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NOTTINGHAM CITY COUNCIL
CHILDREN'S PARTNERSHIP BOARD

Date: Wednesday, 18 December 2019

Time: 4.00 pm

Place: LB 41 - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors and Board Members are requested to attend the above meeting to transact the following business

Corporate Director for Strategy and Resources

Constitutional Services Officer: Catherine Ziane-Pryor **Direct Dial:** 0115 8764298

AGENDA **Pages**

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTERESTS

3 MINUTES 3 - 10
Of the meeting held on 25 September 2019 (for confirmation)

4 AN UPDATE ON CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING IN THE CONTEXT OF NOTTINGHAM CITY'S CHILDREN AND YOUNG PEOPLE PLAN 2016-20 11 - 96
Report of the Director of Public Health

5 DISCUSSION ON CHILDREN AND YOUNG PEOPLE PLAN DEVELOPMENT
Introduced by Sophie Russell, Head of Children's Strategy and Improvement

6 YOUTH CABINET UPDATE
Jon Rea, Engagement and Participation Lead Officer, to introduce.

7 PARTNERSHIP UPDATE: PRIMARY SCHOOLS
Nicky Bridges, Headteacher of Robin Hood Primary School to provide a verbal update.

8 KEY MESSAGES AND ITEMS FOR INFORMATION

9 FORWARD PLAN 97 - 98

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE CONSTITUTIONAL SERVICES OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

CITIZENS ARE ADVISED THAT THIS MEETING MAY BE RECORDED BY MEMBERS OF THE PUBLIC. ANY RECORDING OR REPORTING ON THIS MEETING SHOULD TAKE PLACE IN ACCORDANCE WITH THE COUNCIL'S POLICY ON RECORDING AND REPORTING ON PUBLIC MEETINGS, WHICH IS AVAILABLE AT WWW.NOTTINGHAMCITY.GOV.UK. INDIVIDUALS INTENDING TO RECORD THE MEETING ARE ASKED TO NOTIFY THE GOVERNANCE OFFICER SHOWN ABOVE IN ADVANCE.

NOTTINGHAM CITY COUNCIL
CHILDREN'S PARTNERSHIP BOARD

MINUTES of the meeting held at LB 31-32 - Loxley House, Station Street, Nottingham, NG2 3NG on 25 September 2019 from 4.00 pm - 5.55 pm

✓	Councillor Barnard	Portfolio Holder for Children and Young People, Nottingham City Council
	Councillor Khan	Portfolio Holder for Early Years, Education and Employment, Nottingham City Council
✓	Helen Blackman	Director of Children's Integrated Services, Nottingham City Council
	Nichola Bramhall	NHS Nottingham Clinical Commissioning Group representative
	Peter Bramhall	The Futures Group representative
✓	Nicky Bridges	Primary Schools' representative
	Julie Burton	National Probation Service Nottinghamshire representative
	Zoe Butler	Further Education representative
	Karla Capstick	Small Steps Big Changes representative
	Helene Denness	Public Health representative, Nottingham City Council
	Sarah Fielding	Nottingham Schools Trust and Virtual School representative
	Sue Fielding	Department for Work and Pensions representative
✓	Mathew Healey	Nottinghamshire Police representative
	Derek Hobbs	Secondary Schools' representative
✓	Nick Lee	Director of Education, Nottingham City Council
	Scott Mason	Primary Schools' representative
	Stephen McLaren	Voluntary Sector representative
✓	Alison Michalska	Corporate Director for Children and Adults, Nottingham City Council
	Claire Perry	Voluntary Sector representative
✓	Jon Rea	Engagement and Participation Lead Officer, Nottingham City Council
✓		Representatives for Young People (Youth Cabinet)
✓	Sophie Russell	Head of Children's Strategy and Improvement, Nottingham City Council
✓	Cheryl Steele	Special Schools' representative
	Tracy Tyrell	Nottingham CityCare Partnership representative

✓	Chris Wallbanks	Head of Commissioning, Nottingham City Council
✓	Maria Ward	School Governor Representative

✓ Indicates present at meeting

Tim Brown, Department for Work and Pensions (substitute for Sue Fielding)

Colleagues, partners and others in attendance:

Monica Bryce - Troubled Families Employment Advisor, Department for Work and Pensions
Jane Garrard - Senior Governance Officer
Rob Harrod - Troubled Families Employment Advisor, Department for Work and Pensions
Emily Humphreys - Support Assistant for Children and Adults Directorate and Children's Partnership Board Administration
Laura Jubb - Schools Advisor, Department for Work and Pensions
Andy Shone - Children's Integrated Services

11 MEMBERSHIP CHANGES

The Board noted that:

a) Alison Michalska, Corporate Director for Children and Families is leaving Nottingham City Council and will be replaced on the Board by Catherine Underwood, Corporate Director for People; and

b) Cheryl Steele has replaced David Stewart as the Special School representative on the Board.

12 APOLOGIES FOR ABSENCE

Peter Bramhall
Zoe Butler
Karla Capstick
Helene Denness
Sarah Fielding
Derek Hobbs
Councillor Neghat Khan
Stephen McLaren
Claire Perry

13 MINUTES

The Board confirmed the minutes of the meeting held on 26 June 2019 as a correct record and they were signed by the Chair.

14 DECLARATIONS OF INTEREST

None

15 THE INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE

Alison Michalska, Corporate Director for Children and Adults, Nottingham City Council, gave an update on the Independent Inquiry into Child Sexual Abuse. She highlighted the following information:

a) The Inquiry included looking into historic failures to protect children in the care of Nottinghamshire County Council and Nottingham City Council. This part of the Inquiry focused on three areas:
   i. Institutional responses to disclosures of allegations of sexual abuse in relation to Beechwood since 1967 to the present and the barriers to disclosure of such allegations;
   ii. Institutional responses to disclosures of allegations of child sexual abuse by foster carers and the barriers to disclosure of such allegations; and
   iii. Institutional responses to disclosures of allegations of sexual abuse carried out by children against other children in the care of the Councils and the barriers to disclosure of such allegations

b) The Inquiry's report relating to historical failures to protect children in the care of Nottinghamshire County Council and Nottingham City Council was published in July 2019 and contained two recommendations for Nottingham City Council;

c) The Council is required to publish its response to these recommendations within six months, which it will do;

d) The first recommendation relates to assessing the potential risk posed by current and former foster carers provided directly by the Council and those provided by external agencies in relation to sexual abuse of children. Progress on this is well under way and the Council is reviewing all allegations that it has dealt with to review what was done and whether the right steps were taken. Where is it identified that the Council's response was not robust enough then that will be explored, with disclosure if necessary. The work required with independent fostering agencies is being done jointly with Nottinghamshire County Council. All agencies that have been used will be written to, requiring them to satisfy the local authorities on these issues;

e) The second recommendation relates to carrying out an independent, external evaluation of practices of the Council and its safeguarding partners concerning harmful sexual behaviour. Proposals for undertaking this work are being considered by the Safeguarding Partnership on 30 September 2019 and if approved the NSPCC will be commissioned to undertake the independent evaluation. Once the evaluation has been completed, arising recommendations will be reviewed by the Partnership;

f) The Council's action plan will be wider than just the response to these two explicit recommendations and will reflect other areas for improvement identified;

g) The action plan will be considered by the Council's Executive Board at its meeting in October 2019;

h) In addition, work continues to engage with victims and survivors of sexual abuse to ensure that they are able to get the right support and access their records;

i) The Council also continues to offer its apology to anyone harmed as a result of child sexual abuse whilst in the care of the Council;

j) With partners, the Council will explore the outcomes of the needs assessment being carried out by Lime Culture and will use this to inform the future commissioning of services;

k) One of the issues highlighted by the Inquiry was that senior managers and councillors were not always aware of the extent and nature of allegations of sexual abuse. To address this, there will now be quarterly reporting of allegations to the Safeguarding Partnership and a specific section in the Independent Reviewing Officer's Annual Report about allegations that have been made to ensure that all relevant stakeholders are better sighted on the extent of issues;

l) The Council continues to engage with ongoing criminal investigations;

m) Progress on the action plan will be reported to the Safeguarding Partnership and updates will also be provided to this Board and the Council's Children and Young People Scrutiny Committee.

The Board thanked Alison Michalska for her work on this, and other issues during her time as Corporate Director for Children and Adults.

16 CYPP PRIORITY: EMPOWERING FAMILIES TO BE STRONG AND ACHIEVE ECONOMIC WELLBEING

Sophie Russell, Head of Children's Strategy and Improvement, Nottingham City Council introduced the report and gave a presentation updating on the 'Empowering Families to be Strong and Achieve Economic Wellbeing' priority of the Children and Young People's Plan. She highlighted the following information:

a) 'Priority Families' is the Nottingham name for the national Troubled Families Programme. It works with families facing multiple and complex issues;

b) Colleagues from the Department for Work and Pensions (DWP) are central to the delivery of the Programme and there have been significant improvements made in the relationships between the DWP and the wider partnership;

c) The Programme is funded through payment by results;

d) To date there have been 2833 claims, 680 of which have been for continuous employment and 2153 for significant and sustained improvement;

e) The 2833 families covers 15,250 individuals. From these individuals, 250,000 needs were identified and the Programme has been successful in meeting 77.6% of those needs;

f) The Programme is massively over-achieving against both national and local targets;

g) Funding for the Programme is due to end in March 2020. The recent Spending Review announced funding for the Troubled Families Programme for a further year but the allocation of that funding and priorities for 2020/21 haven't been confirmed.

During the discussion that followed, the following points were made:

h) It is positive that funding has been extended for a further year but this still leaves uncertainty for the period beyond that;

i) It is important to continue raising the profile of this work with Government and lobbying for ongoing funding.

The Board noted the contents of the report.

RESOLVED to

(1) ask Board members to consider how they can continue to embed 'whole family' working beyond March 2020 and integrate it into their strategic plans; and

(2) ask Board members to utilise any opportunities to promote the positive impact of the Priority Families Programme to inform national decisions in relation to funding from March 2020 and beyond.

The meeting adjourned at 4:30pm and reconvened at 5:15pm.

17 PARTNERSHIP UPDATE: THE DEPARTMENT FOR WORK AND PENSIONS

Rob Harrod, Troubled Families Employment Advisor, Monica Bryce, Troubled Families Employment Advisor, and Laura Jubb, Schools Advisor, all from the Department for Work and Pensions (DWP) gave a presentation about the DWP Partnership Team. They highlighted the following information:

a) With the introduction of Universal Credit, the client base that the Team works with is changing;

b) The role of Disability Employment Coaches is changing to take a more holistic approach for the whole family;

c) There are now eight fully trained safeguarding leads in City Job Centres, and another five individuals have just completed their training;

d) There is a fully trained domestic violence specialist in each Job Centre, who works in partnership with children's social workers. It is intended to make connections with adult social care services;

e) The Team also works in prisons, mainly with short-term prisoners to identify barriers for them and ways that these barriers can be overcome;

f) The Troubled Families Programme focuses on employment as a way of easing other problems such as anti-social behaviour, domestic abuse, debt;

g) There has been positive feedback from service users about the effectiveness of partnership working;

h) The role of Troubled Families Employment Advisors includes promoting DWP services, building partnerships, upskilling DWP staff and the staff of partner organisations, leading on safeguarding and domestic abuse issues within the DWP, helping to identify 'troubled families' and supporting Troubled Families Lead Workers and 'troubled families' themselves;

i) School Advisors assist schools to deliver high quality, independent and impartial careers advice to young people in years 8 to 13. The role includes providing advice on routes into traineeships and apprenticeships, providing advice on the local labour market and sourcing and advising on work experience opportunities;

j) Community Engagement Advisors work with young people in gangs and prolific young offenders to help them make the transition to work;

k) The uncertainty about the future of the Troubled Families Programme is a challenge and consideration needs to be given to maintaining relationships and partnerships when the Programme finishes.

l) Other challenges include getting employers to take on school children for work experience, especially for young people with specific needs and getting schools to advertise apprenticeships which can be the best route into employment for some young people;

m) There are lots of opportunities to build on the partnerships now in place, including counteracting the often negative impression of Job Centres and realising savings by upskilling staff and working in a more joined-up way.

The Board noted the presentation.

18 CHILDREN AND YOUNG PEOPLE'S PLAN FROM 2020

Sophie Russell, Head of Children's Strategy and Improvement, Nottingham City Council reported that work was commencing on refreshing the Children and Young People's Plan. She highlighted the following information:

a) The refreshed Plan needs to be in place for March 2020;

b) Children and families will be at the heart of the Plan;

c) The current Plan has four priorities and consideration will be given to whether these should remain the priorities going forward or whether there should be new priorities;

d) Colleagues leading on refreshing the Plan want to hear from stakeholders about what is working well; what the risks and threats are; what needs to happen next; and how opportunities can be maximised.

Board members were asked to identify other forums that could hold conversations about the refreshing the Plan.

Given the lack of time at the meeting to consider the item in detail, the Board decided to postpone consideration of this item until its next meeting.

19 FORWARD PLANNER

The Board discussed its Forward Plan.

RESOLVED to add discussion about the new Children and Young People's Plan from 2020 to the agenda for its next meeting.

