life, their school and their local area. Findings from the survey were used to inform policy development and to measure progress and performance at both a local and national level. The survey represents the views of 253,755 children and young people in school years 6, 8 and 10 in 3,699 schools. Table 2 shows the results from Rotherham compared to England as a whole.

The Rotherham Secondary School Lifestyle Survey is conducted with years 7 and 10. The results from the 2013 survey on how young people think and feel showed the results in Table 3. Responses from both year 7 and year 10 pupils to the questions shown in Table 3 were almost identical.

Table 2 Self Reported Emotional Wellbeing & Mental Health Needs

	Rotherham %	England %	Comparison
Enjoyed good relationships with family and friends	56.4	56.0	√
Children and young people using alcohol	20.0	15.0	X
Children and young people using drugs	2.0	4.0	√
Children and young people smoking	4.0	4.0	=
Reported being bullied	10.5	9.6	X
Consider school deals 'not very well or badly' with bullying	29.0	26.0	X

Source: Respondents from the Tellus4 Survey (2009) sample of school children from years 6, 8 & 10

Key √ means that Rotherham is better than the national position
X means that Rotherham is worse than the national position
= means that Rotherham is equivalent to the national position

Table 3 Rotherham Secondary School Lifestyle Survey

	2012 %	2013 %	Comparison
Feel good about family and home life	64	62	X
Feel good about friendships	77	74	X
Feel good about the way they look	44	37	X
Feel good about school work	57	44	X

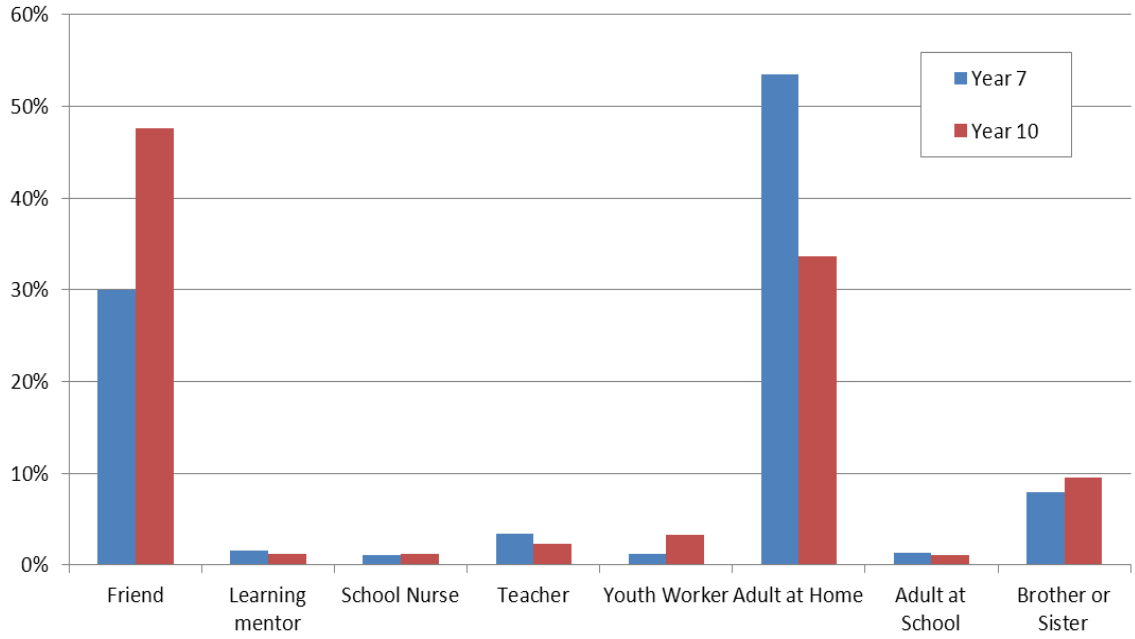
Source: Rotherham Secondary School Lifestyle Surveys 2012 & 2013

Key X means that the position has worsened from 2012 to 2103

Pupils were then asked about who they felt they would mainly discuss their problems with. The results are shown at Figure 3.

The majority of year 7 and year 10 pupils would speak to either an adult at home (54% of year 7 and 34% of year 10) or a friend (30% and 48% respectively). Around 9% of both year 7 and 10 pupils would talk to their brother or sister about their problems. Only 3% of both year groups would mainly talk to a teacher and only 1% of pupils would approach a youth worker, learning mentor, school nurse or other adult at school about their problems.

Figure 3 CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM – REPORT OF THE PUBLIC HEALTH AND PREVENTION SUB-GROUP



Females in both year groups were more likely to mainly speak to a friend about their problems and males in both year groups were more likely to speak to an adult at home.

Poor mental health for adults, children and young people is associated with poverty, social position, poor housing, other disabilities and trauma such as living in households where there is domestic abuse. Table 4.1, 4.2 and 4.3 highlight some of the measures which would indicate that children and young people who are more at risk of having poorer mental health, showing how Rotherham compares to England as a whole.

Key to Tables

Key √ means that Rotherham is better than the national position
X means that Rotherham is worse than the national position
= means that Rotherham is equivalent to the national position

Table 4.1 Wider Determinants of Health / Risk Factors

	Period	Rotherham	England	Comparison
Children living in poverty (all dependent children under 20 years)	2011	22.3%	20.1%	X
Children living in poverty (under 16 years)	2011	2.3%	20.6%	X
16-18 year olds not in employment, education or training	2012	7.4%	5.8%	X
First time entrants to the Youth Justice System (10-17 years) (per 100,000)	2012	435	537	√
Family homelessness (per 1,000 households)	2011/12	0.5	1.7	√
Children in care (per 10,000 under 18years)	2012	68	59	X
Emotional wellbeing of looked after children (4-16 years) (score)	2011/12	15.3	13.8	Not tested

Source: Public Health England

Table 4.2 Health Improvement

	Period	Rotherham	England	Comparison
Excess weight in children (overweight/obese) (4-5 years)	2012/13	22.2	22.2	=
Excess weight in children (overweight/obese) (10-11 years)	2012/13	35.2	33.3	X
Participation in at least 3 hours of sport/PE (5-18 years)	2009/10	48.1	55.1	X
Hospital admissions due to alcohol specific conditions (0-17 years) (per 100,000)	2008-11	42.9	55.8	√
Hospital admissions due to substance misuse (15-24 years) (DSR per 100,000)	2009-12	70.1	69.4	=
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years) (per 100,000)	2012/13	102.3	103.8	=
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years) (per 100,000)	2012/13	117.9	130.7	√

Source: Public Health England

Table 4.3 Levels of Mental Health & Illness

	Period	Rotherham	England	Comparison
Hospital admissions for mental health conditions (0-17 years) (per 100,000)	2011/12	53.5	91.3	√
Hospital admissions as a result of self-harm (0-17 years) (per 100,000)	2011/12	83.8	115.5	√

Source: Public Health England

5.2 Estimated Emotional Health & Wellbeing Prevalence in Rotherham

The cost of poor mental health to the individual child and young person cannot be under-estimated. We know that there are also significant financial costs. For mental health disorders the annual short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 years in the UK are estimated to be £1.58billion and the long term costs £2.35billion (Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

In addition with 75% of adult mental health problems occurring before the age of 18 it is imperative that the burden of disease is monitored regularly (Dunedin Multi-Disciplinary Health & Development Research Unit http://dunedinstudy.otago.ac.nz cited in the Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

If children and young people do not receive early intervention and adequate treatment for their mental health problems there is a higher likelihood that they will have poorer academic achievements, face higher unemployment, premature morbidity and long term physical and mental health problems (Goodman et al cited in the Annual Report of the Chief Medical Officer, 2012*).*

At any one time, between 10% and 20% of children will have a diagnosable mental health problem severe enough to require child and adolescent mental health services intervention at Tier 1 to 4. Around 10% of children and young people have similar, but more severe, complex or persistent difficulties, these are referred to as “mental health disorders□. The prevalence of mental health disorders has been established by detailed studies, notably the *Mental Health of Children and Young People in Great Britain* (Green et al, 2004) published by the Office for National Statistics (ONS) which built on the work of a previous study in 1999.

5.2.1 Estimates for Rotherham

The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors. Based on the socio-demographic profile of Rotherham summarised in 5 ACORN Categories (CACI 2012), the prevalence of mental health disorders in Rotherham is estimated to be 14% above the UK average. This results from the higher levels of deprivation in Rotherham which is reflected in the higher proportion of children in the ACORN Category “hard pressed” families.

According to the Interim 2011-based population projection for 2013, there are currently 62,300 children and young people living in Rotherham aged 0 -19. Table 5 shows the profile of Rotherham’s 0-19 population by age.

Table 5 Rotherham’s 0-19 Population

0-4	5-9	10-14	15-19	Total
16,300	15,400	14,900	15,700	62,300

Data from the 2013 annual school census (PLASC) shows that 84.3% of Rotherham’s school age population are from a white British background and 15.7% from a black and minority ethnic (BME) background. National prevalence rates show that white and black

groups have the highest rates of mental health disorder whilst Indians have the lowest rate. However, higher levels of deprivation affecting most BME communities in Rotherham mean that their incidence of mental health disorders is likely to be higher that suggested by their ethnicity alone.

Table 6 illustrates the findings of the ONS study 2004 and gives the percentage estimates of disorders within the population. From this, using our population data, the prevalence of mental health disorders across Rotherham's Children and Young People have been estimated.

It is possible to estimate the prevalence of mental health disorders for Rotherham based on national prevalence rates (ONS 2004) for children aged 5-16, adjusted based on prevalence by ACORN Category to take account of socio-economic factors. This assumes that there will be a similar prevalence for 0-19 as for 5-16, which is reasonable given that rates increase with age. It can safely be assumed that children aged 0-4 will have rates below average and young people aged 17-19 will have rates above average, which will largely cancel each other out.

Table 6 Estimates of Mental Health Disorders in Rotherham Based on National Prevalence Rates

	5-10		11-16		All
	Boys	**Girls**	**Boys**	**Girls**	**5-16**
Total Number of Children	9,426	8,935	9,270	9,074	36,705
Emotional Disorders	2.2% 240	2.5% 250	4.0% 420	6.1% 630	3.7% 1,540
Conduct Disorders	6.9% 740	2.8% 290	8.1% 860	5.1% 530	5.8% 2,420
Hyperkinetic Disorders	2.7% 290	0.4% 40	2.4% 250	0.4% 40	1.5% 620
Autistic Spectrum Disorder	1.9% 200	0.1% 10	1.0% 110	0.5% 50	0.9% 370
Rare Disorders	0.3% 30	0.3% 30	0.6% 60	0.6% 60	0.4% 180
All Disorders	**10.2% 960**	**5.1% 460**	**12.6% 1,170**	**10.3% 930**	**9.6% 3,520**

In Rotherham, there are an estimated 6,800 children and young people aged 0-19 with a diagnosable mental health disorder, 2,600 with an emotional disorder (anxiety and depression), 4,100 with a conduct disorder (eg oppositional defiant disorder), 1,100 with a hyperkinetic disorder, 640 with Autistic Spectrum Disorder and 280 with a rare disorder.

A notable feature of the estimates is the higher incidence of mental health disorders amongst boys, particularly conduct, hyperkinetic and autistic spectrum disorders. The highest rate affecting any sub-group is for conduct disorders which affect 13.7% of boys aged 11-16 from "hard pressed" backgrounds.

5.2.2 Estimates by Child and Adolescent Mental Health Services Tier

A research study by Z Kurtz in 1996 for the Mental Health Foundation entitled *"Treating Children Well"* reported the prevalence of mental health problems appropriate to a response from each child and adolescent mental health services Tier. Estimates of the level of need in Rotherham are shown at Table 7.

Table 7 Estimated numbers of children & young people aged 0-18 in Rotherham with mental health problems appropriate to a response from child and adolescent mental health services (2013 estimate)

CAMHS	Summary of Services	Prevalence	Number
Tier 1	Primary Care	15%	8,916
Tier 2	Specialist & community based	7%	4,161
Tier 3	Specialist	1.85%	1,100
Tier 4	Highly specialist	0.075%	45

The 15% of children and young people estimated to have mental health problems appropriate for Tier 1 is higher than the 9.6% estimated to have mental health disorders in the ONS 2004 study. This probably reflects the difficulty in estimating lower levels of need where services are not just responding to known disorders, but also providing wider advice and preventative activity. The implication is that around 5% of children and young people are at risk of developing a mental health condition and would benefit from Tier 1 services, but do not have a diagnosable disorder.

5.2.3 Disability Living Allowance

In Rotherham, 2,490 children and young people aged 0-17 are entitled to Disability Living Allowance (DLA). Of these 488 children are entitled to DLA because of a mental health condition (20%), of which 389 are boys and are 99 girls. This reflects the significant gender differences observed in the prevalence data.

Only about 8% of children and young people with a mental health condition claim DLA as a result, which suggests that only the more severe and complex cases are likely to be eligible. The main mental health conditions for which DLA is claimed by people under 18 are hyperkinetic and behavioural disorders. There are very few cases where emotional disorders result in entitlement to DLA. It should be noted that some children claiming DLA because of a physical disability will also have a secondary mental health condition.

5.2.4 Special Educational Needs

A total of 4,332 children in Rotherham schools have a Special Educational Need (SEN) classified as either statemented or School Action Plus. Of these 829 children have behavioural, emotional or social difficulty and 784 have Autistic Spectrum Disorder (ASD). The numbers of children and young people aged 5-16 predicted to have these conditions is 3,960 and 370 respectively. This indicates that far more Rotherham children have ASD than national prevalence rates would suggest, possibly because ASD diagnosis rates have increased since the 2004 ONS study. About 46% of children (5-16) expected to have mental health disorders are not statemented or subject to School Action Plus.

5.2.5 Bullying & Feelings of Safety

The 2013 Secondary School Lifestyle Survey showed that 38% of Rotherham year 7 and year 10 pupils had been bullied, the same as in 2012. Table 8 shows the prevalence of bullying by type.

Table 8 Types of Bullying in Rotherham

Verbal	90%
Being Ignored	22%
Physical Bullying	21%
Cyber Bullying	22%

29% of year 10 pupils said that they were victims of cyber bullying compared with 19% of year 7 pupils. The results show that the main reasons why pupils are bullied are their weight and the way they look (the same as the 2012 survey). A high percentage of year 7 pupils also said that they were bullied for another reason.

Table 9 shows the number of young people who reported bullying and how many received help and support as a result.

Table 9 Bullied Young People

	2012 %	2013 %	Change %
Bullying Reported	44	28	-16
Received Help & Support	43	26	-17

43% of pupils that took part in the survey had witnessed bullying of others (similar to last year). 5% said that they had been involved in bullying someone else in the last four weeks.

Children and young people were also asked where the felt safe with the results shown at Table 10. Home was felt to be the safest place with 90% of pupils always feeling safe there. Year 7 pupils tend to feel less safe than year 10 pupils which suggests that confidence increases with age.

Table 10 Safe Places

Place	2012 %	2013 %	Change %
School	56	51	-5
Travelling to and from school	34	28	-6
On local buses & trains	21	18	-3
Waiting for local transport	17	14	-3
In local communities	29	27	-2
Rotherham Town Centre	14	12	-2

5.2.6 Suicide & Suicide Prevention

In a 2007 survey of young adults, 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. ((McManus S, et al. 2009).Suicide is the leading cause of death in young people. The Office of National Statistics shows that that numbers of suicides (including undetermined deaths) amongst 16-24 have been on the increase since 2007. We know from research that suicide is rarely the result of a one off factor or factor and that for young people the following increases the risk:

- having an existing mental health problems or behavioural disorders
- misuse substances
- family breakdown
- loss of a family member of friend
- social isolation
- abuse, neglect
- mental health problems or suicide in the family

The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person. In addition young people are not a homogenous group and some of the vulnerable groups listed in 3.3 are at higher risk of suicide, for example looked after children, young offenders and LGBT young people.