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Title of paper:	An update on children and young people's health and wellbeing in the context of Nottingham City's Children and Young People Plan 2016-20	
Report to:	Nottingham Children's Partnership Board	
Date:	22/11/2019	
Relevant Director:	Alison Challenger (Director of Public Health)	**Wards affected:** All
Contact Officer(s) and contact details:	Helene Denness (helene.denness@nottinghamcity.gov.uk)	
Other officers who have provided input:	Uzmah Bhatti uzmah.bhatti@nottinghamcity.gov.uk David Johns david.johns@nottinghamcity.gov.uk Marie Cann-Livingstone marie.cannlivingstone@nottinghamcity.gov.uk Jenn Burton Jennifer.burton@nottinghamcity.gov.uk Rachel Clark rachel.clark@nottscc.gov.uk Anna Masding Anna.masding@nottinghamcity.gov.uk	

Relevant Children and Young People's Plan (CYPP) priority:	
Safeguarding and supporting children and families: Children, young people and families will benefit from early and effective support and protection to empower them to overcome difficulties and provide a safe environment in which to thrive.	☐
Promoting the health and wellbeing of babies, children and young people: From pregnancy and throughout life, babies, children, young people and families will be healthier, more emotionally resilient and better able to make informed decisions about their health and wellbeing.	☒
Supporting achievement and academic attainment: All children and young people will leave school with the best skills and qualifications they can achieve and will be ready for independence, work or further learning.	☐
Empowering families to be strong and achieve economic wellbeing: More families will be empowered and able to deal with family issues and child poverty will be significantly reduced.	☐

Summary of issues (including benefits to customers/service users):

This report highlights partnership activity that promotes the health of babies, children and young people. Whilst all outcomes in Nottingham Children and Young People's Plan will be referenced this report specifically focuses on efforts to reduce the:

Proportion of women smoking in pregnancy.

Proportion of year 6 children who are obese.

Percentage of mothers who breastfeed their babies at 6-8 weeks

In 2018/19, 15.9% of mothers in Nottingham City were smokers at delivery, which is significantly

higher than the England average of 10.6% and the fourth highest rate of our statistical neighbours. Whilst this is a welcome reduction from 17.2% in 2017/18, this reduction is not statistically significant reduction and Nottingham's position compared to statistical neighbours has worsened from the fifth highest rate in 2017/18 to the fourth highest rate in 2018/19. Changes in service provision have led to the development of new ways of working to support women to stop smoking in pregnancy. In addition, our social marketing campaign 'Love Bump', launched in March 2019, continues to develop in response to feedback from citizens. In 2018/19, 23.8% of reception age children in Nottingham City were obese or overweight. This percentage increases to 38.7% by Year 6 that is significantly higher than the England average and the third highest of our statistical neighbours. Work is underway to better integrate public health nutrition across the commissioned 0-19 children's public health services and review referral pathways for the children's weight management service. In addition, the whole system approach approved by Nottingham Children's Partnership Board is being advanced.

Recommendations:	
1	Nottingham Children's Partnership Board is requested to note the contents of this report and progress on health and wellbeing outcomes in the Nottingham City Children and Young People's Plan.
2	Nottingham Children's Partnership Board partners continue to support activity to improve health and wellbeing of children and young people in Nottingham.
3	Nottingham Children's Partnership Board partners are asked to continue to prioritise health outcomes for children and young people in their strategic priorities and commissioning plans.

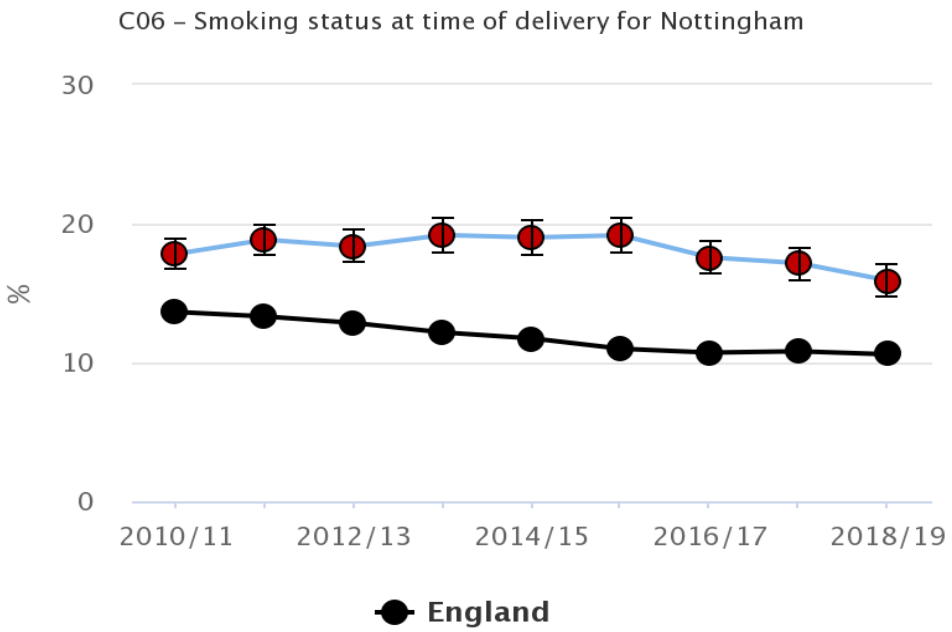
1 BACKGROUND AND PROPOSALS

Good maternal health and healthy babies: Smoking in pregnancy

The proportion of women smoking in pregnancy is recorded by the number of women smoking at the time of delivery (SATOD). Whilst this is the agreed national measure, it doesn't capture those women who are smoking at their 'booking appointment' with their midwife and quit before birth. Local intelligence suggests that the proportion of women smoking at their first midwifery appointment is considerably higher than SATOD. Nottingham's Maternal Public Health Steering Group, a sub group of the City/County Local Maternity Transformation System group, are leading work to reduce smoking in pregnancy and improve data collection and collation.

As figure 1 shows, in 2018/19, 15.9% of mothers in Nottingham City were smokers at delivery which is significantly higher than the England average of 10.6% and the fourth highest rate of our statistical neighbours. Whilst this is a welcome reduction from 17.2% in 2017/18, this reduction is not statistically significant reduction and Nottingham's position compared to statistical neighbours has worsened from the fifth highest rate in 2017/18 to the fourth highest rate in 2018/19.

Figure 1: Smoking status at the time of delivery in Nottingham and England



Source: Public Health Outcomes Framework.

Women who smoke in pregnancy are more likely to have a stillbirth, have a baby born at a low birth weight and/or a baby born with a cleft palate. Babies living in a household with smokers are more likely to die from Sudden Infant Death Syndrome (SIDS).

Through the publication of Better Births, the national maternity transformation plan, there is a renewed focus on reducing the proportion of pregnant women smoking through the Local Maternity and Neonatal System (LMNS). Historically, in Nottingham, we have had 'opt-out' referral to stop smoking services for pregnant women and we are working across the LMNS to re-establish this process.

In Nottingham, services are provided through, 'StubIt', a smoking cessation service launched in May 2019. Whilst midwives can make direct referrals online the service is not receiving the volume of referrals expected. Feedback from NUH is that having different services and referral processes for women living in the city and county causes confusion and presents a barrier for midwives and obstetricians.

To address this issue, the Maternal Public Health steering group has approached the LMNS to fund an administrative post to act as a single point of referral for smoking cessation and weight management. For smoking cessation, the intention would be to streamline and accelerate the process of referral for up to 20% of women who are smoking at booking; an estimated 2,166 women per year at NUH. In addition, a single point of access will enable hospital and community based staff to re-refer women at any stage of pregnancy if she is motivated to attempt to quit any time after her booking appointment. This post would be employed by NUH and based at the NUH Queens Medical site.

Nottingham City Council has worked with CCG partners and Nottingham CityCare to create a new, fixed term smoking in pregnancy post within the Nottingham University Hospital SmokeFree team. This post is working within the NUH maternity division and across the LMNS continuity of carer pilot sites in Bulwell and Leen Valley. The post is:

- Supporting the training needs of staff within the midwifery division regarding smoking in pregnancy:
- Exploring ways to engage pregnant women about smoking throughout their pregnancy and provide advice to stop smoking;
- And will help establish effective referral pathways between midwives and the stop smoking service.

The Maternal Public Health Steering Group are working in partnership with Small Steps Big Changes (SSBC) to explore new pilot projects within the SSBC wards, with the aim of reducing smoking in pregnancy. Proposed initiatives include a maternity support worker model and a peer mentoring programme.

The NHS Long Term plan published earlier this year commits to offering a stop smoking service to all pregnant women AND their partners. However, how this commitment will look in practice or be funded is less clear at this stage and will require collaborative working between the local authority and clinical commissioning groups.

In addition, 2019 has seen the expansion of the 'Love Bump' campaign to promote the dangers of smoking in pregnancy and the benefits to mother, partner, unborn baby and other family members of giving up smoking https://lovebump.org.uk/. In addition to the social marketing campaign, the Love Bump campaign includes additional resources for midwives, namely new conversation packs to use in their daily conversations with pregnant women.

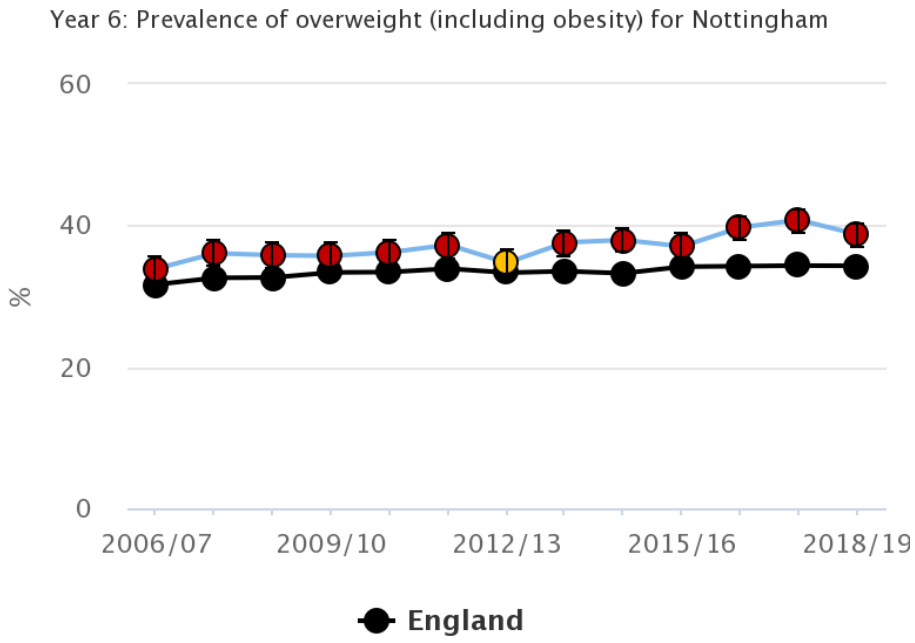
Children and young people adopt healthy lifestyles: Childhood Obesity

How big an issue is Childhood Obesity for Nottingham?

In Nottingham, more than 1 in 4 children (23.8%) were overweight or obese when they started primary school in 2018/19. Upon leaving school, 2 in 5 children (38.7%) were considered obese or overweight. This figure has been heading in the wrong direction for several years and significantly worse than the national average. The prevalence of excess weight in Nottingham, as in the UK, is inequitable and variation is seen by geography, deprivation and ethnicity.

The prevalence of obesity in Year 6 children between 2006/07 and 2018/19 are shown in Figure 2 and suggest an upward trend following a period of relative consistency. There is however, a slight reduction from (40.8%) in 2017/18 to (38.7%) in 2018/19, whilst this is a welcome reduction; this reduction is not statistically significant. It is interesting to note a statistically significant reduction in the prevalence of obesity in reception aged children, from (26.7%) in 2017/18 to (23.8%) in 2018/19.

Figure 2: Prevalence of Year 6 children who are classified as overweight in Nottingham and England (2006 – 2019)



Source: Public Health Outcomes Framework.

What are the health risks?

Children with obesity are known to have a higher likelihood of suffering obesity as adults. However, the health consequences of obesity also impact children i.e. glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

What are the causes of overweight or obesity?

Public and media conversations are dominated by a persistent idea that the problem is driven by individual level choices that balance between energy intake (food) and energy expenditure (Physical activity). This misplaced focus on individuals, increases stigma and ignores the context in which decisions are made. People in the UK today do not have less will power and are not more gluttonous than previous generations. Nor is their biology significantly different to that of their forefathers. However, the way we live, work, travel, play, shop and eat has been transformed greatly in recent decades. There are believed to be over 100 driving factors in domains such as behaviour; biology; socio-economic and commercial determinants; and the environment we live our day-to-day lives. The 300+ interactions between these factors lead to a complex and dynamic system.

What work is underway?

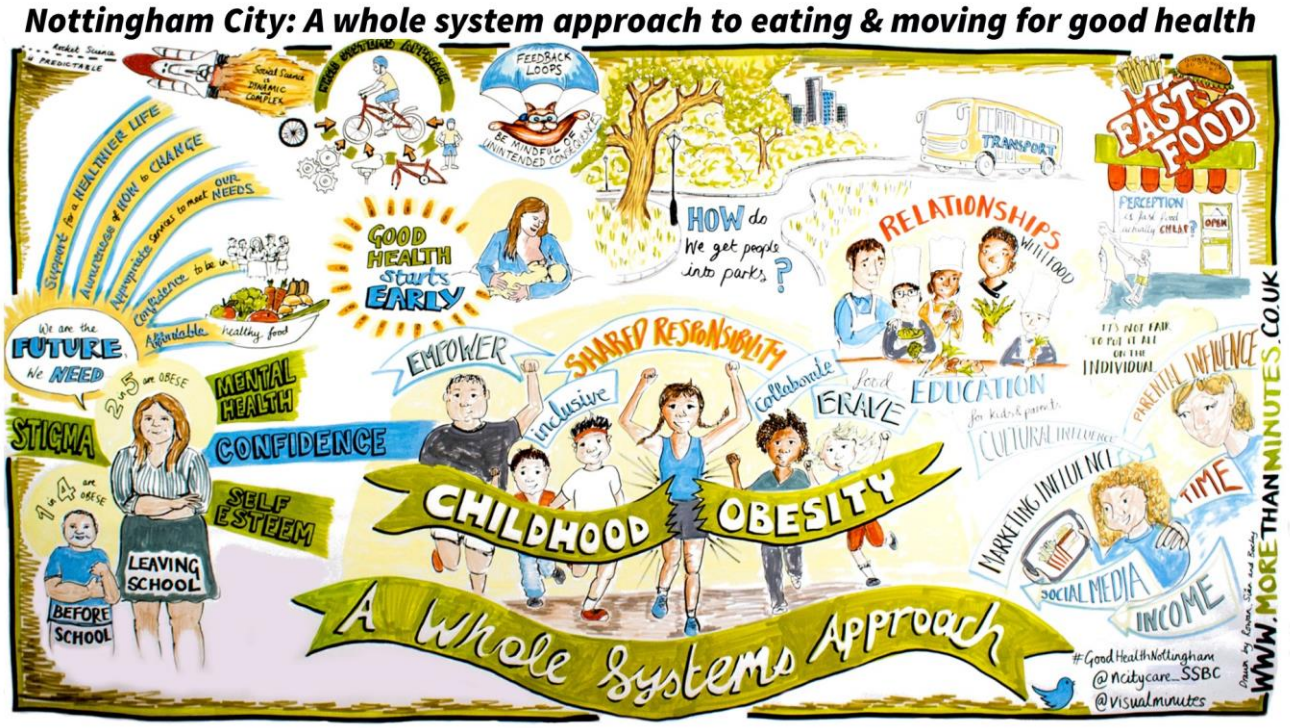
Nottingham City commissions a Public Health Nutrition/Weight Management function within the 0-19 contract delivered by CityCare. This team work with families in their own homes to find practical ways to prompt changes in diet and improve child health. The National Childhood Measurement Programme is commissioned by Public Health and conducted annually. It provides intelligence on those suffering with overweight/obesity down to school catchment area. Nottingham is committed to supporting children and young people to move and eat for good health, by pledging to support citizen to help them become physically active and improve their health, and to reducing child obesity by 10%. See appendix 1 for services related to childhood nutrition and obesity in Nottingham, table 4 for targeted interventions for those most at risk of overweight and obesity.

Nottingham City Council is also working with Small Steps Big Changes to create the whole system approach to eating and moving for good health, approved by the Children and Young People's Partnership Board and Health and Wellbeing Board. In September 2019, around 100 people from local community groups; healthcare providers; clinicians and dietitians; commissioners; SSBC

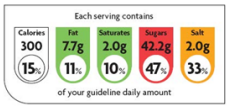
family mentors; and parents, attended a workshop exploring the factors that site behind families' abilities to eat and move for good health. This workshop was well evaluated and sparked many useful conversations. The initial output from the workshop has been visually represented (Figure 3). A small steering group containing members of Nottingham City Public Health, Nottingham Trent University, Small Steps Big Changes and Active Notts, is synthesising the system maps produced by the workshop.

A second workshop is planned for February 2020 to explore, as a system, the actions we must consider and our next steps. Furthermore, discussions with Small Steps Big Changes and the Nottingham City Youth Council are underway to explore how best to engage children and young people in the conversation.

Figure 3: A visual depicting the complexity of childhood obesity in Nottingham City as described by those working and living in our communities. The system also describes the values it wishes to share towards the centre of the image.



Nationally, the government has outlined its plan to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas, by 2030. Many of the policies outlined below are currently under consultation with several additional consultations taking place this year.



LABELLING

- Mandate calorie **labelling on the out of home sector** (including online food delivery)
- Explore what **additional opportunities leaving the EU presents** for food labelling.

SUGAR REDUCTION

- Consider **extending the SDIL** to milk based drinks if they fail to reduce sugar by 2020
- Consider **further use of tax system** if sugar reduction does not achieve the desired progress.
- Consult on introducing a **ban to end the sale of energy drinks to children**

Our national ambition is to <u>halve</u> childhood obesity & significantly reduce the gap in obesity between children from most and least deprived areas, <u>by 2030</u>

LOCAL COMMUNITIES

- **Trailblazer programme** to support LA
- Strengthen **Government Buying Standards** for food and catering services

SCHOOLS

- **Review physical activity offer**
- National ambition for **every primary school to adopt an active mile** initiative
- Update **standards for school foods** and ensure compliance
- Consult on use of **health start vouchers** to support low income families

RETAIL

- Consult on **ban price promotions of HFSS food and drink** e.g. buy one get one free, multi-buy offers, unlimited refills etc.
- Consult on **ban the promotion of HFSS food and drink by location** e.g. checkout, end of aisles

1a. Good maternal health and healthy babies

i) Improving mental health for new mums and mums-to-be

Work to improve the mental health of new mums and mum-to-be is driven by the perinatal mental health steering group, a sub-group of the Local Maternity System Transformation group. Current work is focused on strengthening the pathway of care for women with mental health needs and improving early identification of mental health need in the perinatal period, with a particular focus on mild to moderate and emerging mental health needs, including those who:

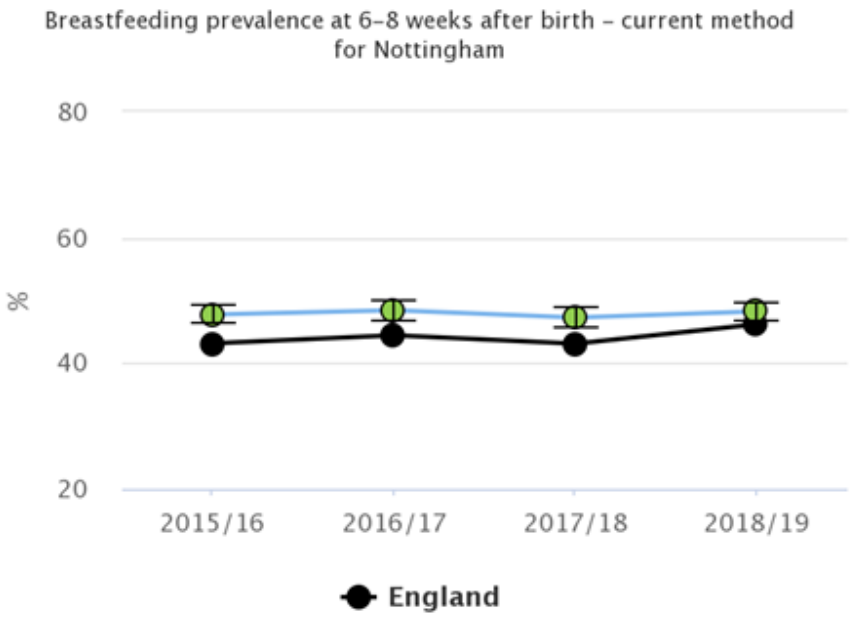
- Enter pregnancy with existing mental health conditions,
- Would benefit from talking therapies (IAPT)[1]
- And those who develop a serious mental health problem during pregnancy or after birth.

The current indicator in the CYP plan is a proxy for the number/proportion of women with low mood and/or a mental health problem that are identified in a timely way, and offered appropriate support. This indicator may be updated as a more robust national method of capturing new mums and mums-to-be mental health is developed.

Breastfeeding: Percentage of mothers who breastfeed their babies at 6-8 weeks

As figure 4 shows, in Nottingham City, in 2018/19, 48.2% of women were breastfeeding at 6-8 weeks, significantly higher than the England average of 46.2%. Nottingham has the fifth highest breastfeeding rate at 6 8 weeks of our twelve statistical neighbours.

Figure 4: Breastfeeding at 6-8 weeks in Nottingham and England.



Source: Public Health Outcomes Framework.

[1] Increasing access to psychological therapies

Public Health have recently analysed breastfeeding rates across Nottingham City and found large inequalities in breastfeeding rates.

- **Location**: Breastfeeding at 6-8 weeks ranged from 31.8% in Bulwell, 35.9% in Aspley and 37.0% in Clifton East up to 69.7% in Sherwood, 74.3% in Radford, 83.3% in Castle.
- **Deprivation**: Women living in the 20% most deprived areas of Nottingham are significantly less likely to breastfeed at 6 weeks (47.6%) compared to those in the 20% least deprived areas (65.4%).

- **Age**: Women under the age of 25 years are significantly less likely to breastfeed. Rates of breastfeeding at 6-8 weeks ranged from 29.1% in 16-20 year olds, 42.9% in 21-25 year olds,65.6% in 31-35 year olds and 64.2% in 36-40 year olds.
- **Ethnicity**: Babies of white ethnicity in Nottingham are significantly less likely to be breastfed at 6 weeks (42.1%) compared to babies of Asian or Asian British ethnicity (67.6%), Chinese and other (73.0%) or Black or Black British (82.6%).

Increasing breastfeeding rates is best achieved through joint efforts of all agencies, statutory and voluntary, working with pregnant women and new parents. The Nottingham City Council commissioned breastfeeding support service is being expanded through CityCare's Children's Public Health 0-19 Nursing service and includes provision of dedicated Nutrition Peer Support Workers across the City. CityCare is working with commissioners to increase the reach of breastfeeding support.

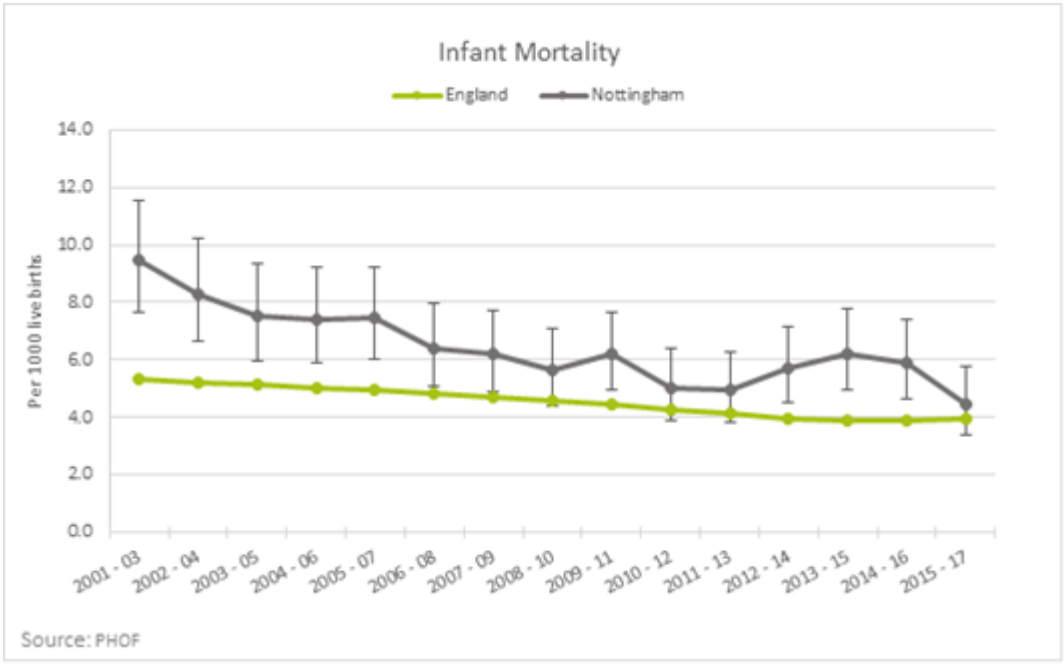
In addition, as part of the new Council Plan, a new Breastfeeding Friendly Nottingham Charter and campaign will be launched in March 2020. This will include:

- Raising awareness of the benefits of breastfeeding:
- Normalising breastfeeding in Nottingham so women feel confident to feed at home, in public and on return to work or education;
- Increasing awareness of the breastfeeding support and information available in Nottingham
- Encouraging businesses and educational establishments to go the extra mile to support breastfeeding, as a public space and employer, by signing up to the Nottingham Breastfeeding Friendly Charter

ii) Infant Mortality

Infant Mortality rate (IMR) is defined as the number of deaths of children under the age of one each year, per 1000 live births. During 2015-17, infant mortality deaths in Nottingham, 4.5 deaths per 1000 live births, is similar to the England average of 3.9 deaths per 1000 live births, and is the fifth lowest mortality when compared to its statistical neighbours (see figure 5). There has been no statistically significant reduction in infant deaths from 2010-12. As the number of deaths in children under 1 year is small, any variation in the rate of deaths should be interpreted with caution as the variation may be due to random fluctuation.

Figure 5: Infant mortality in Nottingham and England (2001-03 – 2015-17)



Source: Public Health Outcomes Framework

All child deaths in Nottingham are reviewed by multi-agency Child Death Overview Panels (CDOPs) as per *Working Together to Safeguard Children 2015* guidance. Learning from CDOP is fed back into the governance structures within NUH. The Child Death Review Team based at NUH manages a detailed database of all childhood deaths. All deaths are discussed with the local Coroner prior to completing death certification.

In Apr 18 - Mar 19, there were 24 deaths of children under 1 year of age. The majority of these deaths 50% (12) were classified as a perinatal/neonatal, which includes babies who are born extremely prematurely, and 33% (4) of these were born to mothers who smoked during pregnancy. 25% (6) had Chromosomal, genetic and congenital anomalies.