There is a growing concern regarding the use of the internet promote suicide and suicide methods and the use of social media in the aftermath of a young person taking their own life. This has been identified as a priority for further research at a national level (Department of Health. Mental Health, Disability and Equality Division 2014).

For young people the protective factors are:

- being loved and feeling secure
- living in a stable home environment
- parental employment
- good parenting
- good parental mental health
- activities and interests
- positive peer relationships
- emotional resilience and positive thinking
- sense of humour.

In Rotherham we are working to improve the support we provide to children who are bereaved as a result of suicide. Research shows that the bereavement due to suicide provokes stronger and longer lasting feelings amongst children and young people (Trickey, 2012). In Rotherham we have introduced a pathway into services/support for children and young person bereaved by suicide this will also act as an alert schools and health professionals.

To date work on suicide prevention includes:

- The development of the Rotherham Community Response plan- Rotherham Multi-agency Guidance for Preventing and Responding to Behaviours which may Indicate Potential Suicide or Self-Harm Clusters, July 2013.
- Rotherham's first suicide prevention conference on 3rd April 2014 to share best practice in relation to suicide prevention and support mangers and frontline staff to understand their role in preventing suicide.
- Launch of the CARE about suicide guidelines for frontline works and the general public
- Provision of information to schools and colleges on suicide prevention including the resource from Samaritans, 'Help when we needed it most'
- Youth Mental Health First Aid Training and roll out of Applied Suicide Intervention Skills Training.

Suicide prevention is not the responsibility of just one sector and requires a multiagency response. Action on suicide prevention for young people needs to include schools, colleges, providers and commissioners of services, police, local media, voluntary sector services, parents, carers and young people themselves.

5.2.7 Self Harm

Self-harm, as defined in the National Institute of Clinical Excellence guidelines (2004), is an:

> *".. an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same." (NICE, 2004)*

Essentially self-harm is any behaviour where the intent is to cause harm to oneself, this includes self-poisoning or self-injury There is sometimes an assumption that self-harm is an attempt at suicide. While an individual episode of self-harm might be an attempt to end life, acts of self-harm are not always connected to attempted suicide. People may harm themselves as a way of coping with overwhelming situations or feelings. For some people, self-harm may actually be a way of preventing suicide. However we do know that people who self-harm are more at risk of suicide than those who do not self-harm.

The estimates for self-harm amongst young people vary and indeed some may be an underestimate because many young people do not disclose that they are self-harming, treating themselves at home and never coming to the attention of services. However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years (Hawton et al. 2013).

Young people may self-harm for a variety of reasons and these include:

- being bullied at school
- not getting on with parents
- stress and worry around academic performance and examinations
- parental divorce

- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (whether sexual, physical, and/or emotional)
- difficulties associated with sexuality
- problems to do with race, culture or religion
- low self-esteem
- feelings of being rejected in their lives

(Brophy, 2006)

In Rotherham the Youth Cabinet are currently looking at this issue and working with providers and commissioners to look at how awareness can be raised and services improved for young people in Rotherham (please refer to 3.5.3).

Rotherham Suicide Prevention and Self Harm Group are looking at developing guidelines for all staff working with children and young people who self-harm.

5.3 Vulnerable Groups

National evidence has identified that there are a number of groups who are considered to be more at risk of developing emotional health problems than others. Children living with Adverse Childhood Experiences (ACE) generally have poorer health outcomes when compared to children with no ACE. The following are examples of ACE:

- low-income households
- families where parents are unemployed
- families where parents have low educational attainment
- looked after by the local authority
- disabilities (including learning disabilities
- black and other ethnic minority groups
- lesbian, gay, bisexual or transgender (LGBT)
- in the criminal justice system
- a parent with a mental health problem
- misusing substances
- refugees or asylum seekers
- gypsy and traveller communities
- being abused
- young carers
- young people accessing pupil referral units
- teenage parents
- non-standard intake to schools, i.e. children and young people who move schools during the academic year

Further information on prevalence rates for these groups is available in Joint Strategic Needs Assessment available at http://www.rotherham.gov.uk/jsna/

Compared to children and young people with no ACE, those with four or more are at greater risk as Table11 shows.

Table 11 Increased Risks for Young People with 4+ ACE

Type of Risk	Increase in Risk
Smoking	3.96 times more likely
Drinking	3.72 times more likely
Incarceration	8.83 times more likely
Obesity	3.02 times more likely

Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. J Public Health (Oxf). 2013 'Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population.' Cited in 2012, Annual Report of the Chief Medical Officer 2012: 2012 Our Children Deserve Better: Prevention Pays .

In addition, children and young people with four or more ACE are more likely to have:

- poor educational outcomes/poor unemployment opportunities
- low mental wellbeing and life satisfaction
- had more recent inpatient hospital care and chronic conditions
- been pregnant unintentionally before age 18

There are targeted resources in Rotherham for some of the ACE groups, for example there are dedicated services for young people misusing substances, young carers, youth offenders and a dedicated LGBT group. In terms of emotional health and wellbeing these services operate at mental health Tier 1 whilst providing a level of counselling and emotional support through assessment and 1:1 working, but do not undertake specific programmes relating to mental health. These services tend to have received training through Rotherham and Barnsley Mind regarding bullying and self-harm and also Mental Health First Aid Training and refer on to IYSS Youth Start and RDaSH CAMHS for mental health interventions.

The Looked After and Adopted Children Children's (LAAC) Support and Therapeutic Team provide a dedicated emotional health and wellbeing service for LAAC, giving emotional, mental health and wellbeing advice and support, as well as providing training, advice and support to foster carers and adoptive parents. The service operates at mental health Tier 2 and provides direct therapeutic work with young people including theraplay, art therapy and family and psychological interventions.

Further equality impact analysis is needed to ensure that children and young people from other vulnerable groups have access to emotional health provision.

5.3.1 <u>The Rowan Centre</u>

As noted above, children and young people accessing pupil referral units (PRU)are at increased risk of developing emotional health problems.

The Rown Centre is a PRU providing KS3 and KS4 education to students unable to attend mainstream school on health grounds (both mental and physical) and school age mothers/pregnant schoolgirls. Education and support is offered to students who have additional needs. The centre provides a small, calm and nurturing setting and works in partnership with parents, carers, schools and a range of agencies including CAMHS.

The Centre offers a range of guidance and support under Tier 1 as well as Thrive assessment and emotional support action plans.

5.4 Parental Wellbeing

> '*What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.'*
> (The Marmot Review, 2010)

We know that there are certain risk and protective factors observed within families which determine both the physical, mental, emotional and social development of an infant. Such protective factors include:

- authoritative parenting combined with warmth
- an affectionate bond of attachment being built between the child and the primary caregiver from infancy
- having parents who are educated and in employment
- living in warm, dry homes
- family harmony
- the primary caregiver having psychological resources including self-esteem

Risk factors would include:

- poor attachment
- inconsistent and critical parenting
- poor parental/carer mental health
- family instability, conflict or violence
- marital disharmony/divorce
- large family size/rapid successive births
- absence of father
- very low level of parental education
- drug and alcohol misuse
- primary care givers having learning difficulties

Pregnancy and the first five years of life are one of the most important stages within the life cycle (Shribman, S. and Billigham, K. 2009). Maternal mental health is so important to the development of the mother/child bond that within 10–14 days of birth women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health. The Chief Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

Maternal mental health is so important to the development of the mother/child bond that within 10–14 days of birth women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health. The Chief

Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

5.4.2 Improving Maternal Mental Health

Maternal Mental Health problems affect 1 in 8 women and are a leading cause of maternal mortality. Psychiatric disorders contribute to 12% of all maternal deaths.

In April 2011 NHS Rotherham implemented a Maternal Mental Health Referral Pathway. This was introduced for three key reasons:

I. NICE guidance (Antenatal and Postnatal Mental Health, Clinical Guidance 45) suggests 1 in 8 women will suffer a maternal mental health problems antenatally or postnatally – this equates to more than 500 women per year in Rotherham with young babies and between 500 and 700 pregnant women who currently have no or only a poorly co-ordinated service to support their Mental health.
II. Suicide is the leading indirect cause of death for women up to a year after childbirth (Lewis, 2007) Rotherham has had 2 maternal suicides in the last ten years.
III. Maternal mental ill health can produce adverse outcomes for babies and other children, with consequent long-term impacts, particularly for the child's development. There is robust evidence that babies of parents with mental disorder are more likely to suffer from attachment disorders, also cognitive development deficits and increased likelihood of child psychiatric illness. (NSF For Children, Young People and Maternity Services – Standard 11, 2004)

The pathway is multi-agency and was developed to cover mild, moderate and severe maternal mental health issues. It was agreed by all partners including The Rotherham Foundation Trust FT and RDaSH. Training in the pathway was provided to Midwives during March of 2011 as detailed in section 4.1.2.1 below.

5.4.3 Targeted Early Help Services, including Family Nurse Partnership

RMBC offers a range of Early Help services to families according to how their needs are assessed. If a family's needs are deemed to require statutory intervention, a Child's Assessment will be completed by Social Care teams and an appropriate response will be led by Social Care, with regular statutory reviews.

If a family's needs do not require a statutory intervention an alternative assessment will be completed; wherever a multi-agency response is required, this will be the Family Common Assessment Framework (FCAF). The Family CAF captures a families strengths and difficulties under the categories of alcohol, substance misuse, mental health and emotional wellbeing, work and money, adult skills and learning, exploitation, housing, social isolation and engagement with local services, parenting and basic care skills, family relationships, domestic incidents, anti-social behaviour and crime.

A coordinated response will be formulated which may draw from a number of different services. Children's Centres specialise in responding to the needs of families where there is a child who is 0-5 years old, each school will have an individual offer for children who are

5-18 years old, and the Integrated Youth Support Service will provide a specialist response to children who are 10-18 years old.

In addition to these there are some specialist services in place, including the Targeted Family Support (TFS) Team, who will provide high quality whole family support in line with Rotherham's Early Help Strategy. The team use multi-agency methodology to support families with vulnerable and complex needs across the borough, working to the principles of the Family CAF model.

The work undertaken by the TFS Team is evidenced based, with solution focused interventions and plans used. The intervention is time limited to a maximum of 12 months. All referrals completed to the TFS Team must evidence there are prevalent issues with family relationships; mental health and special educational needs within either the parent/carer or child/children. To be eligible for service provision from TFS, parents/carers or the child must live within the Rotherham Learning Community reach area and the referred child or young person must be between 5 and 13 years of age.

The Family Nurse Partnership programme is licensed by the Department of Health and is an evidence based programme that can positively change the life-course of the clients and their children. Family nurses receive specialist training to work with first time pregnant teenagers up to the age of nineteen years with an intensive home visiting programme offered from early ante-natal until the child is two years of age when the child and mother graduate from the programme to Universal Health Visiting Services.

The family nurses work with the young people to encourage good maternal mental and physical health, raise aspirations, improve economic self-sufficiency and promote strong attachment and positive parenting.

A targeted response is also available through the Families for Change work, which identifies a specific cohort of families according to criteria set out in the Troubled Families Financial Framework, published by the Department of Communities and Local Government (2012). The criteria that trigger inclusion in this cohort are poor school attendance, anti-social behaviour or youth crime and adult worklessness. At least two criteria must be met, alongside a local filter of poor parental mental health, adult misuse of drugs or alcohol and domestic abuse. The response to families in this cohort will also be coordinated using the Family CAF. If a specific need is identified, families will be able to access targeted family intervention services, delivered by a range of providers at various levels of intensity. A family intervention approach will ensure that each family has a dedicated worker who leads a coordinated response for the whole family and provides hands-on interventions (including practical tasks) within the family home. The most intensive family intervention service in Rotherham is delivered by the Family Recovery Programme, an in-house service with eight outreach workers.

Families for Change is also piloting family mediation, which focuses on a restorative approach to repairing family communications, and Multi-Systemic Therapy. During the pilot period there will be places for ten families to access Multi-Systemic Therapy. Multi-Systemic Therapy is for families with a young person between the ages of 11 and 17 who is at risk of going into care due to serious anti-social behaviour and / or juvenile offending. MST is an intensive way of working with families and works to support parents/carers and other family members to develop and sustain strategies to improve their child's behaviour at

home, in school and out in the community. MST is delivered over a period of three to six months using a variety of techniques based upon holistic assessment of the child's ecology. Interventions ay focus upon cognitive and or behavioural change, communication skills, parenting skills, family relations, peer relations, school performance and social networks.

5.5 Voice of Children and Young People

The information below details some of the work undertaken by child and adolescent mental health services and partners to ensure that young people have a voice within the service.

5.5.1 RDaSH Consultation with Children and Young People

RDaSH CAMHS has taken an innovative approach to facilitate participation and to maximise the engagement and experience of children and young people within services with the role of Peer Support Workers (PSW). These are people with a lived experience of mental health difficulties who are employed primarily to help navigate the transition process from children and young people's mental health to adult mental health or wider services such as college.

A key element of the PSW role is to support and maximise participation and they work closely with the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) project manager on this agenda. The PSWs have agreed a slogan to underpin our participation agenda '*Your Service, Your Say, Your Way';* designed an associated poster campaign to recruit children, young people and families to engage in service planning and consultation; supported a young person to design a poster to advertise self-referral in our services; and led various consultation events in local colleges and schools which have informed service development.

The RDaSH CAMHS teams commenced self-referral in September 2013 and a feedback audit tool has been developed which will be used to invite feedback from those young people who have accessed the service via self-referral since September 2013 and on an on-going basis to inform service planning and delivery.

The PSWs have devised a project plan for participation underpinned by the '*Ladder of Participation*' (Hart 1992) which will be presented for approval. RDaSH recognises the need to further develop direct consultation and service evaluation with young people and aspire to have a participation strategy that is written by young people.

Two young people have recently been on the interview panel for RDaSH CAMHS clinicians appointed to attend the CYP-IAPT Systemic Family Practice Pathway. An Interview panel training session in April is being advertised for people aged 13 – 19 years.

The CYP-IAPT project manager has supported the PSWs to begin using a sessional feedback measure to capture the young person's on-going experience of working with a PSW. RDaSH CAMHS plan to collate this information to understand how young people's involvement in differing interventions impact on both their experiences and their outcomes.

5.5.2 Youth Start

Youth Start interventions with young people take a client informed approach and each young person is instrumental in designing their own package of individual support.

Young people were recently involved in interviewing for a new counsellor within the service via a young person's interview panel.

5.5.3 Youth Cabinet Manifesto for Self-Harm 2014-15

For 2014-15 Rotherham Youth Cabinet has as a manifesto aim around the issue of self-harm. The Youth Cabinet is examining how services provide support and advice to young people around issues of self-harm. This work is being supported by a small number of Rotherham Councillors who sit on the Council's Scrutiny Committees and Officers from the IYSS, Scrutiny and Public Health.

As part of its evidence gathering, the Youth Cabinet have spoken with their peers in schools and colleges across Rotherham to collect views from a wide range of young people. This evidence has formed the basis of their work and has been used in meetings with representatives of provider agencies, schools/colleges and Council services to discuss current provision and to identify ways in which services to young people can be improved. From this the Youth Cabinet have identified a number of priority areas which they discussed with decision makers, school leaders and commissioners of services with a view to incorporation into service design and delivery.

On completion of this work, the Youth Cabinet will take their report to Cabinet, following which the recommendations will be circulated to partner organisations for action. The initial themes emerging from this work include:

- Consistent, concise and simple messages for ALL organisations
- Clear, consistent referral routes for ALL organisations
- Involve young people to develop user-friendly information/media messages (including new technology/social media)
- Ensure that young people are involved in service design e.g. commissioning of school nurses
- Ensure that advice to young people is available through drop-ins, one-to-one sessions as well as web-based materials
- Improve and standardise the provision of information on self-harm to all schools
- Establish better links between schools and colleges and share best practice (for example work around peer support and strategies to address stress and exam pressure)
- Examine ways in which access to school nurses can be improved
- Availability of resources/training/support for schools, colleges, amongst parents, young people etc.

5.5.4 Chief Medical Officer's Report 2012

The report by the Chief Medical Officer captured the voice of children and young people. The following were recommendations specific to mental health services:

- Managing the transition from children's to adult services has been consistently identified as a problem for young people, in particular for some vulnerable groups such as those with long-term disabilities and mental health problems
- Mental health to be taken as seriously as physical health
- Stigma was highlighted as a key issue for young people with mental health problems, mainly as a barrier to their accessing services and support
- More health promotion campaigns and teaching in schools to counter the stigma associated with mental illness
- Children and young people who use mental health services want a confidential, accessible mental health service, when and where needed and for services to be age appropriate, with flexible opening hours at times that suited them. Preferred referral methods include self-referral and drop-in services available through the internet, mobile phones, text or email.
- Many young people want access to counselling services within their school
- Young people want more support at first presentation, quicker access to help during an emergency, and better out-of-hours and crisis services, with inpatient units that are easier to access.
- Staff who are approachable, available and skilled in engaging and listening to young people. Children and young people valued continuity, confidentiality and support, particularly at transition.
- For young people using mental health services, lack of adequate information is a repeatedly highlighted problem

There were other recommendations from children and young people within this report which relate to the role of schools, school nursing and GPs.

5.6 Voice of Parents and Carers

As part of regular capture of service evaluation, the RDaSH CAMHS service invites parents and carers to complete 'Experience of Service' (ESQ) questionnaires which are collated on a quarterly basis. In the 3 month period of October to December 2013 the feedback shown at Table 12 was received from 25 parents/ carers.

Parents and young people can complete ESQ's at any time throughout the journey in RDaSH CAMHS; forms are available for completion anonymously and posted into a box within the reception area at Kimberworth Place. Parents and young people seen within community settings are also offered questionnaires which can be returned to service anonymously too.

The Parent Carers Forum has been invited to and attended some of the CYP-IAPT steering group for the partnership, which includes Rotherham.

RDaSH CAMHS are equally aware of the need to engage with parents and carers and have agreed that a series of open days across the localities will be hosted with one of the aims being to ask children, young people and parents how they would like to work with the service. Activities on offer during these days include a design a letter competition and the PSWs will host 'stress bucket sessions' where both young people and parents can gain skills.

GIFT is a participation service commissioned by the National CYP-IAPT team and have contacted the Rotherham Parent Carers Forum directly to ask how they would like to be involved in local service delivery. GIFT have asked for our permission to publish our 'Guide to Routine Outcome Measures for Young People and Families' as an example of good practice with the MyAPT's audience of child and adolescent mental health services professionals.

Healthwatch Rotherham are working with parents to gather their experiences of using RDaSH CAMHS to gain insight into the perceived culture of the service. The report will be provided to RDaSH in the summer of 2014 for their comments and feedback prior to the report being provided to parents.

Table 12

Parent/ Carer	Certainly	Partly True	Not True	Don't Know
I feel that the people who have seen my child listened to me	19	5	1	0
It was easy to talk to the people who have seen my child	20	3	2	0
I was treated well by people who have seen my child	21	2	2	0
My views and worries were taken seriously	17	6	1	1
I feel the people here know how to help me	16	6	3	0
I have been given enough explanation about the help available here	15	6	3	1
I feel that the people who have seen my child are working together to help me	14	9	1	1
The facilities here are comfortable (e.g. waiting area)	24	0	0	1
My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	10	11	4	0
It is quite easy to get to the place where I have my appointments	19	3	3	0
If a friend needed this sort of help, I would suggest to them to come here	19	5	0	1
Overall, the help I received here is good	19	5	1	0

6. Forthcoming Challenges & Risks

A number of challenges and risks will impact on the CAMHS strategy in the coming years. These include:

- Potentially further reducing budgets, both in Health and Social Care.
- Implementation of the new SEND agenda.
- Future integration of Health and Social care provision.
- The introduction of a different payment system for Mental Health Services.

Appendix 1

Glossary of Terms

ACE	Adverse Childhood Experiences
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black & Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	Child Development Centre
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
CYPS	Children and Young People's Services
DCSF	Department for Children, Schools & Families
DLA	Disability Living Allowance
EHWB	Emotional Health & Wellbeing
EHWBB	Emotional Health & Wellbeing Board
FT	Foundation Trust
GIFT	Great Involvement, Future Thinking
GPs	General Practitioners
IYSS	Integrated Youth Support Service
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAAC	Looked After & Adopted Children
LGBT	Lesbian, Gay, Bisexual & Transgender
NFER	National Foundation for Educational Research
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NSF	National Service Framework
ONS	Office of National Statistics
PICU	Psychiatric Intensive Care Unit
PSW	Personal Support Worker
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster & South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SEN	Special Education Needs
TaMHS	Targeted Mental Health in Schools
TRFT	The Rotherham Foundation Trust

Appendix 2

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Appendix 3

NICE guidance

The National Institute for Health and Care Excellence has produced evidence based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice.

The following list is correct as of September 2013.

Eating disorders (CG9)
Self-harm (CG16)
Anxiety (CG22)
Violence (CG25)
Post-traumatic stress disorder (PTSD) (CG26)
Depression in children and young people (CG28)
Obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
Bipolar disorder (CG38)
Antenatal and postnatal mental health (CG45)
Drug misuse: psychosocial interventions (CG51)
Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
Attention-deficit hyperactivity disorder (ADHD) (CG72)
Antisocial personality disorder (CG77)
Borderline personality disorder (BPD) (CG78)
Schizophrenia (update) (CG82)
When to suspect child maltreatment (CG89)
Depression with a chronic physical health problem (CG91)
Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
Alcohol dependence and harmful alcohol use (CG115)
Psychosis with coexisting substance misuse (CG120)
Autism in children and young people (CG128)
Self-harm (longer-term management) (CG133)
Conduct disorders in children and young people (CG158)
Social anxiety disorder (CG159)
Four commonly used methods to increase physical activity (PH2)
Interventions to reduce substance misuse among vulnerable young people (PH4)
School-based interventions on alcohol (PH7)
Physical activity and the environment (PH8)
Maternal and child nutrition (PH11)
Social and emotional well-being in primary education (PH12)
Social and emotional well-being in secondary education (PH20)
School-based interventions to prevent smoking (PH23)
Alcohol-use disorders: preventing harmful drinking (PH24)
Health and well-being of looked after children and young people (QS31)
Insomnia – newer hypnotic drugs (TA77)
Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
Structural neuroimaging in first-episode psychosis (TA136)
Domestic violence and abuse – identification and prevention (in progress)

ROTHERHAM BOROUGH COUNCIL

	Meeting:-	**Children, Young People and Families Partnership**
	Date:-	**Wednesday 24 September 2014**
	Title:-	**Young Carers**

4. Summary

Many Young People within Rotherham are helping to care for a parent or sibling. The person being cared for may have mental health difficulties, a physical, sensory or learning impairment, a long term illness or they may have difficulties relating to substance misuse.

This report outlines how in Rotherham we directly supported young carers in 2013/14.

5. Recommendations

The Children, Young People and Families Partnership is asked to note the report.

6. Proposals and Details

The commissioned Barnardo's Young Carers Service has provided a successful, statutory Young Carers service for the past 7 years on behalf of Rotherham MBC for young carers aged 8 – 18 years. The person cared for will usually be a family member such as a parent, grandparent, sibling, or someone very close to the family. The person or people they care for will have a serious or long term illness, disability or mental health problems, including alcohol and substance misuse; many young carers also help to care for younger siblings.

Through a process of assessment planning and review the service seeks to minimise any negative impact of the caring role thus enhancing the opportunities for young carers to achieve their full potential. This includes taking appropriate action when the caring role is such that it poses significant safeguarding concerns. The service maintains a whole family approach whilst retaining a specific focus on the young carer.

Service support is delivered through assessed need for individual work; time limited focused group work, family work, mediation, advocacy and signposting.

During the year the service has re-established the Rotherham Young Carers Committee and has been working in partnership with UKYP to introduce a local Young Carers Card to enhance support for young carers in their place of education.

<u>Outcomes in 2013/14</u>

For many of the young carers and families supported- the process of achieving improved outcomes can be erratic. This is reflected in the "no change" and the deteriorating scores.

Change within the family has been a major factor in decreasing scores; be that change in the severity of illness of family circumstance. The service has seen a huge increase in deprivation with families regularly presenting with issues of food, fuel poverty and debt. The service distributes food vouchers to young carers' families during these difficult times and works in partnership with agencies to find solutions to their hardship.

Outcomes Assessment Score Summary for Rotherham Young Carers (cases worked with between April 1st 2013 and March 31st 2014) Barnardo's Outcome	Number of outcomes with an improved score	Percentage of outcomes with an improved score (%)	Number of outcomes with no change in score	Percentage of outcomes with no change in score (%)	Number of outcomes with a degraded score	Percentage of outcomes with a degraded score (%)	Number of cases with more than one assessment score
Rotherham Young Carers - File Room	121		46		10		
1.2.04 Increased resilience	25	56	16	36	4	9	45
1.2.25 Reduced impact of caring	25	78	6	19	1	3	32
2.2.02 Free from bullying	2	67	1	33	0	0	3
2.2.03 Reduced victimisation/discrimination	3	100	0	0	0	0	3
4.1.04 Positive/improved family	11	55	7	35	2	10	20

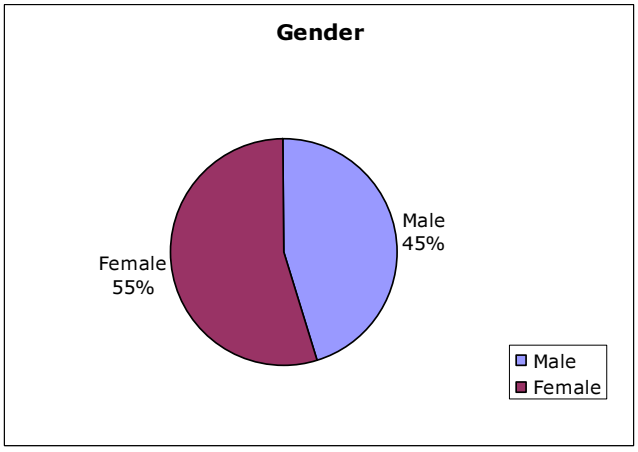
relationships							
4.1.17 Understanding of parent/child illness or disability	20	80	4	16	1	4	25
5.2.01 Satisfactory school/college attendance	4	80	1	20	0	0	5
6.1.06 Enjoy activities/short breaks	17	77	5	23	0	0	22
6.1.10 Access to/use of inclusive resources in community	10	63	4	25	2	13	16
7.1.01 Contribute to planning and decision making	1	100	0	0	0	0	1
7.1.05 Views & opinions voiced and acted on	1	33	2	67	0	0	3
9.5.03 Full receipt of entitlements/grants	2	100	0	0	0	0	2

Outputs

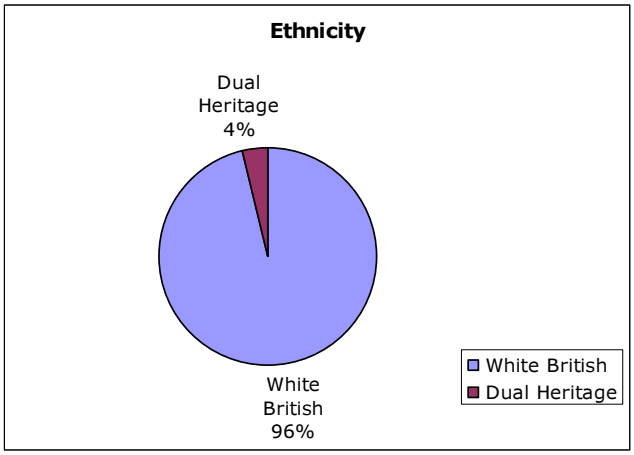
Monitoring Information – Output Statistics

Rotherham Young Carers Service 2013/14	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals 2013/14
Numbers of existing Young Carers on books	61	51	30	34	176
Number of new referrals this quarter	10		7	28	45
TOTAL SUPPORTED	71	51	37	62	221
Number of Breaks for Young Carers provided per quarter *(provide breakdown below)*	282	254	241	179	956
One to Ones	116	74	80	70	340
Family Support	21	11	43	43	118
Outings *(Breaks = YC benefiting. i.e. 2 outings for 10 YC = 20 breaks)* **Residential** **Family Activity**	24	49 23 4	32	0	105 23 4
Group Work *(Breaks = YC benefiting. I.e. 3 group sessions of 6+7+7 attending = 20 breaks)* **Young Carers Committee**	66 18	48 12	49 12	32 9	195 51

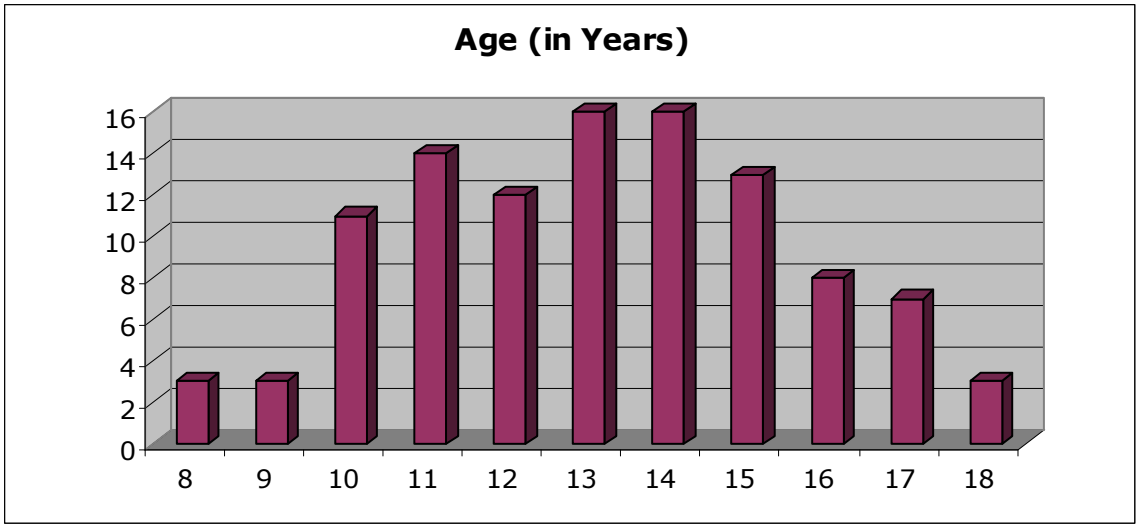
Multi Agency Meetings (TAC, CIN, CORE GROUP, CASE CONF)	26	21	11	13	71
Signposting, advocacy or mediation	8	6	7	10	31
Multi agency work to promote good practice	3	6	7	2	18
	Figures	Below	not	included	in totals
Number of awareness sessions promoting the service	3	6	7	2	18