There were 2 deaths associated with unsafe sleeping in Apr 18 - Mar 19, which is the average over the last 10 years. These are potentially preventable deaths, and therefore the importance of safe sleeping continues to be highlighted to parents and a Safe Sleeping group is in place to mobilise action across health, social care and other partners. Local training sessions targeted at early years and social care have been developed and delivered across Nottingham City (next one planned for Fed). There is also a free online training package, which can be accessed via the Nottingham City Safeguarding website. There is also a free online training package, which can be accessed via the Nottingham City Safeguarding website. (The e-learning training package is only

in County but there is PowerPoint learning on the Nottingham City Safeguarding website, which is currently being updated**.**

IV) Perinatal mortality

In 2015, the Secretary of State announced a national ambition to halve rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction seen by 2020. To help maternity services achieve this aspiration, Saving Babies' Lives care bundle was introduced and designed to tackle stillbirth and early neonatal death, and is a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together:

I. Reducing smoking in pregnancy
II. Risk assessment and surveillance for foetal growth restriction
III. Raising awareness of reduced foetal movement
IV. Effective foetal monitoring during labour

During 2016 and 2018 there were 55 stillbirths in Nottingham, a rate of 4.4 per 1000 births which is in line with the England average of 4.4 stillbirths per 1000 births. However, many of these stillbirths are preventable. Although the causes of stillbirths are often unclear, there are associated risk factors, these include, but are not limited to:

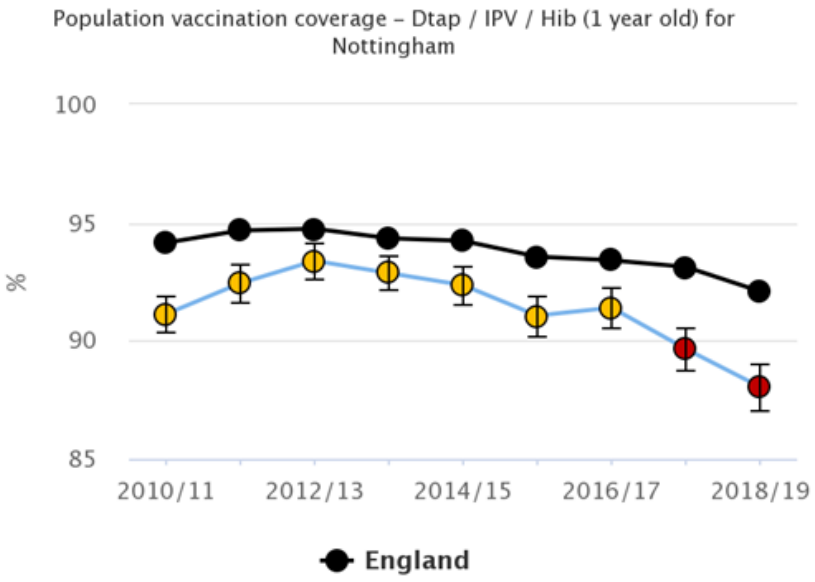
- Smoking in pregnancy
- Maternal age (stillbirth rates are highest for women aged under 20 or over 40)
- Maternal obesity
- living in deprivation
- Multiple births
- Influenza

Saving Babies' Lives care bundle supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births and is driven by the Safe and Effective group, a sub-group of the Nottinghamshire Local Maternity System Transformation group. In 2017, Nottingham City Public Health Team produced, with the support of Nottingham City CCG and NUH, a review of perinatal deaths, including stillbirths, to identify any unexpected themes. The patterns observed were similar to those seen nationally; however, higher levels of deprivation in the city mean risk factors, such as smoking in pregnancy, are often more prevalent. NUH has worked with partners, including Nottingham City Public Health team, to improve learning from stillbirths. This work is ongoing and links with the ambition of the Safe and Effective sub group to reduce the proportion of women smoking in pregnancy, which is the most important, preventable cause of stillbirth and neonatal deaths.

V) Immunisations: Percentage of eligible children who have received 3 doses of Dtap/IPV/Hib vaccine by their first birthday

Locally, the NHSE/PHE screening and immunisation team continues with its MMR:increasing uptake group which meets quarterly. An audit to look at call & recall processes for the childhood immunisation programme will start in the New Year. It is hoped that the audit will identify gaps in practice that can be filled. As figure 6 shows, DTaP/IPV/Hib vaccination uptake for 1 year olds in Nottingham City, in 2018/19 was 88.0% which is a statistically significant reduction from 89.7% in 2017/18. Whilst the England average of 92.1%, is the lowest since 2008-09, Nottingham has the lowest rate of its statistical neighbours. In addition, DTaP/IPV/Hib coverage has declined for all ages.

Figure 6: Population vaccine coverage - DTaP/IPV/Hib (1 year old) for Nottingham



Source: Public Health Outcomes Framework

Nationally, considerable work is being developed to mitigate against the drop in uptake for vaccinations. A national immunisation strategy has been shared for comments. The strategy includes many different workstreams to help support the national immunisation programme and stakeholders to increase uptake. A national project by PHE to look at data issues for immunisations in GP systems has been running since September. The Screening and Immunisation Team has facilitated the sharing of data to be analysed by Nottingham practices. The findings will be made available in the New Year.

Vaccination services are commissioned by NHS England & NHS Improvement with the Dtap/IPV/Hib vaccine being administered in General Practice at 8, 12 and 16 weeks of age. Promotion of immunisations and vaccinations is integrated into the Best Start, 0-19 years' public health service specification as part of MECC (making every contact count) as well as a consistent approach to information provided to families. GP practices provide a 'call and recall programme' so that parents are aware of when children are required to have their vaccination. This work is implemented in partnership with NHS England and Public Health England. Work to explore the opportunity to increase vaccination cover through opportunistic contact with primary care will be implemented in partnership with NHS England and Public Health England

1b) Children and young people adopt healthy lifestyles

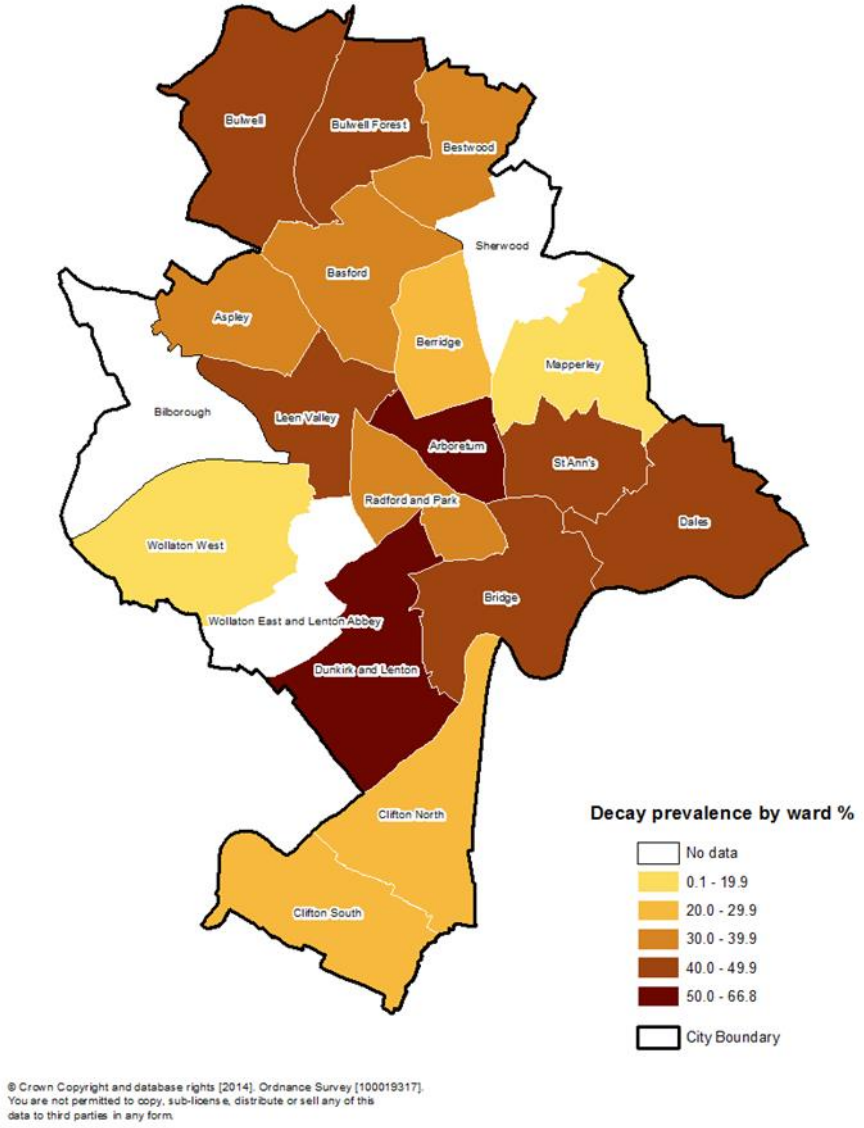
i) Oral Health: Percentage of children aged 5 with tooth decay

Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise with other children. The impacts can be seen educationally with children missing school and in addition can affect parents/carers who would need to take time off work. Nationally, tooth decay remains the most common reason for hospital admissions in children aged five to nine years old (2014-2015). Furthermore, it is a sign of neglect. Significant dental decay, which, if it remains untreated, may be considered a safeguarding concern. Nottingham is committed to improving the dental health of children by pledging to campaign for the introduction of fluoride into Nottingham's water supply.

Nottingham has a similar proportion of five year old children free from dental decay (74.1%) to the England average (76.7%); an improvement, albeit not statistically significant, on 2014/15. The number of decayed, missing or filled teeth on average in five year olds in Nottingham in 2016/17 (1.22 teeth) remains similar to that seen in 2014/15 and higher than the England average (0.78 teeth).

The number of decayed missing or filled teeth is also linked to deprivation within the City. There is considerable variation in the prevalence of tooth decay at the area committee/ward levels in the City Local Area Committee 3 comprising Aspley, Bilborough and Leen Valley has the worse prevalence of tooth decay among 5-year olds in the City (Figure 7).

Figure 7: Percentage of 5-Year-Olds Free from Tooth Decay in Nottingham by wards



Source: PHE 2016/17

Since the oral health promotion service was decommissioned in March 2018, Small Steps Big Changes now commissions Nottinghamshire Healthcare Trust, *Tooth Fairies* to provide school oral health engagement programme in several of its wards. At present, health visitors continue to offer advice and resources to new parents. Public Health England Start4Life resources and 'Dental check by One' messages continue to be cascaded. In addition, the Nottinghamshire Oral Health Steering Group have put forward a proposal to obtain NHSE funding. The funding will help to deliver additional activities to expand the offer of oral health promotion and prevention, help improve access to dental care and align resources across the local system.

A Health Needs Assessment has been completed to explore the full range of data on the oral health of Nottingham City residents. The Nottinghamshire Oral Health Steering group are considering the next steps for taking forwards the recommendations from the oral health needs assessment.

ii) Children and young people's mental health:

Our vision is to provide children and young people with flexible support around emotional well-being, so no child or young person has to face emotional distress alone (see Appendix 3)
The most up to date data from the 2017 Children and Young People's Mental Health National Prevalence Study indicates that one in eight children and young people aged 5 -19 had a mental disorder in 2017.

The *Green Paper on Transforming Children and Young People's Mental Health* (December 2017) and the recent *NHS 10 Year Plan* focused on schools as playing a key role around early intervention and prevention around children and young people's mental health. There is an ambition that all schools will have a 'Designated Mental Health Lead', who will be responsible for the whole school approach to addressing mental health.

Across Nottingham City, engagement and collaboration with schools and colleges has increased to ensure they feel supported to support our children and young people. Schools have been participating in a number of initiatives as detailed below.

Zippy and Apple's Friends academic resilience programmes were piloted in 8 primary schools. The University of Belfast is currently working with the collected data and the final report is due to be published soon.

The Emotional Health and Resilience Charter was set up by a partnership of local services who work with schools on mental health and emotional wellbeing. This is a way for schools to demonstrate their commitment to support the mental health and emotional wellbeing and resilience of their pupils. Once the school has signed the charter they complete an audit to record their strengths and identify areas for development. An action plan is then created and support can be requested from the Emotional Health and Wellbeing Consultants and Partner Services who developed the charter. Schools will then be encouraged to share the outcomes of their development work as case studies which can be disseminated across the city.

The Emotional Health and Wellbeing Consultants also offer Youth Mental Health First Aid (MHFA) training to staff from city schools. Schools are able to access the full 2-day training to become a Youth Mental Health First Aider and/or a 1-day training to become a Youth MHFA Champion. So far this year, 38 staff have been trained in the 2-day Youth MHFA course and 13 teachers on the 1 day training. The staff have come from 37 different schools. 14 schools attended training sessions from the Character Curriculum Programme which was delivered by the Council's Personal, Social and Health Education Team and 17 schools received resources to support their curriculum.

Mental Health First Aid Youth training is also delivered to the wider children's workforce in Nottingham City. To date, 250 members of the children's workforce have become Youth Mental Health First Aiders. The Youth Mental Health First Aiders have the skills to recognise young people showing early signs of emotional distress to more complex mental health need to support them appropriately. This early intervention approach will help towards supporting the (approximately) 1 in 8 young people in the city who suffer with mental health problems. It will also help to build on the 'time to change agenda' highlighting the need for improved public awareness and understanding and aiding people to think differently about mental health issues for young people.

The behavioural and emotional health (BEH) team is a CCG commissioned service that aims to bridge the gap between universal and targeted CAMHS provision for children/young people who are registered with a City GP. The service is primarily receiving referrals for children/young people who have behaviour issues and/or where there are concerns that the child/young person may have autism or ADHD. The CCG has recently commissioned an educational psychologist and a clinical psychologist to ensure the diagnostic service meets NICE guidance. In 2017/2018, the BEH team received 2323 referrals. This high number of referrals each month evidences the level of need within the City, and the increasing number of referrals to the paediatric service in relation to Autism and/or ADHD.

Across Nottingham City young people continue to access Base 51 which offers face to face counselling services and access to wider health support such as sexual health. During 17/18, 223 young people from Nottingham City were referred to Base 51.

Kooth continues to offer open access support to young people across Nottingham City providing online counselling and face to face appointments, as well as a range of other online

emotional health support tools such as moderated forums and self-care tools. During 17/18, 376 young people accessed the Kooth face to face service offered within Nottingham City with 2038 appointments delivered, whilst 892 young people from Nottingham City registered for Kooth online services with 589 online counselling sessions offered. 87% of young people returned to Kooth more than once and 96% reported that they would recommend the service to a friend.

Nottingham City has participated in the MH:2K project. 30 local young people representing the diversity within Nottinghamshire and Nottingham City were trained as citizen researchers and delivered a number of engagement events and engaged over 500 of their peers and set priorities for improving young people's mental health. This project has now been extended until 2020, with a plan to recruit more citizen researchers and produce a short film tackling stigma around mental health

Targeted Children and Adolescent Mental Health Service (CAMHS) prevention and early intervention work, links schools and universal services to offer support and training to staff. A CAMHS practitioner links with schools in a number of ways to offer support, including by:

- Offering support directly to secondary school aged children;
- Piloting a project to support the early identification of mental health needs in primary school aged children;
- And monthly self-harm clinics delivered by the SHARP service in 18 City secondary schools, one in Nottingham College and one for the CAMHS Children Looked After service. Of these, approximately 80% of YP seen over a 2.5 year period have received support from Universal Services and not required input from Targeted/Specialist mental health services, clearly evidencing that early and targeted interventions can reduce self-harm and suicidal behaviours in secondary school students.

The Targeted CAMHS offer also includes parent/carer psychoeducation workshops that cover anxiety, depression, attachment, self-harm awareness and supporting transgender children. The Targeted City's CAMHS 'Single Point of Access' model is quite unique nationally. It ensures referrals are processed quickly and effectively and children and young people can be navigated to the right support for them depending on their presentation and needs. This model has ensured that over the last 4 years 95% of cases remain at a Targeted CAMHS or universal level, only escalating to Specialist Community CAMHS when absolutely essential. Our most recent data tells us that, in 2018/19 from the SPA referrals that require CAMHS input 92.5% remained within Targeted CAMHS who were able to support them within their local community (traditionally known

as Tier 2 services), with only 7.25% needing to be sent onto more specialist services. Of those accepted for treatment at Targeted CAMHS 91.3% were seen and discharged without any need to be stepped up to a supplementary specialist CAMH Service, with only 8.7% stepped up either following assessment or treatment, (2.1% following assessment and 6.6% following treatment). This means that children and young people only need to be escalated into more specialist and costly provisions when it is essential. This means that investments into child and young people's mental health provision not only promotes a model of early intervention/prevention but is also more cost effective.

The service has led a working group to explore ways to further improve easier access into the behavioural, emotional and mental health (BEMH) pathway and/or Targeted and Community CAMHS. This work has led to the agreement from commissioners (CCP) for the redesign the BEMH website to make it young people friendly, and to develop ways for CYP and families to self-refer more easily. The single point of access (SPA) continues to closely monitor our wait times weekly, ensuring that referrals are screened within 5 working days and that CYP get seen within 6 weeks of their referral. Where there is any reach of breaching our agreed wait, this is escalated to senior managers, the Mental Health and Wellbeing Programme Lead, and commissioners.

Targeted CAMHS ensures it has staff trained in a range of evidenced based therapeutic models including a number of specialist staff such as a Cognitive Behavioural Therapy Specialist (for complex and enduring mental health needs). In addition other forms of more specialised work including a Domestic Abuse CAMHS practitioner, and animal assisted therapy with therapy dog, Freud. Targeted CAMHS continue to work on it's Participation strategy 'Your Voice' and attends events in the last year have included Splendour Festival, Pride and Riverside Festival. The service have:

- Developed a participation working group and action plan in line with CAMHS participation aims: Feedback, Community Engagement, Co-design/Co-production. Members include GP, schools, voluntary BME group, invites to parents/YP have been extended
- 'Open Door' sessions for families to come and meet the team and learn more about CAMHS choice assessment and the journey through the service, gain feedback from this group
- Providing a parents/carers support and feedback group – 'Parents in Mind'
- Young people and parents/carers to be involved in recruitment process by engaging experts by experience in meaningful participation
- Support young people to have a voice in their work with CAMHS- 'Teens 4 Truth'

- Continued to embed meaningful participation with children, young people, parents and carers by engaging in community events with partners.
- Started to plan a young people's event for May 2020
- Leaflets for children, young people and families to raise awareness of CAMH services, the feedback loop and how to participate have been produced

The service continue to work alongside the MH2K project, Targeted Child and Adolescent Mental Health Services are developing a co-designed poster detailing available support, which will be on the back of all school toilet doors in order to improve access to support for those who need it. Targeted CAMHS also lead a multiagency working group on participation with the aim to improve co-production and participation in the service's development. Alongside a CAMHS newsletter that goes out twice a year updating on all services developments for BEMH pathway and CAMHS and aims to reduce stigma and promote positive mental wellbeing. Targeted CAMHS have been successful in a securing the funding to implement a NHS England Trailblazer to set up 2 mental health support teams for City schools.

The Mental Health Support Teams (MHST) approach was set out in Transforming Children and Young People's Mental Health Provision, the 'Green Paper' which builds on existing government commitments, set out in Future in Mind and The Five Year Forward View for Mental Health, to create integrated partnerships to keep children and young people at the heart of mental health care, and ensure that everyone is able to access the right help, in the right setting, when they need it. MHSTs are for children and young people in primary, secondary and further education (ages 5 to 18) and the education settings in which they learn.

MHSTs will form part of the mental health approach within education settings, providing timely, evidence-based support, care and interventions for children and young people who are experiencing mild to moderate mental health problems. They will also support children and young people who present with developing or emerging problems and may provide support for those who present with more complex needs, which will require joint working with and signposting to appropriate services such as into our CAMHS. The MHSTs will also work with senior leads to support wider approaches to mental health and wellbeing across the education setting, including advice, consultation, training and psychoeducation.

In 2018/19:

- 1839 referrals were received and processed by the CAMHS Single Point of Access; of them 1000 assessments in total were offered to CYP and their families, including 124 joint assessments with Community CAMHS.
- 102 consultations were offered to professionals
- CHI service satisfaction outcomes were 22/24 for CYP and 23/24 for parents and carers
- Over 70% of CYP self-reported improvements in anxiety and depression the same is true with over 70% improvement for SDQ (strength and difficulties) which measures emotional and behaviour difficulties overall following treatments.
- 94% of young people offered feedback on their assessment experience with Targeted CAMHS said they would recommend us to a friend, 6% said they didn't know, and 0% said they wouldn't.

SHARP (Self-harm Awareness & Resource Project)

SHARP was created five years ago as a response to the significant increase in young people presenting with self-harm and suicidality at Children's Emergency Department, the key element of the SHARP model is to identify self-harm behaviours early and offer immediate support and prevent escalation. SHARP is an established citywide service, we work with front-line professionals and services with an aim to raise awareness, build confidence and skills, and enable them to intervene and manage children and young people who present with self-harm and suicidal behaviours.

Data collected from over 9,000 children, young people, parents and professionals as part of the 2017 National Prevalence Survey indicated that 5.5% of 11-16 year olds had self-harmed at some time, with the proportion higher in girls than boys. This figure was higher for 17-19 year olds with 15.4% overall having reported to have self-harmed, again with higher incidence in girls than boys.
SHARP is a preventive self-harm service model that have trained 3980 professionals since October 2015 through 411 training sessions. SHARP have delivered assemblies to 650 children/young people aged 11–16 years, raising awareness around healthy coping strategies and breaking down barriers to access to services. 7000 front-line professionals have been trained since SHARP was formed just over 5 years ago.

SHARP have delivered 6 'Exam Stress-LESS' workshops to children/young people over the last few months and have another 12 schools booked in for this academic year reaching out to

approximately 400 CYP. SHARP produced a training package called 'If Toys Could Talk' as an action from a Serious Case Review in 2017 which focusses on helping professional to recognise and support young children where self-harm is a concern. This training is available for all City primary schools.

SHARP oversee all self-harm follow-ups and joint protocols (a joint assessment within 48 hours with social care for high risk young people) which come through the City SPA, ensuring a timely and accurate risk assessment is completed and a robust safety plan is in place with clear recommendations of further support for the child/young person/family and offering the professional network consultation if required. SHARP is a community based service providing support for front-line professionals (health, education, social care, voluntary) through professional consultation and 11 various training workshops, also offering face to face support to CYP using evidence based therapeutic interventions and groups. SHARP also offer monthly educational self-harm clinics (in secondary and further education settings) ensuring that a self-harm/suicidal risk assessments are completed to identify appropriate support. This includes a robust risk assessment for CYP/family/professional network, distress tolerance techniques and distractions, useful contact information and therapeutic interventions, all indictors of risk have management oversight. 24 monthly clinics across the city, reaching up 72 CYP per month with aftercare support for professionals, children and their families.

SHARP also offer 9 'SHARP4Parents' workshops across the city annually encouraging all parents/carers to learn about self-harm and how to manage this behaviour in the home environment. SHARP also deliver workshops to young people in secondary schools (Exam Stress-LESS and Riding the Wave), SHARP ensure that the service has a visible presence throughout our schools and community raising awareness and distributing resources (mental health week, world suicide prevention day, trans visibility day, self-harm awareness week). SHARP have a rota set up to support City SPA (single point of access) to ensure that all self-harm follow-ups and Joint Protocols (CAMHS & Social Care) are completed in a timely manner ensuring a recommendation of further or the most appropriate care is determined quickly. This is unique nationally and is a robust multiagency approach to suicide prevention and early intervention.

SHARP training workshops;

- Under the Skin (self-harm awareness)
- Suicide Everybody's Business
- One Bad Choice (drugs and mental health)
- If Toys Could Talk (understanding harmful behaviours in primary children)

- MHFA (2 days and Lite)
- A to Z of Your Head
- Safe from Harm (Safety Planning)
- Understanding Teenage Girls Who Self-harm
- Breaking the Silence (males and suicide)
- I'm Trans – Get Used to It (gender variance awareness)

To be developed:
- LGBT+ Awareness
- Assessing the Risk

CYP workshops:
- Riding the Wave (Harm Reduction and Distress Tolerance)
- Exam Stress-Less

Parent/Carer workshops:
- Self-harm Awareness
- Transgender Child

SHARP offer per annum:
- Specialist Practitioner Sessions – 54 sessions per quarter (216 per annum)
- Parent support group sessions – 9 per annum
- Training Sessions – 45 per quarter (180 per annum)
- Professional Consultations – 40 per quarter (160 per annum)
- School Self-Harm Clinics – 16 school clinics offered over 9 months (144 per annum)
  (This used to be 48 per quarter and 192 per annum.
  However, this changed after the service review meeting in June 2018 as SHARP school clinics are only offered during school term, which is 9 months)

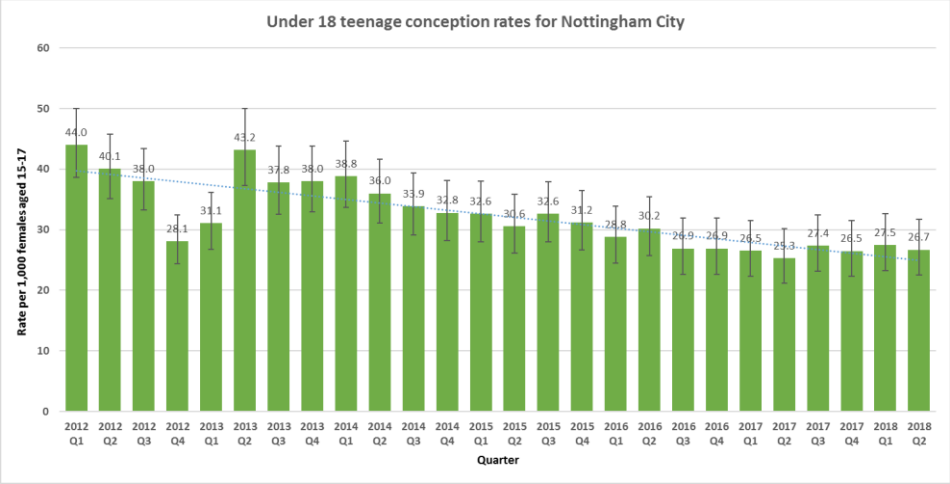
SHARP also offer CYP development workshops, school assemblies, conference presentations, safety planning with parents/carers, awareness day stall/resources, CYP and professional resources packs. SHARP have developed a Critical Response Guidance to Suicide which has been approved by the Local Preventing Suicide Strategy steering group. Quarterly data is submitted to Commissioning (CCP), evaluations and feedback is collated from all training, CYP workshops and professional consultations and ROM's are collected from any therapeutic face-to-face intervention

iii) Teenage Pregnancy

In Nottingham for the rolling year ending June 2018 (Quarter 2 2018), the most recently available *provisional* conception data, there was an increase in the number of under-18 conceptions from

120 to 126 in the rolling year to Q2 2018; a 4.8% increase. During the same 12-month time period the conception rate increased by 5.2% from 25.3 per 1000 girls aged 15-17 to 26.7 (Figure 8).