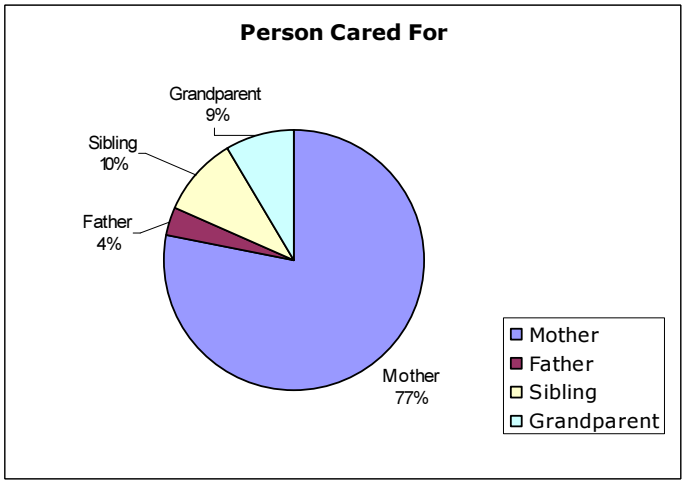


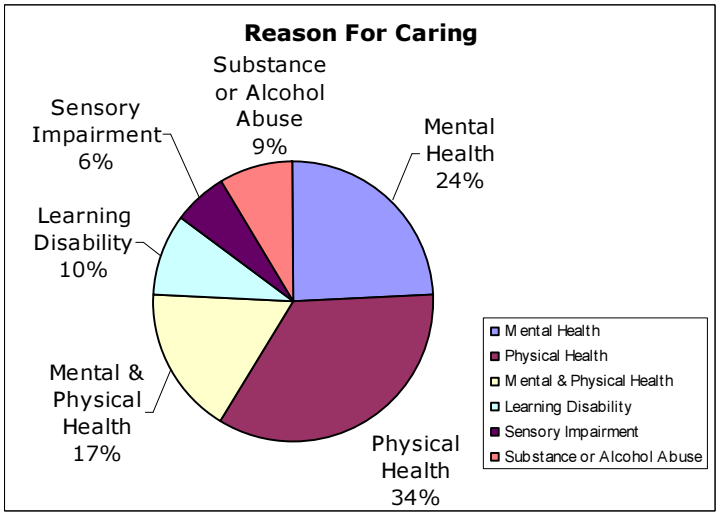
Male – 48
Female – 58

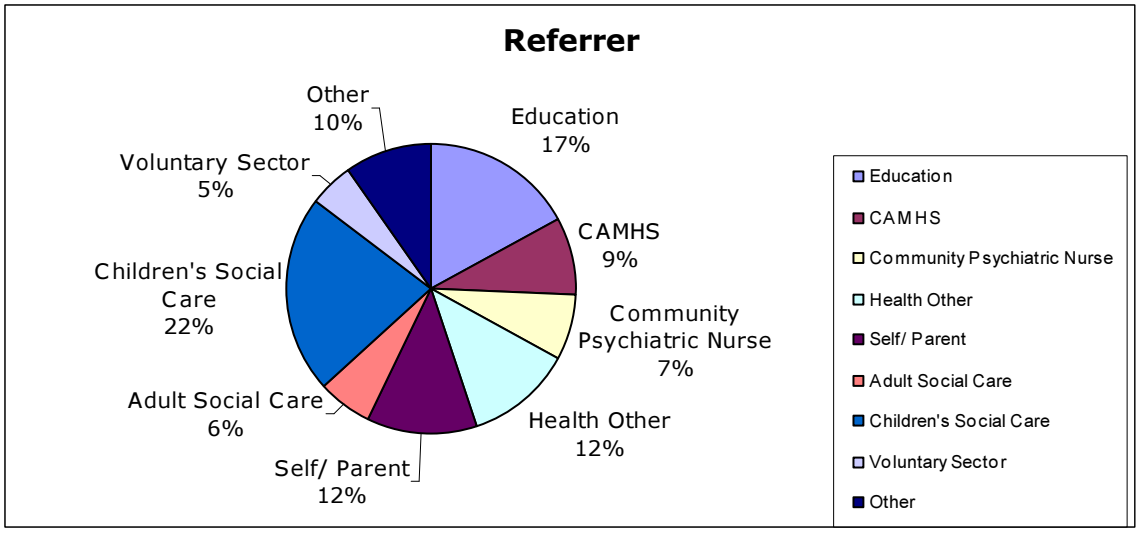


106 young people and their families received a service


Age (in Years)
16
14
12
10
8
6
4
2
0
8
9
10
11
12
13
14
15
16
17
18


Person Cared For
Grandparent 9%
Sibling 10%
Father 4%
Mother 77%
Mother
Father
Sibling
Grandparent


Reason For Caring
Substance or Alcohol Abuse 9%
Sensory Impairment 6%
Mental Health 24%
Learning Disability 10%
Mental & Physical Health 17%
Physical Health 34%
Mental Health
Physical Health
Mental & Physical Health
Learning Disability
Sensory Impairment
Substance or Alcohol Abuse



Case studies

Girl (X) age 10
X currently lives with mum who has several physical health problems and is often hospitalised, father is alcohol dependant and also suffers with some physical health problems; there are four younger siblings.

Background:
X was referred to the service by a children and families social worker in July 2012. At the time of referral the children were at 'Child in Need' level. The family has been very reluctant to accept support from outside agencies, including Rotherham Young Carers. Contact was finally made and work started in November 2012 however we did try and make contact with the family on several occasions from August 2012. The children were made subject to a Child Protection Plan in October 2013. Dad was also imprisoned for breaching his probation and attempted burglary in December 2013 leaving mum to deal with all the children alone over Christmas. This also increased X's caring responsibilities.

Responsibilities:
X took on the responsibility for most of the household cleaning and looking after younger siblings. X is also socially isolated due to her responsibilities.

Impact on X

X was very reluctant to talk about her home life and as a result it was hard to assess what impact her home life had on her as a young person. She was very guarded about what she said and the majority of the time she would say that everything was fine at home. X was socially isolated.

Work with RYC

As X was socially isolated we used social activities to help us build a trusting relationship with X and made it the main focus of the work we offered her. In addition we gave emotional support on a monthly one to one basis, although X remained reluctant to talk about home. The majority of focussed work with X was done through group work as she really enjoyed the sessions. X attended 12 group sessions throughout the time she worked with us. X attended 6 social activities, one of which was a two night residential to Kingswood. X did start to build trust with the service and a noticeable difference was seen in her confidence. X was also referred to the local youth service, who have agreed to early contact as X is not yet 11. School also agreed to fund some after school clubs and X now attends at least one after school club a week. X's grandmother now contributes respite at least once a week. There has also been an improvement in X's attendance at school.

X's confidence grew more and more over time and is now at a position where she personally no longer needs support from RYC. The family has also now agreed to work with a family support worker which will continue to improve the family situation even further.

Rotherham Young Carers (RYC)

Boy age 14

X was referred to the service by Wales High School due to the emotional impact of his parent's separation and his mother's mental and physical health.

Responsibilities

X is worried about leaving mum when he is at school which has a considerable emotional impact on X. These worries X has are impacted by hearing mum cry. X will say that he is ill so that he does not have to attend school, limiting his educational successes and opportunities to socialise and progress.

Work done by RYC

X was offered one to one sessions on a number of different topics that X wanted to discuss. The sessions included; identifying his worries which were; mum's health, home, dad's pending surgery on his back, being bullied again, X's organisation skills, mum's depression and mum generally. Another session was based on creating a poster to help X to remember things he needed to do.

One to one sessions were delivered based on mental health and an information leaflet written by other young carers was given to X to help him realise that other young people are in a similar situation. Work was also completed on physical health, his dad and also ways to manage his anger. X was put on the list for the residential trip.

The work the service completed around mum's mental and physical health has provided X with the confidence and reassurance to attend school and consider activities after school.

X was given the opportunity to attend an activity at Clifton Park however; he was at his dad's. X was also given information on air cadets to take part in after school, which dad bought the uniform for and X was attending with a friend.

An in-house grant application was completed whilst X was with the service for the installation and the use of Rothercare Community Alarm Service for a year to reassure X that mum will be ok when he is not at home, therefore increasing his school attendance and social opportunities. X does have a good support system at home so he has someone to talk to on a daily basis if any worries reoccur before they become unmanageable. X was seeing MIND and the school nurse in school however; X does not meet their criteria. X is also working with a social worker.

Contact Name:

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ROTHERHAM BOROUGH COUNCIL – REPORT TO CHILDREN, YOUNG PEOPLE AND FAMILIES PARTNERSHIP

1.	**Meeting:**	**Children, Young People and Families Partnership**
2.	**Date:**	**24th September, 2014**
3.	**Title:**	**Performance Information for the academic year 2013-2014**
4.	**Directorate:**	**CYPS**

5. Summary

This report presents a headline summary of the available performance data for the academic year 2013/14. The data has not been validated and national comparative data is not yet available. The attached paper Educational Outcome in Rotherham Schools and Setting explains the background to the data at each Key Stage.

6. Recommendations

The contents of this report are noted

7. Proposals and Details

The 2014 assessment results show improvements at every key stage

EYFS

- Rotherham's performance for a good level of development has increased by 6.5% to 62.2%. This is 2% above the national average at 60.3%.
- Average Total Points (ATP) has increased by 1.3 to 34.3 and 0.5 above the national average at 33.8.
- The percentage inequality gap was reduced by 3.2% to 32.5%, this is 4.1% below the national average in 2013.

Phonics

- 68.7% of pupils in year 1 achieved the standard mark in the national phonics screening check in 2014; this is an increase of 6.2%. This compares to the national figure of 74%, an increase of 5%. The gap to the national average is reduced slightly to 5.3%.

Key Stage One

- The improvement in overall results in Rotherham in 2014 is in all subjects and levels. The improvement at L2+ is below the national average improvement therefore the gap has widened.
- Gaps to the National average for all pupils range from in line at L3+ writing to 6.1% below at L2+ Reading. The gap is wider at L2+ / L2b+ than at L3+.

Key Stage Two

- The KS2 results in 2014 show an increase in all subjects at all levels. The rise is between 2.4% and 5.3% at L4+, between 6.7% and 7% at L4b+ and between 3.9% and 8.3% at L5+. Progress measures have increased by 5% in reading, 2% in writing and 2% in mathematics. The gap to national averages has narrowed in all subjects at all levels and above the national average in mathematics for the first time. The significant improvement at L4b+ in all subjects has shown an increase of 6.9% in the Government's 'good level 4' outcome.

Key Stage Four

- The provisional 5+A*-C including English and mathematics average is 60.1%
- The provisional 5+A*-C average is 67.1%

Narrowing the gaps

Girls continue to outperform boys in reading and writing at all key stages but the gap has narrowed in 2014. There is a significant improvement in boys attainment at KS2 in reading and L4b+ mathematics, this has impacted on the improvement in the L4b+ R,W&M combined outcome.

Attainment at KS1 for those pupils eligible for pupil premium has increased at L2+ and L2b+ in 2014. Attainment at KS2 for those pupils eligible for pupil premium has increased at all levels in all subjects with a significant improvement in reading and L5+ mathematics.

In Rotherham the percentage of pupils in good or better schools is 78.8% as of 31/08/2014. (72.2% primary, 87% secondary and 100% special schools)

Key Stage 5(A level results)
2014 A Level results Rotherham schools overall pass ratereported on results day was 98.6% against a reported National average of 98%

Whilst this is -0.1% lower for Rotherham than in 2013 it reflects a trend seen nationally with the pass rate reported to be down for the first time in over 30 years

8. Finance

N/A

9. Risks and Uncertainties

N/A

10. Policy and Performance Agenda Implications

N/A

11. Background Papers and Consultation

N/A

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Head of School Effectiveness *Karen.Borthwick@rotherham.gov.uk*

Education Outcomes in Rotherham Schools and Settings

The National Curriculum is divided into Key Stages that children are taken through during their school life.

Early Years Foundation Stage Profile (EYFS)

The EYFS Profile is assessed when children reach the end of Foundation Stage (age 5) through ongoing and summative teacher assessment**.** Rotherham's Early Years performance in many areas relating to children's outcomes has been on an upward trajectory since 2009. The framework was revised in 2012 and due to the changes in the way children are assessed at the end of the Foundation Stage it is not possible to make comparisons between 2013 assessments and historical data**.**

The expected level to achieve at the end of EYFS is a 'good level of development'.

- In 2013 the LA average was 3.7% above the national average for a good level of development at 55.7%.
- Average Total Points (ATP) is at the national average at 33.0.
- The LA average is expected to meet or exceed the national average in 2014.

Key Stage 1

Key Stage 1 is taught during Years 1 and 2 of primary school when pupils are aged between 5 and 7. This includes the phonics screening check which is administered to all children in Year 1. It also includes tasks and tests which can be performed at any time during Year 2, so children may not know that they are being formally assessed. These tasks and tests are designed to be administered informally as part of normal classroom activity. The results inform teachers' overall assessments in English, mathematics and science, which are reported to parents and the DfE.

Phonics Screening Check

This is a short assessment that was introduced in 2012 and designed to confirm whether pupils have learned phonic decoding to an appropriate standard by the age of 6. All year 1 pupils in maintained schools, academies and free schools must complete the check.

The phonics check will help teachers identify any children who need extra help so they can receive the support they need to improve their reading skills. These children will then be able to retake the check in year 2.

The standard mark was 32 or more out of 40 in 2012 and 2013. The standard mark for 2014 will be released on the 30th June.

- In 2013 62.5% of pupils in year 1 achieved the standard mark in the national phonics screening check in 2013, this is an increase of 7.5%. This compares to the national figure of 69%, an increase of 11%. The gap to the national average is 6.5%.
- The LA average is expected to improve and reduce the gap to the national average in 2014.

End of Key Stage 1 Teacher Assessments
The statutory Key Stage 1 tasks and tests in reading, writing and mathematics are designed to test children's knowledge and understanding of the associated programmes of study. They provide a snapshot of a child's attainment and help inform the final teacher assessment judgement reported for each child at the end of Key Stage 1 (Year 2, aged 7).

Pupils are expected to achieve Level 2b+ or more in reading, writing and mathematics.

- In 2013 attainment in Rotherham remained static, whereas National averages increased in all subjects therefore widening the gap.
- Rotherham trends in attainment show that girls continue to outperform boys in reading, writing and maths at all levels.
- The Rotherham gap between girls and boys attainment has increased in 2013 as boys attainment has decreased in all subjects at each level and girls attainment has increased in all subjects at each level.
- The attainment of boys in Rotherham is well below the attainment of boys nationally and the gap is significant in 2013.
- In 2014, the performance of boys in Rotherham need to improve in a number of schools to narrow the gap to the national average.

Key Stage 2
Key Stage 2 is taught during Years 3, 4, 5 and 6 of primary school when pupils are aged between 7 and 11. Programmes of study set out what teachers should cover in every subject during the Key Stage. The Key Stage 2 national curriculum tests are designed to test children's knowledge and understanding of specific elements of the Key Stage 2 programmes of study. They provide a snapshot of a child's attainment at the end of the Key Stage.

Pupils are expected to achieve L4+ in reading, writing and mathematics and make two national curriculum levels of progress from the end of Key Stage 1 to the end of Key Stage 2.

The Department for Education floor standard measure in 2014 has increased to at least 65% of pupils achieving Level 4 and above in reading, writing and mathematics and above the national median progress measures between KS1 and KS2 in reading, writing and mathematics.

In 2013, the KS2 results show an increase in writing, mathematics and the new combined reading, writing and mathematics measure at L4+ and in mathematics at L5+. The increase is between 1.6% and 3%. The reading results decreased by 1% at L4+ and 3.7% at L5+. Progress measures have increased by 1% in writing, 4% in mathematics and decreased by 3% in reading. The gap to national averages remains too wide particularly at L5+ and the progress measure in reading.