Figure 8: Nottingham conception rates by quarterly rolling years from 2012 to 2018

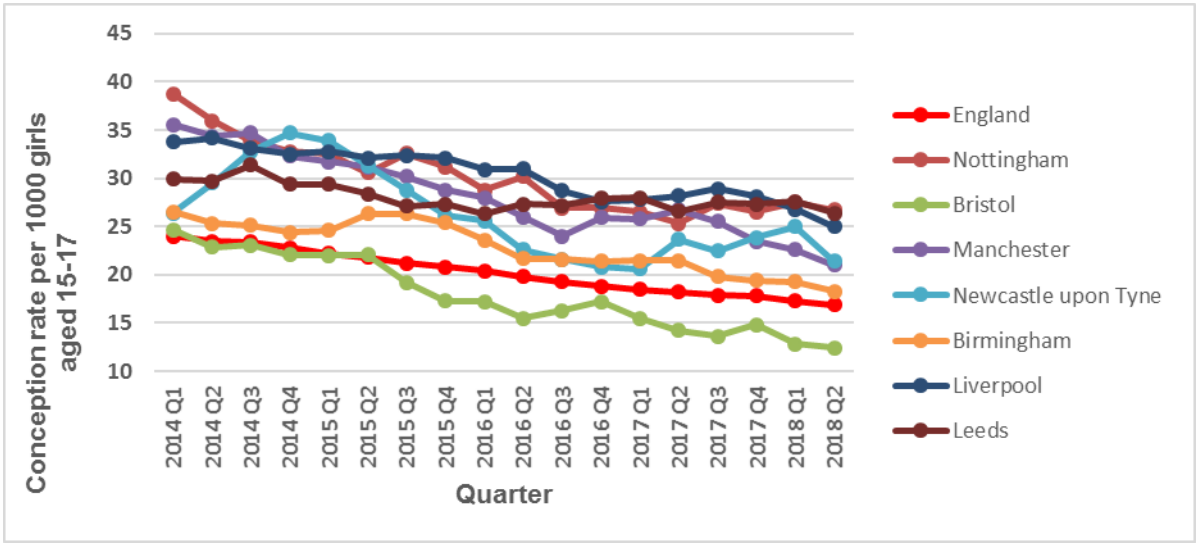


Source: Office for National Statistics (2019) Conception Statistics England and Wales

The Nottingham under-18 conception rate has decreased significantly, by 64.3%, since the baseline year of 1998 when the under-18 conception rate was 74.7.

However, Nottingham's under-18 conception rate is still higher than the England average rate of 16.7 conceptions per 1000 girls aged 15-17 in the rolling year to the end of Q2 2018 and is higher than the Core Cities average rate of 21.6 per 1000 girls aged 15-17 (Figure 9). Nationally, and locally, around 80% of teenage conceptions are to 16 and 17 year olds and approximately 20% are to 13-15 year olds.

Figure 9: Under-18 conception rates for the Core Cities by quarterly rolling years from 2014 to 2018

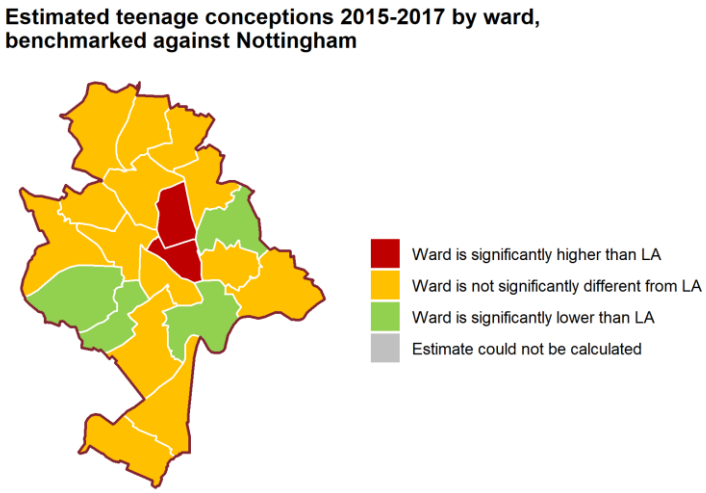


Source: Office for National Statistics (2019) Conception Statistics England and Wales

Figure 10 benchmarks teenage conception rates for individual wards against the Nottingham average. The aggregated data for the three years from 2015 to 2017 shows that the two wards of Berridge and Arboretum had rates that were significantly higher than the Nottingham average. This has changed from the last data reported for 2014 to 2016, when Berridge, Arboretum, Aspley and Bilborough all had rates significantly higher than the Nottingham average. Work to tackle unplanned teenage pregnancy in Nottingham is delivered through universal services for children, young people and families as well as through targeted support for those most at risk.

Over the past few years, we have directed some of our council commissioned services to work in Aspley due to the stubbornly high rates of teenage conceptions. Therefore, we cautiously hope that the targeting of services is having an impact as, for the first time in many years, Aspley does not have a rate significantly higher than the Nottingham average.

Figure 10: Teenage conceptions 2015 -2017 by ward benchmarked against Nottingham



Source: Public Health England (2019) Estimated ward conception rates for local authorities in England

Teenage pregnancy prevention and support services

Primary prevention services

- Nottingham City's Integrated Sexual Health Services for young people deliver accessible and integrated sexual health services within the community offering advice and support whilst offering the full range of contraceptive services.

- The C-Card scheme provides free condoms to young people aged between 13 and 24 at 37 registration points and a further 50 pick-up points across the City.

- General Practitioners provide information and contraception, including Long Acting Reversible Contraception (LARC).

- Pharmacies across Nottingham provide a range of services including emergency contraception and pregnancy testing.

- The Public Health Nursing for school-age children and young people service (formerly known as the School Nursing Service) provides information and practical support through a suite of options including the delivery of 'clinic in a bag'.

- The delivery of effective Relationships and Sex Education (RSE) is encouraged in all schools as an evidence-based approach to reducing teenage pregnancy rates Nottingham City Council.

- Family and Community Teams have staff trained to deliver sexual health, contraceptive and positive relationships advice for young people aged 13-25.

Early intervention and support services

- Termination of pregnancy services include counselling and support whilst making a decision and after the decision has been made.

- Accommodation services for vulnerable teenage parents and their children are available within bespoke self-contained hostel accommodation in the City.

- The Family Nurse Partnership programme provides support and guidance for up to 200 pregnant girls and mothers each year. It is an intensive health visiting programme that visits the teenager from early on in her pregnancy until the child is two years old enabling teenagers to have a healthy pregnancy, improve their child's health and development as well as plan their own futures and aspirations.

- The education support officers provide support for pregnant teenagers and teenage parents to engage in education. The officers monitor the participation and attainment of all pregnant teenagers and school-age parents assisting them to overcome barriers.

- The Teenage Pregnancy Midwifery Service is available to support all pregnant under-18s offering flexible one-to-one care for teenage parents to increase self-esteem, promote a sense of self-worth and boost their confidence as parents.

2 RISKS

Children and young people who do not receive the right support at the right time in childhood are more likely to experience health problems in adulthood. Budget pressures across the statutory and voluntary sectors could reduce the support available to children, young people and families.

3 FINANCIAL IMPLICATIONS

None

4 LEGAL IMPLICATIONS

None

5 CLIENT GROUP

All children and young people, and their parents/carers and families, especially those with physical and/or mental health problems

6 IMPACT ON EQUALITIES ISSUES

Children and young people who identify as LGBT are more likely to experience mental health problems than other young people.

7 OUTCOMES AND PRIORITIES AFFECTED

Promoting the health and wellbeing of babies, children and young people: From pregnancy and throughout life, babies, children, young people and families will be healthier, more emotionally resilient and better able to make informed decisions about their health and wellbeing.

Appendix 1

Table 3: Services related to childhood nutrition and obesity in Nottingham

Age Group	**Services in relation to need**
Pregnant women	**Slimming world Adult weight management on referral** Free access to 12 weeks of classes via GP referral only. Available to overweight 16 and 17 year olds, and adults with a BMI over 30 (including pregnant and post-natal women)
2 - 4 years	**Healthy Child Programme (Level 1)** - Families of overweight children receive brief intervention and intensive support including signposting to local healthy living opportunities by Health Visitors, Family Nurse Practitioners, GPs and Practice Nurses. - There is capacity for all eligible families. - There is no specific intervention provided for level 2- 4 year olds who are identified as obese other than support offered through the Healthy Child Programme by health visiting.
5 - 16 years	**Brief Intervention (Level 1)** - Overweight children/families receive brief intervention and intensive support including signposting to local health living opportunities by school nurses, GPs and practice nurses. - There is capacity for all eligible families through the Public Health Nursing Service (Healthy Child Programme, 5-19 years).
5-16 years	**Healthy Weight Support Programme** - Nottingham's Healthy Weight Support Programme is an evidenced based targeted weight management service provided by Nottingham CityCare Public Health Nursing service which encourages children and families to establish and maintain healthy lifestyles by promoting skills and knowledge around nutrition, physical activity and behaviour change. The service consists of an individually tailored package of support including home visits/assessment and 3 follow up sessions with school nursing. This service launched in September 2014. - There is capacity for 80 children/families to have a 3-month package of support per year.

Table 4: Targeted Interventions for those most at risk of overweight and obesity

Healthy Child Programme embedded in the integrated 0-19 service provided by CityCare	The HCP seeks to reduce health inequalities and meet the needs of the most at-risk children, young people and families through a progressive universal model. Parents of overweight and obese children receive appropriate information and signposting to further sources of advice/ support and referral to appropriate weight management services.
Breastfeeding peer support	CityCare Partnership has provided a breastfeeding peer support programme since September 2012. This service offers targeted one-to-one support for mothers aged under 25 years by paid peer supporters. Midwives, health visitors and peer supporters distribute breastfeeding materials to young mothers.
Healthy Start - Free vouchers for fruit and vegetables	Healthy Start is open to pregnant women and families with children under 4 years. Vouchers are provided to exchange for fresh fruit and vegetables as well as milk and infant formula milk.
Healthy Weaning Programme CityCare	Healthy weaning education targeting those living in deprived areas of the City.
Cook and Eat sessions – practical cooking skills CityCare	Practical cook and eat sessions for parents to increase cooking skills and promote healthy eating incorporating behaviour change techniques targeting those living in deprived areas of the City e.g. Eatwell for life

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The Targeted Citywide CAMHS Offer 2018/19

Our vison and mission is:

- "Our vision is to provide children and young people with flexible support around emotional well-being, **so no child or young person has to face emotional distress alone**."
- Our mission is that-We strive to offer an honest, open, creative and respectful service to support positive change; so that all children and young people will have the skills to cope with life's challenges, to feel happy with themselves, and will be empowered to be proud of who they are to achieve a brighter future." *(Targeted CAMHS, SHARP and CYP Group Teens 4 change)*

Our Aims:

- We aim to be a responsive and innovative CAMHService that offers children, young people and families a high quality emotional and mental health service as quickly as possible.
- We aim to continue to develop a service where **meaningful** participation and co-production is built into all we do, and our children, young people, parents and carers help us to shape our services to be responsive to their needs.

This document is an overview of our current prioritises and performance in the following six focus areas:

- Prevention and early intervention
- Single Point of Access
- Choice and Partnership Approach (CAPA)
- Evidenced based interventions for vulnerable groups
- Participation work and our 'Young Minds Amplified' project
- Our performance:
    - How we know we make a difference (performance)
    - Monitored weekly wait-times (performance)

Prevention and Early Intervention:

- **Universal Services CAMHS Practitioner** who works directly with schools and universal services to offer support and training to staff in schools/other services, to help them to gain confidence in working with mental health needs, and prevents services referring to CAMHS when this is not required.
- We have a number of ways that they **link to our local schools to offer support**:
    - An initiative called **Time4Me,** where young people can access direct monthly support in their secondary school from a consistent and present CAMHS professional.
    - A pilot project for primary schools called, **'Amazing Me': Early Intervention to promote Emotional Wellbeing in primary schools.**
    - **Next Steps:** A joint partnership venture with NSPCC Childline developing ways we can help CYP to achieve their **next steps and goals** following their support from CAMHS.
    - **Monthly Self-Harm Clinics**

A Single Point of Access:

- The City's CAMHS SPA model is quite unique nationally, sitting alongside our City's MASH. Our SPA model has clear protocols to ensure that referrals are processed quickly and effectively and that the CYP can be navigated to the right support for them depending on their presentation and needs.
- Our model offers many strengths and benefits by ensuring that CYP who have emotional health needs that would ordinarily be rejected by the more traditional NHS CAMHS clinical model services.
- As we manage all the referrals for the city, we can ensure that our children and young people can get access to emotional health support in different ways as early as possible. This model has ensured that **over the last 4 years 95% of cases remain at a Targeted CAMHS or universal level,** only escalating to specialist community CAMHS when absolutely essential. **(See link below on page 5, link 'Copy of Referrals to Community CAMHS).**
- Over the last 6 months a specialist clinician from our NHS provider of specialist community CAMHS, has been co-located with our SPA, with the aim to improve access into specialist community CAMHS when this is required.
- Our SPA has representation from all services on our behavioural emotional mental health pathway and works closely with our social care colleagues daily.
- A multiagency **Access Working Group** led by Targeted CAMHS, with all partners of the pathway, GP's and education representation. The group is working to increase and strengthen how CYP/families can self-refer to us, and get access to help quickly, including guided self-help as a first line of treatment, or whilst they are waiting for their CAMHS appointment and access to other forms of support such as **Exam Stress Less** etc. **(See action plan appendix 1)**
- **Self-harm joint-protocol** ensures we respond jointly, alongside our social care colleagues, within 48 hours when there are serious concerns about a child/young people's self-harm or suicidal behaviours. A thorough a joint assessment is completed at home and self-harm risk assessments and safety plans are implemented jointly with the young person and their family.
- **Self-harm follow up's: SOL to provide**

Choice and Partnership Approach (CAPA):

CAPA is a service transformation model that combines collaborative and participatory practice with families to enhance effectiveness, leadership, skills modelling and demand and capacity management.

CAPA brings together:

•The active involvement of children, young people and families, demand and capacity ideas/'Lean Thinking', and a new approach to clinical skills and job planning.

As a service, we can then:

•Do the right things (have a clear working goal with the child/young person and their family).

•With the right people (use therapists with the appropriate clinical skills).

•At the right time (without any external or internal waits).

CAPA improves services to families by focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning, and by improving, access by ensuring timely appointments that are fully booked i.e. no waiting lists. By ensuring children and young people are seen by a clinician with the right skills, uses outcome measures.