In 2014 Rotherham averages need to improve to meet national averages and narrow the gaps at L5+. A number of larger schools with historically underperforming cohorts have new leadership arrangements and the improvements should impact on overall Rotherham LA averages.

Key Stage 4

Key Stage 4 is taught during Years 10 and 11 of secondary school when pupils are aged between 15 and 16. At the end of this stage, pupils in Year 11 (usually aged 16) are normally entered for a range of external examinations. Most frequently, these are GCSE (General Certificate of Secondary Education) exams and a range of other qualifications, including National Vocational Qualifications.

The Secretary of State for Education announced that, with effect from 29 September 2013, only a student's first entry to a GCSE examination will count in their school's performance tables.

The first entry across the subject, regardless of qualification type, will be the one that counts. This means that wherever a learner achieves a BTEC and a GCSE in the same subject in the same year, the GCSE result will always take precedence over the BTEC result, and is the one that will be reported in performance tables, since the GCSE exam will always come before the BTEC Entry Date.

The impact of these changes may show a decline in results in some schools in Rotherham and Nationally. In summer 2013, nationally 23% of maths entries (170,537 entries) and 10% of English entries (70,134) were from pupils who were not yet at the end of their key stage 4 study.

The outcomes for Rotherham pupils continues to improve, GCSE results rose for the 11th successive year in 2013. Rotherham has exceeded national averages in all the attainment thresholds except English Baccalaureate.

- 5+A*-C including English and mathematics increased by 3.6% to 63.6% against an increase in the national average of 1.8% to 60.8% (state-funded schools) and a decrease of -0.2% to 59.2% in the national average (all schools). Rotherham LA average is 4.4% above the national average (all schools) and 2.8% above the national average (state-funded schools). This is the second year Rotherham averages have exceeded national averages for this threshold.
- The 5+A*-C indicator increased by 0.9% to 84.8%, national averages remained at 2012 results. Rotherham's average is 1.7% above the national average (state-funded) and 3% above the national average (all schools). This is the third year Rotherham averages have exceeded national averages for this threshold.
- % A*-C in English increased by 2.6% to 70.8% and continues our upward trend. Rotherham LA averages are above National averages by 2.9%, this is the third year Rotherham averages have exceeded national averages. (data source NCER EPAS)
- % A*-C in maths has risen by 4.5% to 70.9% and in line with the national average. This is a significant improvement and the first year that Rotherham has met the national average.

Key Stage 5

Key Stage 5 describes the two years of education for students aged 16-18.

Results are published as an average point score per A level entry and average point score per A level student.

Rotherham averages remain below national averages. There is a decline in both Rotherham and national averages APS per student 2011 -2013.

Help and Protection for Children and Young People
Their experiences and progress

Our Strengths

- 28.5% improvement in the timeliness of assessments since the introduction of the new framework
- Well embedded Early Help Assessment Team
- Additional investment in Contact and Referral Team (CART) Social Worker Resource
- Partner agencies co-located completing phase 1 of Multi Agency Safeguarding Hub (MASH)
- Multi-Agency CSE team co-located to support MASH
- Partners trained and utilising threshold descriptors
- Threshold descriptors developed for CSE
- Graded care profile model for neglect cases agreed and in use
- All newly qualified social workers supported by dedicated Social Work Practice Consultant through ASYE vacancy rate at 4% compared to 8% regionally and 14% nationally
- Low agency rate 3%
- 82% of children's centres graded good or outstanding
- Strong Family Recovery Programme and additional support for Troubled Families (Families for Change)
- Early Help Dashboard developed to support Performance Management

Priorities

- Further embed the voice of the child
- Develop, align and integrate processes for MASH – Phase 2
- Establish feasibility of a single view of a child ICT solution
- Ensure appropriate engagement and response to the emerging needs of minority communities
- Ensure all relevant children have a CIN plan review every 8 weeks
- Evaluate the impact of Early Help provision
- Continuous review of caseload sizes

Children Looked After
Their experiences and progress

Our Strengths

- Looked after children numbers remain stable
- Strong Corporate Parenting Panel
- In-house fostering placements increased from 146 in Dec 13 to 186 in July 14
- Increased placement choice
- Regional commissioning frameworks developed for out of authority placements
- Regular consultation with Looked After Children (LAC) Council
- Embedded LAC and Adopted Children Support & Therapeutic Team
- Children's Homes improved 3 out of 5 rated 'Good'.
- 96.92% attendance rate for primary school pupils
- No permanent school exclusions
- Fostering plus scheme developed and first carers approved

Priorities

- Continued focus on LAC strategy priorities including
  - Placement stability and permanence
  - Educational achievement for LAC
  - Emotional wellbeing and physical health
- Ensure all children and young people have a quality PEP, reviewed termly
- Increase the number of children who have health and dental assessment
- Further reduce the number of out of authority placements
- Continue development of our Fostering Plus scheme to increase adolescent in-borough placements
- Develop further supported lodgings so that more young people will be able to "stay put"
- Work with courts to improve completion rates for care proceedings within 26 weeks to fully implement Public Law Outline (PLO)

'Working together to improve the lives of all Rotherham's children and young people'

Our CYPP Priorities are:

- Ensuring children have the best start in life
- Engaging with parents and families
- Reducing the harm to children and young people who are exposed to domestic abuse, alcohol/substance misuse and neglect
- Focusing on all children and young people making good progress in their learning and development
- Targeting support to families in greatest need to help access learning/employment opportunities
- Working across the partnership to eradicate child sexual exploitation

Adoption
Seeking permanence

Our Strengths

- Year on year increase in children adopted; 36 in 2013/14
- Increase in adoptions for traditionally difficult to place children
- Reduced the number of days between children entering care and placement with adopters from 634 to 453 days
- Reduced the timescale between placement order and matching decision from 284 to 183 days in the last 6 months of 2013/14
- Children leaving care via adoption has increased from 21% to 27.69% since 2012/13 which is higher than the national average
- Adoption Team capacity increased
- Created Dedicated Family Finding Team
- Established fostering to adopt service
- Increase in the number of approved adopters from 18 in 2012/13 to 31 in 2013/14
- Increased the provision of adoptive families for our neighbouring authorities
- Increased regional working within the Yorkshire and Humberside Consortium

Priorities

- Improve the timeliness of stage one adopter assessments
- Continue with our Adoption Activity days in partnership with our Adoption Consortium to find placements for harder to place children
- Continue to reduce the time between children entering care and placement
- Continue to improve the timeliness for children between their placement order and matching decision
- Further improve our capture of the views of children
- By March 2015 meet our target to increase the number of adoptive families by 42

Care Leavers
Their experiences and progress

Our Strengths

- 96.3% of care leavers are suitably housed
- Effective use of management information to drive improvements in practice
- Newly integrated care leaver service resulting in fewer changes of social worker and continuity of care
- Joined up management oversight of LAC and leaving care
- Better management oversight and the ability to consistently carry out monthly staff supervision
- Managers are positive about the changes and have high aspiration for LAC and Leaving care children and young people

Priorities

- Increase the number of young people who are in Education, Employment or Training (EET)
- Strengthen support for and opportunities open to care leavers
- Continue to develop the role of the Virtual Head and Virtual School to improving attainment, aspiration and engagement of care leavers in EET
- Ensure Risk Assessments are consistent and linked to care plans
- Further improve the quality of assessment, recording and care planning for children

Leadership, Management and Governance
An effective strategy for services that make a difference

Our Strengths

- Strong political and organisational commitment to the children's agenda
- Lead member and Chief Executive lead children's issues at a regional level
- Qualified, stable and committed frontline workforce, appropriately trained with strong CPD opportunities
- Commitment to transparency (Jay report)
- Increasingly visible, challenging Local Safeguarding Children's Board (LSCB) with effective Independent Chair
- Effective partnership working
- Continue to develop links between corporate parenting, Rotherham local safeguarding board and Health and Well Being Board
- Protection of front line service safeguarding budgets
- Clear Strategies for Change
- Strong corporate parenting function
- Views of young people used to inform practice

Priorities

- Commitment to implementing all recommendations from the Jay report
- Strengthen scrutiny arrangements
- Continue to develop LSCB through establishment of executive group
- Continued development of partnership strategies across key priorities
- Continue to develop and embed the Performance Management Framework
- Develop and improve the case recording system (CCM)

ROTHERHAM METROPOLITAN BOROUGH COUNCIL

1.	**Meeting:**	**Children, Young People and Families Partnership**
2.	**Date:**	**24th September 2014**
3.	**Title:**	**Transformation Challenge Award**
4.	**Directorate:**	**All**

5. Summary

In late April the Government announced the availability of £105m Transformation Challenge Award (TCA) grant and a further £200m capital receipts flexibility.

Cabinet approved on 18th June 2014 that an Expression of Interest should be submitted to secure £0.7m of grant funding from the TCA programme.

Our Expression of Interest presented in July 2014 was well received and Rotherham has been invited to present a Final bid proposal by 1 October 2014.

It is proposed that a Final bid proposal from Rotherham is submitted to fund the development of a Multi-Agency Safeguarding Hub (MASH) underpinned by the development of a Single view of a Child information dashboard

6. Recommendations

i) To note the principle of Rotherham submitting a Transformation Challenge Award bid and for this to be developed further for submission on the 1st October 2014.

7. Proposals and Details

It is recognised that **local authorities face challenges** in delivering high quality services from a combination of demographic pressures, increasing user expectations, and fiscal consolidation.

To meet these local authorities **need to re-engineer their business and redesign** their services to make them sustainable over the long term. Key to achieving this is the coming together of different authorities and parts of the public sector to share staff, other resources including IT, and core services; joining with major partners in their area; and making the most of their assets. These kinds of **radical changes can require upfront funding**. The Transformation Challenge Award is available to provide this kind of funding, targeted at the best proposals which are likely to make the biggest difference across the country.

Source: CLG guidance on Transformation Challenge Award

The Transformation Challenge Award is a challenge fund which makes £120 million grant (£15 million in 2014 to 2015 and £105 million in 2015 to 2016) and a £200 million facility to use the capital receipts from asset sales flexibly to support transformation. The 2014/15 is predominantly (if not exclusively) for district councils to share chief executives and / or management teams.

The Government press release relating to the scheme stated the funding:

> *"is to be made available … to areas with ambitious plans for improving services that could include integrating health and social care; getting the unemployed back to work; or early intervention to get children ready for school. At the heart of all these plans will be a renewed drive to redesign public services in a way that works for users, as well as efforts to reduce long-term costs to the taxpayer by making public bodies both more efficient and more effective".*

The critical criteria to be met for the scheme are:

- Savings must exceed the amount of grant / capital receipt flexibility sought.
- The bid must have a positive impact on service users.
- As a minimum, bids must be in partnership with at least one other partner. This could be another local authority, public authority, the Voluntary and Community Sector or a private sector partner.
- ***For capital flexibility only***. That the value of the asset sale is genuinely additional to those disposals that would have happened anyway.

Background:

RMBC and its partners have committed to the development of a Multi-Agency Safeguarding Hub (MASH).

The MASH will help to bring about positive outcomes for children and young people, their families and carers through a multi-agency approach to referral, decision making, assessment and the provision of services at the right time, in the right place and by the right person.

It will focus on safeguarding children and dealing with domestic abuse. The co-location will enable agencies working with children, young people, their families and carers to work collaboratively to offer a co-ordinated response to families. This will be carried out by agencies collectively assessing need and identifying services from the point of contact, through referral and decision making to the provision of services to safeguard children and support their families. The objective is to provide an improved 'journey' for the child or parent/carer with a greater emphasis on early intervention.

Single View of a Child

To underpin this work a "single view of a child" integrated data dashboard is proposed. The dashboard will provide an holistic view of performance across partners, underpinned by a single view of the child/family. This will provide the following benefits:

- Improve the accuracy of information shared.
- Enable partners to share information more effectively and timely.
- Provide one holistic view of the child created by the information held by partner agencies.
- Provide the most up to date information about the child and family.
- Enable visible identification of the child's and families journey and where they are in the process.
- Provide a tool for the collation of partner data and the ability to monitor and manage performance against this data

As part of the contract for the social care system with Northgate an infrastructure was purchased in 2013 which will be the basis for further developments around a single view of a child

It is envisaged however that this will be rolled out wider to include our Foundation Years Service and to support our Families for Change work (troubled families), it would be hoped that the IT development could then be shared (sold on) to other Local Authorities for use in their multi-agency teams.

Next steps:

The next steps and timescales providing the recommendation is approved by Cabinet are as follows:

- Formal signature from Partners – 29th September

- Expression of interest deadline - 01st October
- Winning bids announced – November

Partnership Commitment to this is critical and the project was discussed at the Children Young People and Families Partnership on the 21st May and partners gave their verbal commitment to supporting the bid.

The Final bid documentation is presented in a prescribed format in which our proposal is structured across five thematic cases (strategic, financial, economic, commercial and management). This presentation is based on the appraisal and evaluation methodology developed by HM Treasury (The Green Book) and includes a Cost Benefit Analysis. A draft of the Final Bid Proposal is appended to this report.

The final decision on which schemes will receive funding will be made by the Ministers based on an assessment of whether the bid meets the eligibility criteria, the value for money offered by the scheme, and whether it is viable and desirable.

8. Finance

There are no financial implications associated with the bid process, however if successful there could be a significant amount of investment in Rotherham to implement the MASH development which is underpinned by an IT solution for sharing information with partners.

It is anticipated that the project costs will total £1.2m to receive:

- £0.7m of external grant funding,
- £0.5m of additional funding through the sale of assets under the flexible use of capital receipts facility.

The aim of the flexible use of capital receipt policy is to allow local authorities flexibility to spend their capital receipts from new asset sales, which can normally be used for capital expenditure, on a one off revenue costs of service reform.

A large amount of these costs is related to the IT platform to support the single view of the child work. The project costs are still under review and the final figure may be reduced once project costs are confirmed with all service areas.

It is recognised that working in a more multi-agency way and intervening earlier where there are concerns about a child will reduce duplication and bureaucracy, increase productivity, result in a reduction in the number of inappropriate referrals and reduce the number of people accessing high cost services. These costs savings and fiscal benefits are anticipated to be close to £2.7m over ten years. This information will be presented in the Cost Benefit Analysis prepared for the bid. Thus the project will deliver on the objective that DCLG identifies for the transformation bid, by providing the evidence that savings much exceed the amount of grant / capital receipt flexibly sought.

9. Risks and Uncertainties

There is no risk associated with the bid process. Failure to bid leaves the Council with a missed opportunity to obtain potentially significant funding to support the selected transformation project. Project risks are in relation to Partner commitment, realisation of savings, ability to deliver IT solution, total costs exceeding grant investment, There may be ongoing revenue costs from 2016/17 not funded through the TCA, (for example £85k per year for ICT licences and maintenance), although these ought to able to be offset by savings through reducing the costs of care and administration.

10. Policy and Performance Agenda Implications

The proposed project makes an important contribution to corporate priorities in relation to “protecting our most vulnerable people and families, enabling them to maximise their independence”.

11. Background Papers and Consultation

- Transformation Challenge Award documentation

12. Contact Names:

Colin Earl, Director of Audit & Asset Management, ext 22033,
Sue Wilson, Performance and Quality Manager, ext 22511

Transformation Challenge Award

2015-16 Final Bid Form B

B. Encouraging places that have ambitious plans to work in partnership across the public sector and with the voluntary and community sector or private sector to re-design services.

Disclaimer
There shall be no expectation of grant until authorities have been formally notified in writing by the department. All the applicant's costs and charges incurred as a result of making this application shall be for the applicant's account and cannot be claimed as part of the project.