As a service who have implemented, and been using CAPA for several years, we are able to demonstrate what we are doing and to whom. We can provide data weekly on own capacity and activity. (© CAMHS Network 2017)

Specific and Targeted Evidenced Based Interventions for Vulnerable Groups:

- **CBT (cognitive behavioural therapy) Specialist** working with CYP with more complex and enduring mental health needs, such long-standing depression and more enduring anxiety disorders
- **Evidenced based therapeutic models**: **50% of our workforce are trained** in specific evidenced based therapies the offer includes:
    - **Interpersonal Psychotherapy for adolescents (IPT-A)** is a treatment for young people with depression, which looks at the relationships around the young person.
    - **Systemic Family Practice (SFP)** enables family members, couples and others who care about each other to express and explore difficult thoughts and emotions safely
    - **Enhanced Evidence Based Practice (EEBP)** trains CAMHs practitioners to deliver CBT-based interventions, to enable CYP and families to learn specific techniques.
    - **Pilot of Time Limited Adolescent Psychodynamic Psychotherapy (TAPP)** to support adolescents who require more in depth assessment and therapy for more complex or trauma history presentations such as attachment disorders and emotional dysregulation. **(For case studies, see appendix 2)**

- **Animal assisted therapy:** We have a trained and qualified **therapy dog named Freud** led by his animal assisted qualified practitioner, working with CYP who need more support to feel comfortable to develop therapeutic relationships, or who have additional needs making accessing talking therapy more difficult. **(See individual report appendix 3)**
- Part time **Domestic abuse CAMHS practitioner**- offering bespoke support and consultation to professionals, for CYP who have mental health struggles/trauma symptoms having experienced domestic abuse

- Part time **Syrian/Asylum seeker CAMHS practitioner**- funded by the Home Office developing ways to link to vulnerable groups in the community to ensure they get access to the right emotional health support/assessments (currently under review)

Participation:

- **'Teens 4 Change'** who come together to support each other, do lots of amazing projects and who consult with us to co-design our services to fit their needs. **(See individual report appendix 4)**
- **We are an Amplified Trailblazer with Young Minds!** Who are supporting us to embed our parent/carers participation strategy/action plan and parent/carer support group by November 2018- to then showcase via Young Minds-best practice to other areas around the country **(Please see report appendix 5)**
- **Our Participation events so far:**
  - Splendour Festival
  - Ruby Wax at the Play House
  - Expo parenting teens event

- **Parent/carer Psychoeducation Workshops:**
  Targeted CAMHS are developing and offering 5 x 45 minute workshops on:
  - Anxiety
  - Depression
  - Attachment
  - Self-harm Awareness
  - Transgender Child
  - Workshops will be 45mins, followed by a 15min Q&A.

  The dates are:
  - 24th Jan – sessions running throughout the day
  - 19th Feb – sessions running throughout the day
  - 22/01, 29/01, 05/02, 12/02 and 18/02 – sessions between 18:00-19:00

- **MH2K:** working jointly with this project, has captured the voices of **647 young people** about mental health who have told us that they want us to work on 5 key main priorities. We want to truly hear and understand their recommendations and how we can shape our services to meet ***their*** needs; we are therefore working hard to begin to implement their recommendations. Starting with the co-design of a poster detailing support available to them from the pathway- to be on the back of all toilet doors in schools so CYP can access the support they want when they need it. **(See appendix 6)**
- Our **CAMHS Newsletter** with the aim of helping us to better communicate and tackle the miss-conceptions of CAMHS, to promote mental health and wellbeing using an anti-stigmatising approach. With articles from CYP and professionals on all different topics related to mental health, (2 editions per year, spring/summer and autumn/winter) **Please see link CAMHS Newsletter Issue 4 May 2018.pdf**

How we know we make a difference: What CYP/Families tell us (our performance):

We have implemented Routine Outcome Measures (ROMS) so we obtain regular views from children, young people and families about how their therapeutic intervention is going, what they like, dislike, and if the support being offered is helping them or not.

Please refer to CAMHS data for more specific performance data **Copy of Q2 - 2018-19 - Targeted CAMHS Quarterly Report Final.xls** **and** **Copy of Referrals to Community CAMHS from Targeted October 2018.xlsx** Below is a 'snap shot' of how we know we are making a difference:

In 2017/2018:

- **1857 referrals** were received and processed by the CAMHS Single Point of Access of them **918 assessments** were carried out with CYP and their families.
- **94%** of young people offered feedback on their assessment experience with Targeted CAMHS said **they would recommend us to a friend.**

In Quarter 2: (2018-19)

- **78% of CYP** told us that they saw a clear **clinical reduction** in their depression and anxiety after their CAMHS intervention (reported by the clinical measure called RCADS).
- **81% had an improvement** in a clinical outcome measure (for the closed cases).
- **100% of families were offered the opportunity to feedback** on their satisfaction with the service using the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) from this **78% of families chose to offer feedback** and from that feedback the average scores were:
  - **Parents/Carers scored: 23 out max satisfaction of 24**
  - **CYP scored: 22 out of max satisfaction of 24**
  -

Specific comments around their experience included:

- "Young Persons key worker was very understanding of our anxieties and was quick to arrange our appointments."
- "The care was really good because the person who saw me understood me and helped me achieve my goals and to manage my anxiety."
- "My therapist listened to everything I had to say and supported me through tasks that be easily achieved."
- "I felt listened to and the resources I was given helped me."
- "I really liked working with Freud (Therapy Dog) as it meant I did not feel awkward in sessions."

- "My worker was nice, cool and knew what she was on about; genuinely care for me as well. Didn't take any of my constant swearing too personally."
- "There was nothing that I didn't like; I loved every bit of it. Also I did like the people who helped me, they were both really kind".
- "My daughter has been able to open up more to myself and her Dad. If she is worried about anything that is worrying her i.e. school, friends."
- 'They always listen to me and take me seriously on everything'.
- 'Everything we did together was great; I really enjoyed it and feel much better.'
- 'Everyone listened, not only to my child but also to me and came up with some good strategies.'

Wait Times (our performance):

In 2017, we introduced an assessment team, with its existing staff, to better manage caseloads and wait times. Since the development of this team, the recruitment to the vacant posts, and with better strategies and innovation within the service, the current waits have reduced in line with our commissioned targets. We produce weekly stats to ensure that we closely monitor waits and raise any pressures in the service internally and with our commissioners. Please refer to our most up to date weekly data sheet. **(See appendix 7)**

Self-harm Awareness and Resource project (SHARP) Offer 2018/19:

- SHARP have trained **3600 professionals** since October 2015 and delivered **398 training sessions.**
- **SHARP training has been delivered to varied front-line professionals in our city including Social Workers and Family Support Workers, Health Workers, Clinical Practitioners (including CAMHS), Education and many of colleagues from the City Voluntary Sector.**
- **6000 front-line professionals have been trained** since SHARP was formed just over 5 years ago.
- Our training sessions are varied with a focus on self-harm and those impacted by self-harm and includes:
    - **Under the Skin (Self-harm Awareness)**
    - **Suicide Everybody's Business**
    - **Breaking the Silence (Males and Suicide)**
    - **Teenage Girls who Self-harm**
    - **Safe From Harm (Safety planning and risk assessment)**
    - **Transgender – Get Used to It**
    - **One Bad Choice (Substance misuse and the impact on Mental Health)**
    - **A to Z of Your Head**
    - **If Toys Could Talk (Identifying harmful behaviours in primary children)**
    - **Exam Stress-LESS (workshop for young people)**

- SHARP offer monthly self-harm clinics to **18 City secondary schools** and also 1 to Nottingham College and 1 to Children Looked After – approximately **80% of YP seen over a 2.5 year period have received support from Universal Services and not required input from Targeted/Specialist MH Services, clearly evidencing that early and targeted interventions can reduce self-harm and suicidal behaviours.**
- SHARP have delivered assemblies to **650 CYP aged 11 – 16 years** – raising awareness around healthy coping strategies and also breaking down barriers to access to services - informing CYP about SHARP clinics and other support such as Kooth, Childline, CALM-App and Base 51.
- SHARP have delivered 5 **'Exam Stress-LESS' workshops** to CYP over the last few months and have another 5 schools booked in for the next academic year.
- SHARP produced a training package called **'If Toys Could Talk' as an action from a Serious Case Review in 2017** which focusses on helping professional to recognise and support young children where self-harm is a concern **22 City primary schools have been trained.**
- **Trans4Me has supported around 40 YP aged 13 – 19 years** who identify as transgender/non-binary – our group runs weekly ensuring this group of YP have a safe, accepting space where they can build confidence and social interaction, this support has helped reduce maladaptive behaviours such as self-harm/suicidality, improve self-esteem and mood, reduce anxiety and support these YP to access the correct health pathway.

- **25 training sessions** raising awareness around transgender/gender dysphoria have been delivered over the last 2 years.
- **SHARP4Parents** continues to offer support to parents/carers across the city through twilight awareness workshops.
- Currently developing training around **'harmful and risk behaviours'** (using a high risk CSE case study).
- Researching and developing recommendations on how we can **break down barriers for young males and BME groups accessing mental health services.**

Anna Masding
Nottingham City Council CAMHS Service Manager

Appendix 1

Improving Access to BEMH Pathway – Action Plan

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
Early and easy access to any service on the pathway	Online Self-referral developed	New CYP and Family referral form active and self-referrals increased by 15% in 2018/19	If agreed with CityCare and website provider	Consultation with YP Website redesign time	March 2019	Jo Powell
	Diverse communities Access (including faith, BME, gender etc.)	3 drop-ins and awareness raising events	If through partnership working – could be linked with parent's participation events for CAMHS?	Staff time Information leaflets	March 2019	??
	Leaflets and posters (back of toilet doors	Leaflets produce and distributed to all CAMHS link schools and an additional 15 children's' centres and Youth Groups in Nottingham	Yes – with funding	Consultation with YP £££ Design time Links with schools, community groups and play and youth	January 2019	??

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
Better and more appropriate referrals into the service	Mini-assessments taking place on SPA	Criteria created for appropriate mini-assessments	Yes – once clear criteria and appropriate staffing on SPA	Base 51/Kooth input on SPA	October 2018	Jo Powell and Elayne Forster
	Review and Re-write referral forms for BEMH and GP services (Self-referral, Professionals and GP forms)	Forms have been re-written and reviewed by CYP, Parents and Professionals	Yes – as long as they can be amended on the BEMH website	Time Input from professionals, CYP and parents	January 2018	??
	Guided Self-Help offered as an intervention from SPA	Set self-directed workbooks for specific presentations used with 10 early intervention cases from SPA monthly	Follow up support - Timeframe for follow-up support (July/Aug)	Base 51/Kooth input on SPA Appropriate self-help resources for ages and presentations	October 2018	Tammy Gibson and Elizabeth Kelly
	Professionals consultation line	Consultation available 2 afternoons per week	Yes once universal services fully staffed	Universal services staff	October 2018 -1 afternoon per week January 2019 - 2 afternoons per	Tami Brown

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
					week	
	Upskill workforces (e.g. schools, youth groups)	Training sessions – MHFA-Y – 4 per year to universal services Recognising neurological disorders – BEHT – 4 per year Interventions to work with ASD – 2 per year Interventions to work with ADHD – 2 per year MeSource – 8 schools/youth groups per year What is BEMH Pathway - Awareness raising around pathway to community groups, play and youth, GP's, Social care. Resources section on the website for professionals	Yes with buy in from all partners on the pathway If website redesign is agreed	Staff time Training materials Advertising/ marketing Need to develop website to include stats – downloads	Start October 2018 March 2019	All services on pathway Jo Powell (all group members reviewing

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
				etc.		resources
CYP and Families able to access most appropriate 'treatment' without waiting for more than 6 weeks	Self-help section on website with links to crisis and support services (plus self-referral) in place)	Links to directed self-help for different ages in: • Anger • Worry and anxiety • Confidence and self-esteem • Bereavement and loss • Low mood • Panic • Post-Traumatic Stress • Social Anxiety? • Sleep difficulties • Managing stress • Managing your emotions Info section... • Self-harm • Feeling suicidal • Eating • Gender identity • Healthy Relationships • Bullying	If website redesign is agreed	Need to develop website to include stats – downloads etc.	March 2019	Jo Powell (all group members reviewing resources)

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
		Links section available for youth groups, and activities for accessing support – outburst, trans4me)				
	Parents section on website – including how to refer, how to write a referral, support for parents, things you can do with your children.	Increased referrals from parents – 10%	Yes with website redesign agreed	Parents resources Links to external sources agreed Web design time	March 2019	Jo Powell
	Better referrals (criteria)	Criteria sent out to all link schools, City GP, paediatricians, social care (GPPLT – GP Protected learning time meetings, Head Conference etc.) Examples of referrals (what info we need etc.) sent out to all current	Yes – may be challenging to access GPPLT and Heads Conferences Yes	Criteria (printed and on website) Time	December 2018 October 2018	Jo Powell Elayne Forster/ Sarah Fernandes

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
		referrers				
	CYP only assessed when needed	YP assessed within 3 weeks of referral No re-assessments in other pathway services	Stats – if above has be done!	Ability to share assessments Assessments meet all services needs	January 2019	Jo Powell
	Evidence based and alternative groups	3 different groups running: • CAT Project • Managing your emotions • Embodied or parents group	Yes with staffing	Manuals for EB groups	January 2019	Jo Powell

Appendix 2

Citywide Targeted CAMHS: Interventions and outcomes

Evidence Base Practice Interventions:

- **Cognitive Behavioural Therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.** It is most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems. CBT is based on the concept that your thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a vicious cycle.