The Data Protection Act: Freedom of Information Act 2000
The Department for Communities and Local Government undertakes to use its best endeavours to hold confidential any information provided in any application form submitted, subject to our contracting obligations under law, including the Freedom of Information Act 2000. If you consider that any of the information submitted in the application form should not be disclosed because of its sensitivity, then this should be stated with the reason for considering it sensitive. The department will then consult with you in considering any request received under the Freedom of Information Act 2000 before replying to such a request.

Applicants should be aware that the following conditions will also apply to all bid applications:

- We may use your information for the purposes of research and statistical analysis and may share anonymised information with other government departments, agencies or third parties for research and statistical analysis and reporting purposes.
- Our policies and procedures in relation to the application and evaluation of grants are subject to audit and review by both internal and external auditors. Your information may be subject to such audit and review.
- We propose to include light touch monitoring by the department utilising publicly available information. We would encourage applicants to regularly publicise progress on their websites and disseminate good practice.
- The department will publish summaries of all successful bids.

2015-16 Transformation Challenge Award (TCA) – Final Bid Form

Completed final bid forms should be approved and signed by the Section 151 officer of each local authority partner to the bid and authorised person for other partners. The form should be returned in electronic format to transformation@communities.gsi.gov.uk by no later than 5pm on 1 October 2014. Please also complete and send a complete New Economy CBA Tool with your application.

PART A: BID INFORMATION

DRAFT VERSION PREPARED 18/09/2014

Section A1: Bid information

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Local authority name/Name of bidding organisation:	Rotherham Metropolitan Borough Council
Name of contact(s):	Colin Earl
Position in authority:	Director of Audit and Asset Management
Telephone number(s) of the contact(s):	01709822033
Email address of the contact(s):	Colin.earl@rotherham.gov.uk
Amount of grant bid for:	£700,000
Amount of capital flexibility bid for:	£522,876
Name of partner organisation(s):	Rotherham NHS Foundation Trust

	South Yorkshire Police
Short project title:	Multi-Agency Safeguarding Hub (MASH) in Rotherham
Short project summary *[max 150 words]*:	To create a Multi-Agency Safeguarding Hub (MASH) that will act as the central resource for the whole of Rotherham receiving all safeguarding and child protection enquiries. The MASH will be staffed with professionals from a range of partner agencies including Social Care, police, and Health. These professionals will share information to ensure earlier identification of vulnerable children, and take a whole family approach to safeguarding children. The MASH will adopt a 'single view of the child approach' by gathering information from every agency and use this to decide the most appropriate intervention to respond to the child's and families identified needs. The MASH method will provide a 'single front door' that can draw on multi-agency experience, create swifter checks ensuring that services for children work more effectively together at the point of referral and decision making. The MASH will help simplify processes and communication between professionals and with families.

Section A2: Eligibility criteria

Note: This bid is for the Transformation Challenge Award 2015-16 B.
Please tick to confirm that the bid meets all the following eligibility criteria:

1. Savings must exceed the amount of grant / capital receipt flexibility sought. √
2. The bid must have a positive impact on service users. √
3. As a minimum, bids must be in partnership with at least one other partner. This could be another local authority, public authority, the Voluntary and Community Sector, or a private sector partner. √
4. *For capital flexibility only*. That the value of the asset sale is genuinely additional to those disposals that would have happened anyway – tick or specify not applicable. √
5. The proposal has been signed off by your Section 151 officer. √

PART B: BUSINESS CASE

Section B1: Strategic Case

This section should cover:

Objectives and rationale

a. Objectives - what are you trying to address/improve
b. The reason for transformation - why the existing approach needs to change and the impact of not transforming services
c.

Proposed transformation

d. The new service model you are proposing *[high level description is fine]*
e. Any other options have you considered and why is this is the best option *[this only needs to be covered at a high level – you are not required to cost other options]*
f. How this transformation fits with wider priorities for you and your partners

[Please complete in the box below – maximum 3 pages]

a. Objectives

The purpose of the MASH is to contribute to improved outcomes for safeguarding children, young people, their families and carers, and victims of domestic abuse through collaboration and close integration of services and processes.

Our primary objective is to improve decision making at the point of the initial referral and assessment through the sharing of partnership information to develop an efficient multi-agency approach that has strong positive outcomes for the service and the service users.

This will result in:

- Robust and timely decision making processes among professionals who will gain greater ability to step up and step down risks assessments and allocate resources accordingly,
- Eliminate duplication of process across public services,
- Faster, more co-ordinated and consistent responses to new safeguarding concerns about vulnerable children and adults such as Child Sexual Exploitation/Prevention,
- Greater ability to share information quickly and identify repeat incidents and potential vulnerability.

The MASH method will enable more preventative actions to be taken, addressing

cases before they escalate. It will enable faster and more co-ordinated responses to safeguarding concerns and help to detect long standing patterns of abuse and neglect. It will provide improved journey for the child and parent/carer with a strong emphasis on early intervention.

The MASH will help simplify processes and communication between professionals and with families.

b. Reason(s) for transformation

:

The reasons for transformation are found in our drive for service improvements, our search for greater efficiencies across services and faster responses to safeguarding concerns. The development of the MASH will also address recommendations contained in the Rotherham Local Safeguarding Children Board Child Sexual Exploitation review carried out in late 2013 and fulfil the commitment to improve responses to domestic abuse, and the decision of the Rotherham Domestic Abuse Priority Group to manage domestic abuse services through the MASH.

In developing the Rotherham MASH we recognise the needs to reduce bureaucracy and duplication of processes:

- To allow a focus on the most relevant cases,
- To provide greater ability to target the most urgent cases before escalation,
- To address an increase in repeat referrals and cases ending in 'no further action',
- To reduce the number of inappropriate referrals and non-referrals,
- To increase the use of early help assessments such as the Common Assessment Framework,
- To reduce the number of people accessing high cost services unnecessarily.

MASH arrangements have already been tested by a number of other Local Authorities. Feedback from these projects indicates that the MASH model provides more robust decision making processes and enhanced communication mechanisms between professionals.

More reasons for transformation are to be found in projected demographic trends in Rotherham. The long term trend is that children and young people will become ethnically more diverse with evidence of growing disadvantage and social deprivation in these groups. Greater awareness of safeguarding children issues may translate in rising numbers of interventions and will call for enhanced processes and communication between professionals and with families.

The New Service Model

From August 2014, the Police and Social Services operational staff have been co-located to the Riverside House building to offer a single 'front door' to draw on multi-agency expertise. These will be joined by Health in October 2014. The new location regroups on the same floor our Early Help Assessment Team, Education Welfare, Integrated Youth Services and the Independent Domestic Violence Advocacy service and Child Sexual Exploitation Team.

Our priority is to introduce new procedures and protocols to reduce the number of children and families inappropriately accessing costly services. This work is placed under the leadership of the Children and Young People's Partnership Group.

The new governance structure will be built on strong partnership working and information sharing models. The new co-location arrangement will facilitate better use of information sharing in line with the data protection act and based on protocols already agreed between agencies that are committed to a common approach. The TCA funding will support the development of the ICT platform to provide timely and comprehensive information which will inform decision making and reduce information processing duplication. It will help reduce costs of intervention.

The MASH process will enable partner agencies to contribute to decision making following contact and referral and will ensure that families receive a relevant, timely and co-ordinated response.

Other options considered

Other options were considered as follows:

No change to compartmentalised culture – Teams are co-located but without a review of procedures and protocols and no integrated data process. Co-location on its own would not lead to improved communication channels and removal of errors and duplication. The status quo is unsustainable due to the year on year increase in referrals, resulting in inefficiencies in current system putting children at risk and exposing council to financial pressure.

Co-location with review of procedures and protocols but without implementation of the single view of the child solution - This would improve decision making and enhance the safeguarding activity of all partners by streamlining procedures to reduce the number of inappropriate referrals. Efficiency gains would be limited by the absence of robust integrated information sharing protocols. Tighter strategic fit would be obtained between agencies but efficiency gains would not be secured from the removal of duplication and data errors. This option does not realise the benefits of a fully co-located MASH team enabling information to be shared more easily and quickly across teams providing enabling a more reactive response to address vulnerability

Operational staff remains in partner buildings and communicate via non face to face methods such as phone, email and Skype. Information sharing is entirely reliant on integrated IT systems and on individual organisation taking ownership of the data cleansing process. Integration would be fully dependent on the quality of the IT protocols and the efficient use of technology. Redesign of process and case management protocols will not be organic and initiated at operational level. Again this option does not realise the benefits of a fully co-located MASH team enabling information to be shared more easily and quickly.

Wider Priorities for RMBC and partners

RMBC wants to oversee a transformation in public services so that service providers work collaboratively to deliver integrated services, empowering communities and

individuals to be part of the solution rather than part of the problem.

Public sector agencies in Rotherham face significant challenges to deliver more customer-focused services with smaller resources. This involves looking at new ways of delivering children's services and providing greater value for money.

The drive for multi-agency partnership workings where agencies work more closely together to assess and define need is underpinned by a raft of national reviews and their recommendations among them:

- Climbié Inquiry Report (2003)
- Laming review (2009)
- Working Together to Safeguard Children (2010, 2012)
- Munro Review into Child Protection (2011)

In particular, the Laming review (2009) identified key weaknesses in the way that a range of agencies and individuals, who are separately in contact with a child at risk, share pertinent information with one another. The review concluded that in the absence of a multi-disciplinary approach and strong partnership protocols between agencies no individual or team has a complete picture of a child's circumstances.

Rotherham has made real improvements in recent years to strengthen the quality of its assessment and care planning protocols as highlighted in the Jay report (2014). More needs to be done and this involves looking at new ways of delivering children's services with smaller resources. Rotherham will capitalise on the work already engaged with its partners to improve the quality and consistency of risk assessments through the MASH intervention.

Section B.2: Financial Case

This section should cover:

Financial impact

a. Using the New Economy CBA Tool *[to be submitted with bid]* please provide the following information:
   - Net present budget impact
   - Payback period
   - Breakdown of cashable savings by each partner
     - What discussions have you had with partners to confirm these

Funding

b. Any other sources of funding, setting out the extent to which these are confirmed and whether they are dependent on the Transformation Challenge Award

Risks and sustainability

c. Any financial risks, for example the potential for costs to increase.

d. The sustainability of savings in future years

Additionality:

e. If you have agreed or are bidding for other funding, how will Transformation Challenge Award funding enable you to achieve additional benefits

f. If bidding for capital receipt flexibility, how the asset sale is additional to what would have happened anyway

[Please complete in the box below – maximum 3 pages]

Risks and sustainability

Costs to increase because of:

A change in law leading to redefined priorities:

- Incidence of criminalisation of domestic violence on safeguarding interventions
  - Acts of psychological controls
  - Acts of violence
- Increase in the recording of domestic abuse incidents and prosecution
- Legal duty to combat domestic violence placed upon police and other agencies.
- Involvement of greater number of agencies (schools, general health practitioners…)

Changes in demography

- New migrant families
- Change in Ethnic Minority Groups – new demand to address patterns of behaviour and social norms
- Incidence of Welfare Reform on low income families
- Increase in social deprivation due to lower than planned local economic growth and growing inequalities leading to hardship, reduced social and family cohesion and risk of neglect.

These additional costs to be (partly) offset by savings.

The sustainability of savings in future years

Long-term sustainability will be secured through:

Better information sharing – elimination of duplication and more coherent approach to information sharing leading to greater efficiency

Well established community of practice – greater cohesion between agencies

Better process and protocols between agencies eliminating duplication and unnecessary referral measures to concentrate on early interventions and prevention to reduce costly corrective measures.

Additionality

Other funding sources – to confirm with Finance.

Capital Receipt Flexibility – Why is the asset sale additional?

If no external funding Rotherham would

- not invest in ICT development
- rely on co-location to improve cohesion between services
- take longer to review process and protocols with limited internal resources
- consider developing other method of communications between agencies.

Would result in loss of efficiencies and maintain layers of duplication for longer.

Section B.3: Economic Case

This section should cover:

Economic case impact

a. Using the New Economy CBA Tool *[to be submitted with bid]* please provide the following information:
   - Net present public value
   - Summary of costs and benefits (fiscal, economic and wider social) over life of project
   - Key assumptions made and how they have been tested, including any assumptions on optimism bias

Sensitivity analysis

b. Any sensitivity analysis you have carried out on key assumptions

Non-monetised costs and benefits

c. Any non-monetised costs
d. Any non-monetised benefits
e. The anticipated benefits to local people

[Please complete in the box below – maximum 3 pages]

Net Present Value

Overall Financial Return on Investment - Every pound invested in the project, will return £1.67 in fiscal returns to be shared between all project partners.

The Net Budget Impact generated by the project can be summarised as follows:

Financial Case	Net Present Value (NPV)
Discounted Costs	£1,381,697
Discounted Benefits	£2,310,351
Net Budget Impact	(£928,654)
Overall Financial Return on Investment	1.67
Pay back	6 years

Summary of costs and cost savings

Before optimism bias corrections (please add 15% =£1,381,697 for final costs in CBA)

Costs	Grant Funding	Capital Spending	Total Project Costs
MASH hub co-location set up	-	£72,876	£72,876
Consultancy work for the design of new processes and protocols	£250,000	-	£250,000
ICT Development	£450,000	£450,000	£900,000
Total Project	£700,000	£522,876	£1,222,876

The ICT development costs could be itemised as follows:

- £900,000 for ICT development, of which:
  - £200,000 for staffing costs (secondment and project management)
  - £400,000 for data cleansing (secondment of service areas staff)
  - £ 30,000 for third party professional services
  - £100,000 for SQL licensing for virtual server farm (Infrastructure Software)
  - £150,000 for infrastructure (ICT hardware)
  - £ 20,000 for configuration of network appliances

- TCA funding will assist with the formation of an internal ICT project team to coordinate the creation of a Single View of a Child solution. The single view of a child will be developed in conjunction with other internally funded RMBC projects such as the Rotherham Customer Index (RCI), Better Care, and Care Act 2014 and involve person matching and the possibility of NHS number matching as a pre-requisite.

- The project proposal requests financial support for essential 3rd party professional services and consultancy. This will enable RMBC to draw on the specialist knowledge of its software application providers, to assist with the integration required from the various systems already supporting its services.

- The requested infrastructure contribution will assist with pulling in data from partner systems, as we don't currently have a mechanism by which the partners can supply this data to us. This contribution assumes a regular, scheduled, one-way pull of data in to the warehouse – i.e. that there is no requirement to write data back to the source systems.

- The requested capital spending approval will meet the costs of third party

software and licensing for the development of the IT platform architecture to meet the council's overarching strategic objectives in relation to information management.

The success of the MASH will be measured from a social care perspective will create greater efficiency and will result in service improvements and budgetary savings.

£390,912 cost savings over 10 years will offset part of the project costs and will be created by greater efficiencies and service improvements as follows:

- Improved timeliness of decision making contacts leading to a reduction in the number and intensity of safeguarding interventions
- Improved partnership understanding of the threshold for social care interventions, leading to a reduction of social care costs
- More children are safeguarded effectively first time, leading to a drop of re-referral rates
- Improved partnership working to safeguard children, leading to service improvements for all project partners
- Children's assessments are completed in-line with the needs of the child to deliver greater children and family quality of life and well-being.

Key Performance Indicators set for each of these categories will measure progress against each measure and inform the evaluation of the project.

Summary of benefits

An estimated £2.3m of overall gross fiscal benefits will be generated over 10 years; in addition £9m of social and economic benefits will be generated by the project. The benefits could be summarised as follows:

(All figures quoted below include -40% Optimism bias corrections)

Benefits	Fiscal Case	Economic Case	Public Value
Reduced Incidence of domestic violence	All figures to be reviewed before final proposal		
Reduced incidence of children taken into care			
Reduced truancy and exclusion from school (combined)			
Reduced A&E Attendance			
Reduced Incidence of crime			
Improved Well-being			
Total	£2.3m	£9m	£11.3m

Non-monetised costs and benefits

It has not been feasible to collect and analyse data to accurately evaluate all impacts of the MASH. Some of the benefits can't be monetised for the purpose of this bid proposal because it would be too costly and time consuming to collect the necessary financial information to measure the impact of the MASH in relation to:

- Measuring the benefit of generating a more dynamic response to new situations
- Preserving/enhancing the business reputation of RMBC and the project partners
- Involving more closely service users in the delivery of the safeguarding service
- Increased well-being of children and their family by helping reduce dependence on welfare services
- Better life chances for children who benefit from early safeguarding interventions

Sensitivity analysis

Project costs – 3 cases to be presented (low/medium/high optimism bias) to justify our project cost estimate. **Work In Progress.**

Cashability

The fiscal benefits will be reinvested in service improvements and in new safeguarding children initiatives. It is not anticipated at this point that any of the fiscal benefits generated by the project will be cashable. **Work In Progress.**

Anticipated return to local people

Outcomes for children and their families where a MASH has been implemented include:

- More robust decision making,
- Avoid duplication of services,
- An increase in the use of early help assessments such as CAF,
- A reduction in repeat referrals,
- Improved information sharing and knowledge management and enhanced engagement of health.

These system improvements will lead to the following benefits for local people:

- Faster, more co-ordinated and consistent responses to new

safeguarding concerns about vulnerable children and adults.

- Greater ability to share information quickly and identify potential vulnerability
- More preventative action to be taken, dealing with cases before they escalate
- Faster more co-ordinated and consistent responses to safeguarding concerns.
- Better safeguarding of children and young people with low levels of concerns involved with multiple agencies
- An improved 'journey' for the child or parent/carer with a greater emphasis on early intervention
- Better informed services provided at the right time, in line with the corporate priority: 'Right Time, Right Place. Right Person."
- Collaborative decision making based on a "single view of the child" enabling a tailored plan of action to be developed for the child
- Better information sharing across partners – enabling better safeguarding of the children and young people
- Greater awareness and ability to target the most urgent cases step up or down an assessment

Section B.4: Commercial Case

This section should cover:

a. How the new service model will be delivered and why is this the best way of doing it
b. If external providers are required, provide a brief procurement strategy, including any assessment of market capacity
c. Any key contractual arrangements required to implement and deliver the new service model
d. If any payment mechanism will be applied, and why
e. Risk transfer - provide information on any risk to be transferred to external providers and why the provider is best placed to manage these risks

[Please complete in the box below – maximum 3 pages]

How will it work?

The key components of the project are:

- Co-location in our new Council office building in Riverside House will offer a single 'front door' to draw on multi-agency expertise. Our multi-disciplinary team composed of the Police, Health and Social Care Services will gain greater ability to share information quickly and identify vulnerability. The new location will regroup on the same floor our Early Help Assessment Team

alongside Education Welfare, Integrated Youth Services and the Independent Domestic Violence Advocacy service and the Child Sexual Exploitation Team,

- New governance to support single tasking protocols for the whole team and a streamlined centralised function. The Rotherham Local Safeguarding Board will review its procedures and protocols to reduce the number of children inappropriately accessing costly services,

- Information governance – the partnership already has a joint confidentiality agreement and information sharing protocols, these will be enhanced to reflect the new arrangements,

- Information sharing – develop the Single View of a Child solution to provide timely and comprehensive information which will inform decision making and reduce costs of intervention through the removal of duplication,

- Strong partnership working between agencies who are already committed to such an approach as part of the Rotherham Safeguarding Children Board, the Local Strategic Partnership Chief Officer Group and Children and Young People and Families Partnership.

In relation to the Rotherham Single View of a Child work stream the key components of the work are:

- RMBC currently records and processes data relating to its customers within disparate Service orientated applications, with limited automated sharing of data or system integration capabilities.

- This restricts RMBC's ability to understand its customers in a holistic manner, to confirm service entitlement, to visualise current service utilisation and to accurately predict future needs.

- An opportunity exists to leverage technology to create an application (Rotherham Single View) that links together data from these disparate systems to allow the identification and reporting of distinct customers at an Authority level.

Most of the work required for the completion of the project will be delivered in-house to the exception of the following project components:

- External consultancy costs to help with the rewriting of safeguarding children protocols and processes advising on best practices from authorities which have already implemented a MASH,

- The required ICT infrastructure and associated software necessary to the implantation of the Single View of a Child solution will be purchased via the

Authorities procurement process, and will involve the creation of a tender via the Procurement Department.

- In particular the service of specialist networking contractors will be tendered for the installation of firewall appliances to secure data feed to an externally facing and staging webserver devices.

Procurement Strategy for providers (IT specialists and consultants)

Public sector organisations must act in compliance with the government agreements and the European Procurement Directives and Regulations. The preferred procurement method for this project is the restricted procedure under which a selection is made of those who respond to the advertisement and only they are invited to submit a tender for the contract. This will allow Rotherham to avoid having to examine a large number of tenders and takes into account the specialist aspects of the work to be conducted.

[Richard C and Sue W to confirm that this is our preferred procurement option and that we don't have pre-competed arrangements with specialist providers (for example for firewall technology and other technical aspects)]

The procurement process will follow EU regulations to ensure all suppliers and contractors are treated on equal terms. The criteria will cover:

- Specification stage – how requirements must be specified, avoiding brand names and other references and using performance specifications rather than technical specifications
- Selection stage - the rejection and selection of candidates in particular in relation to economic and financial standings and their technical capacity and ability to deliver the project.
- Award stage – To adhere to UK Government policy guidance to determine which is the most economically advantageous tender (MEAT) instead of lowest price criterion.

Key contractual arrangements including payment mechanisms and risk transfer

As a general principal, our approach is to relate the payment to the delivery of service outputs and the performance of the contractors. The following procurement guiding principles will be strictly adhere to:

- Payment on the delivery of agreed outputs to ensure that payments do not commence until the contracted services come on stream,
- Fixed price/costs to provide an incentive to deliver services to time, specification and cost,
- Technological obsolescence – that various upgrades can be included in the initial price to ensure that the technology underpinning the Single View of a Child solution is kept up-to-date
- Risk Transfer – the private sector will be invited to take responsibility on the components of the project where it has full control and ownership. Opportunities to reserve shared responsibilities on specific aspects of the design and construction of the IT solution will be considered.

[Section to check with Richard C and Procurement Team]

Section B.5: Management Case

This section should cover:

Governance

a. The governance arrangements and project management arrangements, necessary to deliver this proposal

Implementation

b. How you will implement this new service model/project. Please include a high level project plan covering:
   - the duration of the project and key milestones dates
   - the key dependencies (for example with partners or suppliers)
   - proposed checks / review points to monitor progress

c. Any plans for evaluating the project

Risk Assessment

d. The risks to the success of the proposal have been identified

e. How identified risks have been adequately addressed through contingency/mitigation plans

f. Why the proposed timetable is realistic

[Please complete in the box below – maximum 3 pages]

Governance Arrangements

The MASH project will be overseen by the Chief Executive Operational Group (CEOG) which comprises of senior representatives from the key partner agencies and will act as the steering group for the project, providing direction and guidance, reviewing progress and providing the steer to address unresolved and escalated issues.

The RMBC Director of Safeguarding for Children and Families will act as Project Sponsor and will provide updates at a strategic level and report into the Chief Executives Officer Group (CEOG).

The project will be initiated in two work-streams each requiring a tailored governance structure. The Project Manager will oversee each of these work-streams, monitoring and managing activities to coordinate resources and maintain overall coherence. The project manager will assess and review risks and address concerns to ensure the project objectives are met within strict timescale and budget targets. The project manager will

report to the Project Sponsor who will chair project meetings on a monthly basis. The Project Steering Group will receive monthly reports highlighting key operational issues and an update of the risks register.

MASH Operational Process – Project Management Arrangements

The MASH Operational Development Team, which includes service area experts from all the partner agencies, will be responsible for the development of new processes, protocols and procedures. The team will seek approval and sign off of the final MASH operational model from the leaders of the key operational partners (CYPS, Health and Police) and from managers of partner organisations for smaller changes to service specific processes. The group will also act as the Project Team in respect of implementing the process, identifying and addressing risks and issues, monitoring progress. Where an issue cannot be resolved this will be escalated for resolution to the Project Sponsor and Project Board.

Single View of a Child - Project Management Arrangements

The ICT Leadership Team will undertake overall responsibility for the project and sign off the design and costs of the Single View of the Child Project. The ICT Leadership Team is composed of the Head of ICT, Operations and Development Manager and the Governance and Change Manager. The project manager will work with the specialist teams to develop the ICT technical design solutions under the supervision of the Operations and Development Manager.

The project manager will work closely with specialist teams to ensure that the project remains within budget, is cost effective and meets Public Service Network Compliance. Weekly technical installation review process will be conducted with a board of senior staff and technical experts to ensure that all technical installation have been audited prior to completion.

Implementation

The project has two distinct work-streams which will be run in parallel commencing on the 12th January 2015. Both will be led by a dedicated Project Manager.

MASH Operational Process - Implementation

The development and implementation of the Operational MASH is expected to take 9 months. The key steps of the implementation plan are mapping of services, service improvement review, consultation, dry runs testing, sign off by the leads of key partner agencies, training of the workforce and project evaluation.

An Operational Development Team will be created consisting of representatives from all MASH partner agencies. This team will meet fortnightly and their remit will be to inform and develop the mash model, processes and policy in relation to the Rotherham MASH. Together, partner representatives will:

- Inform and develop the requirements of the MASH including in particular: process flow, structure, role and governance, information sharing protocols, policies and procedures, business support and baseline data
- Feedback decisions made into the organisation they are representing and gain

agreement for any proposals through their governance structure.
- Remove obstacles in the development of the MASH
- Highlight Risks and Issues to the development and implementation of the MASH
- Make timely decisions and take action so as not to hold up the project.

The mapping of current processes will be undertaken with each of the partner organisations to understand how the process is carried out now, how and where the processes and resources interlink, the policies and procedures that support the process, and who is responsible for what. On completion of this initial stage, workshops with key partners will be organised to inform how the MASH will operate and integrate with new process flow, roles and responsibilities, governance structure and information sharing protocols. The revised process will be tested in the form of dry runs utilising case studies to identify any issues for resolution. In addition a baseline of current data available will be taken and agreed KPI's developed to monitor the success of the project. This is an iterative process that will be conducted through the life of the project and will be informed by the project's evaluation arrangements.

Prior to the start of implementation the revised process including supporting policies, procedures and KPI's will be signed off by the leads from the key partner agencies.

Training and Development Plans will be designed to deliver a robust programme of training and awareness to be undertaken with key partners within the MASH and with voluntary organisations that are involved in the Children Safeguarding work.

Go live is scheduled for the 1st September 2015. Prior to this a final test run will be conducted involving all partners within the MASH and any final adjustments made. The key partner leads will be informed of the outcome and their final approval to go ahead will be obtained.

Reviews will be undertaken following implementation and again after 3 months to analyse how effective the process is and ensure it is supporting the achievement of the project's outcomes; required changes will be undertaken to resolve any issues identified.

The following high level project plan has been developed for the delivery of the project which shows the key milestones for delivery and the expected delivery date.

MASH Operational Process – Key Milestones

Date	Milestone
23 Jan 15	Service specialists identified and Operational Development Team formed and advised and workshop dates set.
30 Jun 15	New MASH Process created and supporting processes re-vised. Written Policies and Procedures Written KPI's and Evaluation and continuous improvement processes agreed
07 Jul 15	MASH Process and supporting documents approved by CEOG
01 Sep 15	Go live

A detailed project implementation timetable is provided in Appendix D

Single View of a Child - Implementation

The project will leverage technology to create an application that links together data from disparate systems to allow the identification of distinct clients at an authority level. The key steps of the implementation plan are: co-production and agreement of date sharing protocols between parties,

Project concept - To support the creation of the MASH Rotherham MBC will create a 'data warehouse' which will bring together key information from a number of systems (NHS, RMBC, Voluntary Sector and Police) which hold data about children. This data will be presented to practitioners via a web browser and will allow the subject matter experts, for the first time, to have a single view of the child. This will improve decision making and enhance the safeguarding activity of all partners.

A key part of the Single View solution will be the co-production and agreement of data sharing protocols between all parties, including mechanism to ensure that citizens provide consent for their data to be shared. Discussions with colleagues in Health are well advanced and the recent adoption of the shared Information Governance Toolkit will be a great help. Negotiations with colleagues in South Yorkshire Police are less well developed and these will continue while the Single View platform is being created.

Detail of the design of the single view solution and of the activities to be engaged in preparing the data is provided in Appendix A.

Implementation Plan - The Single View of a Child Solution is expected to take up to 12 months to complete and will require the creation of a dedicated ICT Project team, consisting of 3 members of staff, who will coordinate and implement the ICT elements of the project, in conjunction with members of staff from the Performance and Quality section, who will lead on the overall project.

The ICT solution will consist of the creation of a resilient virtual server farm, consisting of a data matching server and SQL database servers, of which there will be a live, test and training environment. The ICT department have in depth experience in this type of infrastructure and will be able to call upon existing staffing resources to complete this initial work, which will allow for the data cleansing of the existing datasets, from a number of internal and external application servers holding child data.

The required ICT infrastructure and associated software, will be purchased via the Authorities procurement process, and will involve the creation of a tender via the Procurement Department.

The initial data cleansing exercise will be undertaken once the data matching server is operational, and will allow for the production of exception reports, which will be provided to the relevant departments, this will also enable departmental staff to undertake various business process reengineering tasks, so that future data entry is of a higher quality and leading to the reduction in the creation of future exception reports, and therefore reducing the administrative duties of social care staff. This exercise will need the input from various 3rd party suppliers, as amendments will be required to existing application databases, and also the amendment of application views for the improvement of social care data, and citizen detailed data entry.

The next stage will require the services of a specialist networking contractor to install newly purchased external firewall appliances, to secure the parameter of the authority's network, and allow for a secure data feed to an externally facing webserver, which will hold the single view of a child search facility. An additional externally facing firewall will also be required, for a secure connection to an externally facing staging server, where 3rd party organisations such as South Yorkshire Police, and the NHS will be able to feed data too, this data can then be crossed matched against the cleansed RMBC data, to produce an overall dataset to be viewed via the webserver.

The dataset will be held in the RMBC data warehouse, and the data supplied to the search facility, will only be a single way feed, and no data manipulation will be undertaken in the data warehouse. In the interest of reducing complexity and cost any data cleansing our updating of source systems will be carried out manually by acting upon the exception reports. An example of search screens is provided in Appendix B.

Finally the high-level platform design is shown in Appendix C.

Single View of a Child – Key Milestones

Date	Milestone
23/01/2015	Creation of ICT Project Team
Xx/xx/xx	Design approved by ICT Leadership Team Firewall penetrating testing validation User testing
Xx/xx/xx	Initial System Live use

A detailed project implementation timetable is provided in Appendix D

Key dependencies (partners/suppliers)

The following key dependencies have been identified in relation to the Single View of a Child work stream:

No.	Owner	Dependency	Comments
1	Project Manager	Representation by all partner agencies at development workshops	Potentially resulting in key tasks within the process not being identified and the process not working
2	Project Manager	Joint agreement and buy-in of the MASH process by lead partners	Potentially resulting in the project being stopped.
3	ICT	Compliance of security to external web server and web pages	Non-compliance will affect the Public Services Network accreditation
4	ICT	Ability to obtain correct data sets from internal applications and accuracy of the cleansed data	Resulting in data presented being incomplete and inaccurate

Proposed checks / review points to monitor progress

Detailed in the project implementation plans.

Project Evaluation arrangements

The following project evaluation arrangements will be considered:

- Focus groups comprising representatives from each of the partner agencies to review effectiveness of new protocols and procedures, identify problems and further improvements required,
- Focus groups held with users of the IT system to identify improvements to the content, look and feel and determine further developments to enhance the information and alignment with new procedures and protocols.
- Regular monitoring of the Single View of a Child solution to measure and evaluate use of the system
- Monitoring of Key Performance Indicators
- Project Evaluation report (including CBA updates)

Risk Assessment and mitigation plans

The major project risks were considered in the risk register in Appendix E. The risk register reviews the major risks to undermine the success of the project, their implication and likelihood and suggest mitigation actions. The risk register will be regularly maintained and updated through the life cycle of the project and will be part of the monthly highlight report to the Project Sponsor and to the Steering Group (CEOG).

Proposed timescale deliverable?

The co-location of the multi-disciplinary team in 2014 will enable a prompt start of the project in 2015 ensuring that management structures and frontline teams are fully prepared to work together and share the same safeguarding children priorities. It will enable the IT teams to refine the project implementation plan and map out the necessary tender process to select the best technology as soon as funding is confirmed. The IT teams have a strong track record of delivering similar projects against strict timetable and on budget.

Appendix A – Single View of a Child Design and Activities

The Single View of a Child solution has been designed to be as simple as possible:

- Step 1: Data is extracted from source systems as CSV files and stored in a central database (the ‘data warehouse’).
- Step 2: Matching rules are applied to the data to allow us to understand where a child in one system matches with a child in another.
- Step 3: Exception reports are presented back to the system owners the purpose of these is twofold:

  - To allow for the data to be cleansed ready for the next extract
  - To allow for business processes to be reviewed to understand how dirty data found its way in the system to begin with. Is it possible, for example that we can apply validation to certain fields at the time of data entry to improve data quality?
- Step 4: Present the matched data, in a secure way, to practitioners in NHS, RMBC, Voluntary Sector and Police.
- Step 5 (out of scope of this submission): Apply data analytics and predictive modelling tools to the new data warehouse to better understand our clients and to make better use of out resources.

Steps 1 through 4 are iterative and ongoing with each new extract improving the quality of the data. Step 5 is currently out of the scope of this project and is included to illustrate the future uses which our cleansed data might be put to. These activities are described in the table below.

Activity Layers	
Extract	System extracts from Line of Business systems, kept simple (reports to xml, csv etc..) to keep development and support costs low and ensure future flexibility.
Match	Rule based matching process to automatically match as many records as possible, with exception and manual matching stages where the match certainty is too low.
Store	Storage of matched records in an efficient structure, including key attributes and data items, to enable data view and reporting/analysis.
Cleanse	Using a data steward model (linked to the identified information asset owners), cleanse the source systems to remove duplicates, correct bad data and harmonise the systems to support future matching runs.
Report	Output predefined and bespoke reports based on identified business requirements. This will include exception, safeguarding, fraud detection and data update reports.
View	Present a view of the matched data to both internal and external stakeholders (ensuring PSN and IL standard are adhered to), secured based on their entitlement to view the data.
Analyse	Advanced analysis and reporting of the data using professional reporting tools. This may incorporate GIS based reports, trend analysis, predictive analytics etc..

Appendix B – Single View of a Child Search Screens

An example of how the search screens may appear, in their simplest form, can be seen below, but this will need additional input from the various parties involved.

Rotherham Single View of a Child

Results for child: Billy Smith Child ID RSV1234567890

Child Details | Service Provision

Child		Address Details	
Family Name	Smith	Address Line 1	3 The Croft
First Name	Billy	Address Line 2	Croftside
Date of Birth	10/07/2007	Address Line 3	Croftingshire
Age(Approx)	7	Address Line 4	
		Postcode	CR01 3FT

Parent Carer Details	
Family Name	Smith
Given Name	Susan

Rotherham Single View of a Child

Results for child: Billy Smith Child ID RSV1234567890

Child Details | Service Provision

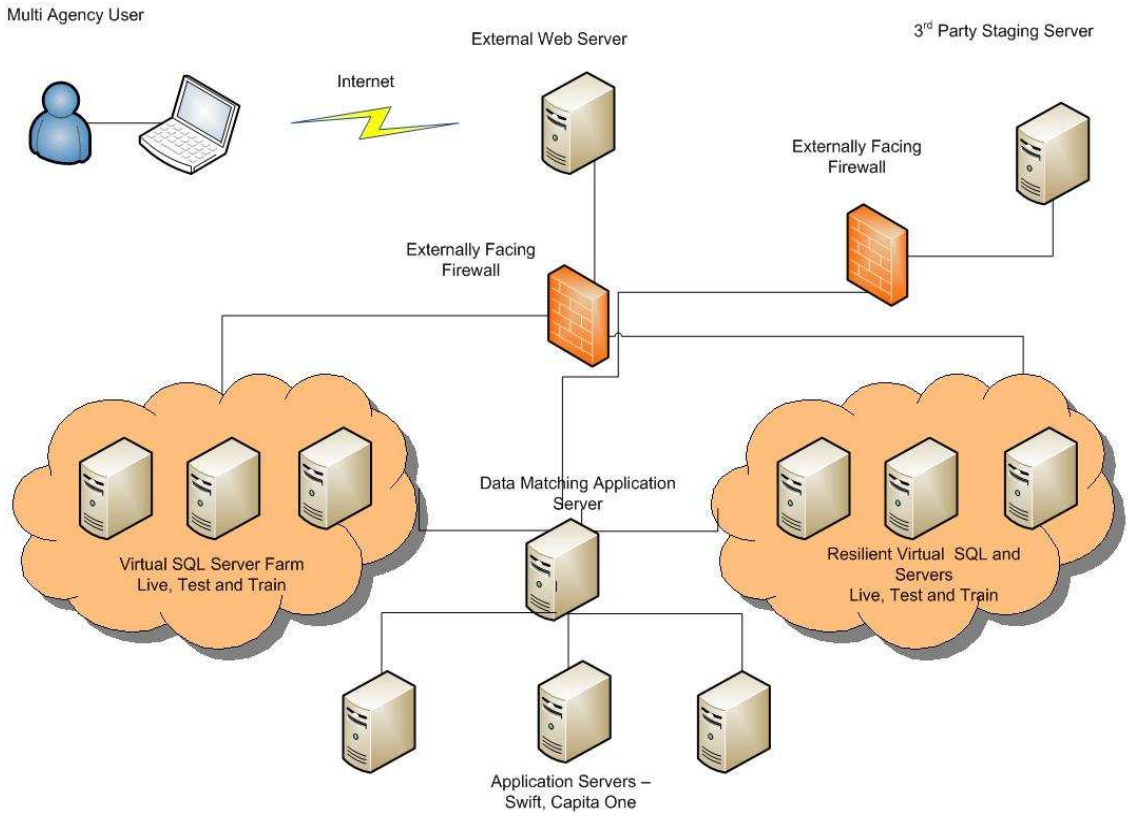
Service Provsion Name/ID	Start Date	End Date	Organisation	Provider Contact
Education Services	01/09/2010		Croft Primary	SENCO, 01709 123456
Education Services	23/11/2010	25/02/2010	Education Welfare	EWO, 01709 234567
Health Care	01/09/2010		School Nurse	SN, 01709 345678
Health Care	17/02/2013	10/03/2014	Specialist Service	Therapist, 01709 456789
67896787878	10/06/2012	28/08/2012	Social Care	Key Worker, 01709 567890

Indicators	Start Date	End Date	Contact Details
CAF			
Strengthening Families			

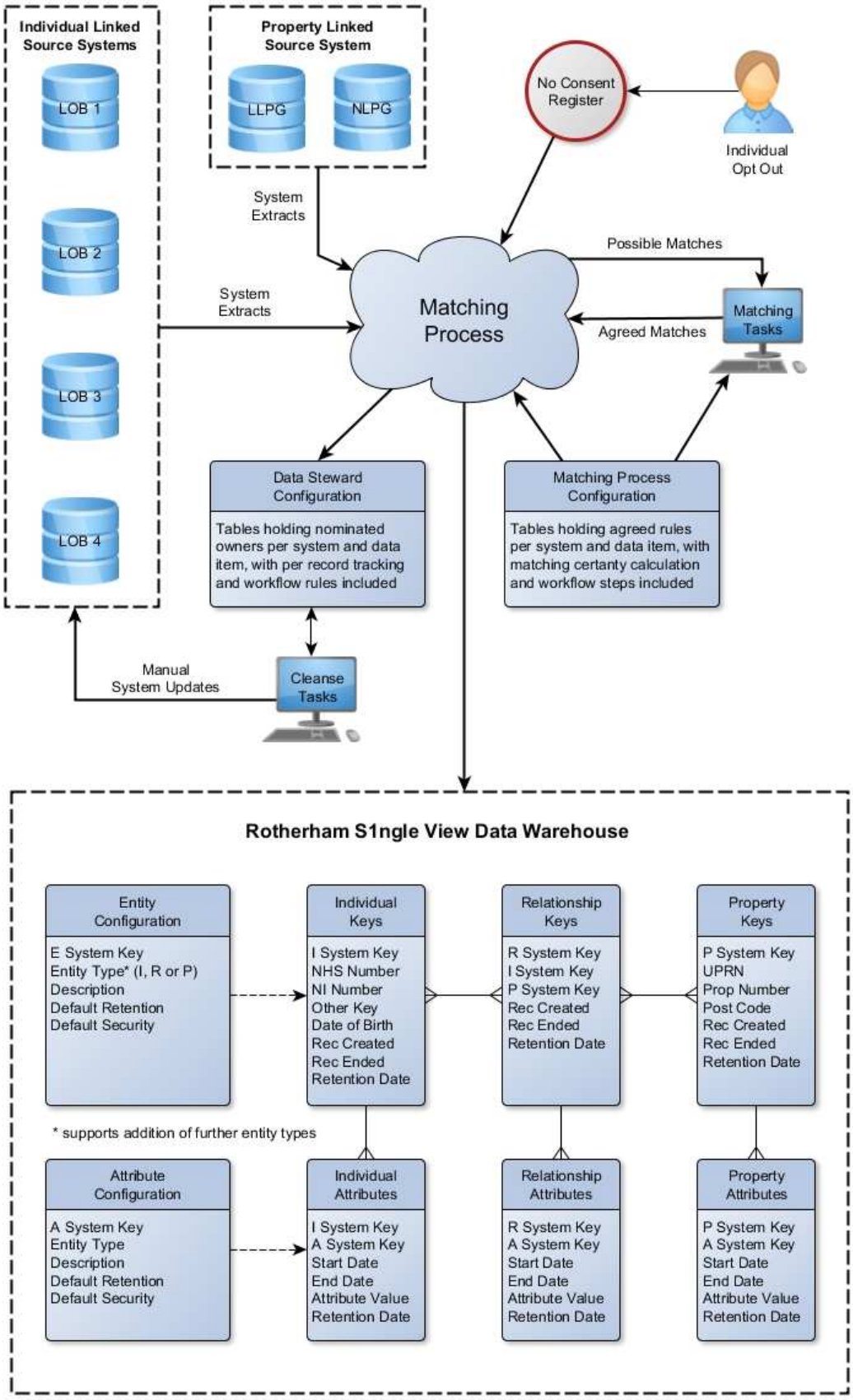
Access to the Single View search facility will be tightly controlled and 2 factor authentication technologies will be employed. Access logs will be maintained to track which practitioners have searched against records.

Appendix C – Single View of a Child High Level Platform Design and Work Flow

A high-level platform design is shown below –



The diagram below is a schematic representation of the workflow involved in the day-to-day operation of the Single View platform.



Appendix D – MASH Project Detailed Implementation Timetable

Activity Number	Task	Duration Days	Completion / Delivery Date
MASH Operational Process Development			
1	Creation of the Operational Development Team	10	23/01/15
2	Evaluation and design of As-Is processes including Sign Off by Operation Team	20	13/02/15
3	Development of NEW MASH Operational Process	20	20/03/15
4	Dry Run of the NEW MASH Process and final adjustments	2	24/03/15
5	Identification of KPI's to monitor success	5	31/03/15
6	Development of KPI's and reports	30	12/05/15
7	Design and documentation of To-Be Service Processes incorporating revised MASH Operational Process	15	02/06/15
8	Development of key supporting policies and documented procedures including *Information sharing protocols *Operating principles *Roles and Responsibilities / Structure	20	30/06/15
9	**Sign Off of New MASH Process and KPI's by Lead Partners (CEOG)***	5	07/07/15
10	Development of Training and Communications Plan	10	14/07/15
11	Sign Off of Training and Communications Plan by Partners	5	21/07/15
12	Deliver Training	25	25/08/15
13	Pre-Go Live Test Run	2	27/08/15
14	Go Live	1	01/09/15
15	Post Implementation Review	2	03/09/15
16	3 Month Review	10	18/12/15
IT Project Single View of a Child			
1	Creation of ICT Project Team	10 Days	23/01/15
2	Appointment of Networking Contractor	5 Days	
3	Evaluation of Design	5 Days	
4	Confirmation of Design	5 Days	
5	Preparation of bill of materials for tender	3 Days	
6	Tender Process	20 Days	
7	Goods Ordered	20 Days	
8	Goods Received and Asset Tagged	5 Days	

9	Kit Configuration and Installation	30 Days	
10	Firewall Installation	10 Days	
11	Firewall Penetration Testing	5 Days	
12	Engagement with 3rd Party Suppliers	10 Days	
13	Creation of Exception Reports	On going	
14	Amendment of Application Views	20 Days	
15	Design of Web Search Tools	30 Days	
16	Testing	20 Days	
17	Design Amendments	10 Days	
18	User Testing	20 Days	
19	Initial System Live Use	Ongoing	

Appendix E – MASH Risks Register

Risk	Implication	Significance	Likelihood	Risk Score	Mitigation Actions
Weak project partners' commitment	Reduce scope and delay implementation of objectives	High	Low - Police and Health partners fully committed	Low	Project steered by Chief Exec Officers Group and overseen by CYPP
New governance & process not in place	Intended fiscal and non-monetised benefits not delivered	High	Low - Robust partnership working arrangements and co-location agreement	Low	Robust project management and multi-agency planning in place
Ability to deliver IT platform within timescale and budget	Failure to deliver Single View Child tool	High	Medium – experienced in-house development team & external assistance	Medium	Robust project management approach and detailed project initiation document
Ability to achieve expected savings	Failure to deliver savings to improve the quality of safeguarding children service	High	Medium - Baseline and targets clearly defined and agreed with partners	Medium	Robust Business Improvement and Project Management Process KPI agreed and monitored
Roll over to more	Effective information	Medium	Medium – Well defined	Medium	Robust multi-agency working

partners is delayed or postponed	sharing to meet early intervention objectives		IT design and clear project scope, strong information sharing governance		arrangements and cost benefit analysis developed to evidence benefits in terms of fiscal and social impact.

PART C: APPROVAL

Note: This bid is for the Transformation Challenge Award 2015-16 B.

Approval: Bid approved and signed off by Section 151 officer (or authorised person in other public sector partners) for each partner to the bid.

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Organisation	Click here to enter text.
Date Approved	Click here to enter text.

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[for additional partners, please add more boxes as required]