  Evidence for use with – Depression and anxiety disorder (all), PTSD, OCD

- **Interpersonal Psychotherapy for adolescents (IPT-A)** is a treatment for young people with depression, which looks at the relationships around the young person. IPT-A helps the young person to make sense of the difficulties they are experiencing and to understand how their relationships with other people contributed to how they feel.

  Evidence for use with – adolescent depression

- **Systemic Family Practice (SFP)** helps people in a close relationship help each other. It enables family members, couples and others who care about each other to express and explore difficult thoughts and emotions safely, to understand each other's experiences and views, and make useful changes in their relationships and their lives.

  Evidence for use with – Depression and self-harm – conduct disorder (12 plus) – eating disorders (Community CAMHS)

- **Enhanced Evidence Based Practice (EEBP)** trains CAMHs practitioners to deliver CBT-based interventions, to enable children, young people and families to learn specific techniques (for example, thought challenging and behavioural activation) with the aim of relieving distress and improving daily functioning.

  Evidence for use with – anxiety and depression

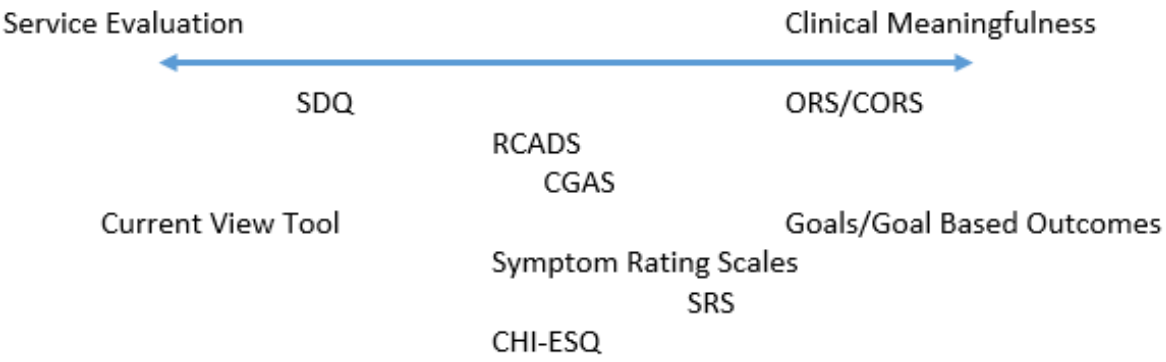
Non-IAPT Approaches with growing evidence based

- **Dyadic Developmental Psychotherapy (DDP)** is based on a theoretical understanding of attachment and intersubjective relationships; and the impact of developmental trauma. DDP uses the principles of PACE Playfulness, acceptance, curiosity and empathy, which is a way of thinking, feeling, communicating and behaving that supports connection with the child and helps them to feel safe.

  Growing evidence base for Attachment disorders or issues
- **Dialectical Behaviour Therapy (DBT)** is a type of talking treatment. It is based on cognitive behavioural therapy (CBT), but has been adapted to help people who experience emotions very intensely. DBT focusses on finding a good balance between acceptance and making positive changes.

  Growing evidence base for Emotional dysregulation – no evidence base for this in teenagers – based on Borderline Personality Disorder in adults where is has a strong evidence base to work with emotional instability.
- **Time-limited Adolescent Psychodynamic Psychotherapy (TAPP)** based on psychodynamic thinking and working relationally with transference and countertransference, this model aims to work with transitions and on a developmental focus for the young person – from 14-25 years of age. It can include confusion and pressure from the social world, anxieties around events in their social worlds e.g. exams/education, changes within family, difficulties in relationships (including self-destructive relationships, self-harming behaviour and suicidal ideation), anxieties and difficulties with separation, depression, where the earlier treatment was in a different modality, and TAPP is offered as a second treatment, when there is an external time-limit, when presentation is post-trauma, to support transition from CAMHS to Adult Mental Health.
  Within the City we are part of a group developing and evidencing this model - it has yielded positive results for depression, emotional dysregulation and attachment issues by focusing on the relational and developmental areas of these presentations

Outcome Measures



Acronyms

SDQ – Strengths and Difficulties Questionnaire

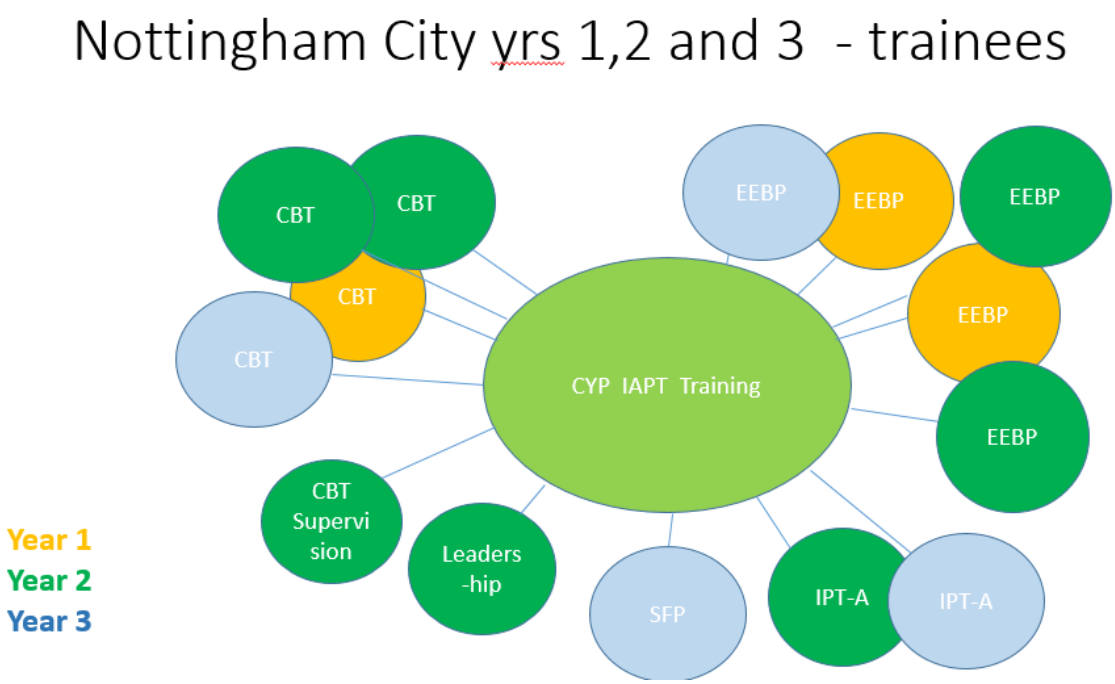
ORS/CORS – Outcome Ratings Scale – Child Outcome Ratings Scale

SRS – Sessional Rating Scale

RCADS - Revised Children's Anxiety and Depression Scale

CGAS – Children's Global Assessment Scale

CHI-ESQ – Commission for Health Improvement Experience of Service Questionnaire



IAPT Model: Systemic Family Practice

Referral

13-year-old female referred into CAMHS by GP to talk about low mood and self-harming.

Decision to allocate to Systemic Family Practice to explore the system around the young person and how it can help with some of the problems she was facing.

Individual work

Individual work around understanding anger, friendships and self-esteem.

Exploration of difficulties in relationship with Mum and how young person struggled with parental communication.

SFP

14 sessions: 11 with YP and Mum; 1 individual session; and 2 sessions with Mum and Dad.

Young person and Mum agreed and worked on goals of improving trust and communication, taking small steps to reach these goals.

Work with Dad and Mum together to support a more consistent environment and parenting style that both followed.

Discharge/ Ending

RCADS: Young Person: Start depression was 78 end score 45.

Parent: Start depression 76 end score 48.

Family Scores

	YP Feb 2018	YP August 2018	Mum Feb 2018	Mum August 2018
Strengths and adaptability	18	15	14	12
Overwhelmed by difficulties	24	10	12	10
Disrupted communication	24	19	13	9

IAPT Model:

CBT for social anxiety using The Cat Project;

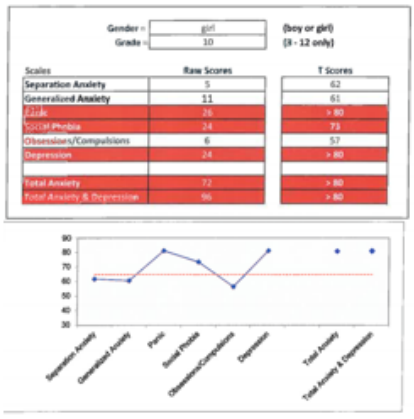
16-year-old Female of Polish descent.

YP fear of sounding weird and being judged due to being from Poland and worrying about pronunciation of English language – created a barrier to making friends, participating in school and going out/asking for things in a shop in public.

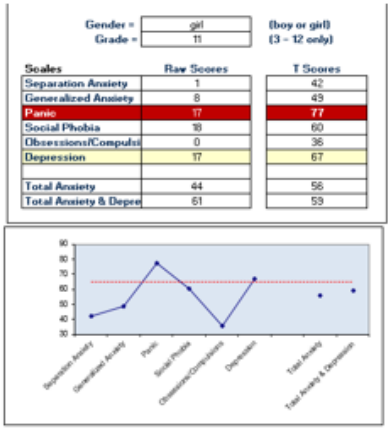
Protocol covered; psychoeducation around anxiety, psychoeducation of somatic symptoms of anxiety, raising awareness of negative thinking patterns and using coping self-talk, problem solving and experiments. Also included a parent session to include in the process.

ROMS;

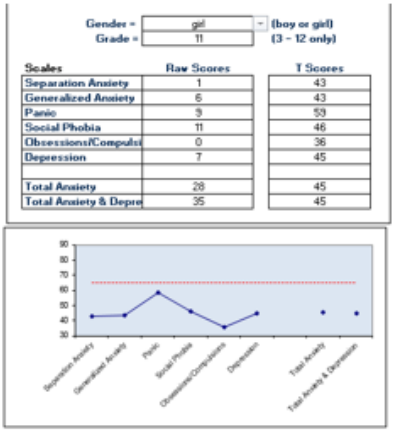
19/12/2017 – Beginning RCADS



28/08/18 – Review RCADS



01/10/18 – Closure RCADS



IAPT Model: Enhanced Evidence Based Practice

Case Study 1

10 year old, British Asian. Follows Sikh religion. High achieving student at school.

The referral was made by the GP advising that RS has anxiety that mum will die and therefore avoids school and extracurricular activities.

Onset: young person was on an ice-skating outing 1.5 years ago, mum was sat on the side watching where young person could see her for most of the time. However, as she finished and was coming off the ice, she could not see mum amongst the crowds and thought something had happened to her and got into a state of panic. Since then separating from mum has been really difficult. Mum advised, for example, when she drops young person and young person' sister to school, young person has to be the last one to give mum a hug and she will hug her really tight like it's the last time she will see her. On odd occasions where mum has picked young person up late from school due to traffic or something coming up at work, young person starts to panic and often crying uncontrollably. On days where mums out and is not home by the time she says she will be young person will be clock watching and will ringing her to check if she's ok and will be very anxious.

Young person advised that the panic and worry sets in roughly 15/20 minutes before she leaves mum and will start again 15/20 minutes before mum is due to pick her up.

<u>Symptoms:</u>

Thoughts - Something will happen to mum or dad (mainly mum), mum will have a car accident, mum will die.

Emotions – Sad, upset and angry.

Behaviour – Clings to mum, has emotional outbursts. Mum advised that she will not allow young person to stop going places without her because of her anxiety but it just makes drop offs really emotional and difficult.

Physiological symptoms – Crying and heart races, cannot think clearly.

Goal: young person not to worry when leaving mum.

Evidence Based Intervention: Worry management intervention, which covered looking at the thoughts, behaviour, feelings and physiological responses. We covered distractions, worry time, worry tree, problem solving, relaxation and breathing exercises, constructive positive self-talk and talking back to worries.

Treatment feedback: young person and mum felt the goal had been met and they advised that they found the treatment helpful.

Young person Raw Scores and T Scores:

Separation anxiety – 12 and 76
Generalized anxiety – 13 and >80
Social Phobia – 1 and 32
Depression – 3 and 49
Total anxiety – 31 and 59
Total anxiety and depression – 34 and 57

RCADS at the end:

young person Raw Scores and T Scores:
Separation anxiety – 4 and 49
Generalized anxiety – 5 and 53
Social Phobia – 0 and 29
Depression – 1 and 44
Total anxiety – 12 and 43
Total anxiety and depression – 13 and 43

Case Study 2

17 years of age, polish, female, Catholic. Lives at home with mum and dad, no siblings.

CAMHS received a referral from the GP advising that young person appears to be suffering with symptoms of anxiety and depression. Reporting that she 'has not felt like she is real' for quite a while, feels like she 'is watching everything from a TV', Like 'everything is happening around her without her'. Poor concentration. Decreased motivation getting out of bed. Has lost interest in things she used to do. Gets scared that everyone will abandon her. Feels empty and can go from feeling okay to feeling very low very quickly.

Young person reported feeling like this for the last two years approximately and feels as though it is getting worse and is more prominent.

Triggers – young person advised she does not know what the trigger is, however there has been difficulties at home with mum and dads relationship, with constant arguments. Both have said that they are only together because of her - for this, she holds a lot of guilt and blame.

She scaled mood at 4 during the day and at 5 in the evenings, drops to 1-2 at night when she is on her own in her room.

She is currently not eating in the day, only tends to have dinner.

Young person advised she gets roughly 3 to 4 hours sleep a night as she finds it hard to fall asleep, once she falls asleep she sleeps throughout the night.

Thoughts: what is the point, why do I even try, what have I done wrong, what is my future going to be like.

Feelings: feels numb, the sadness feels really heavy, lonely.

Behaviour: Stays in bed just lays there, stares at the wall, said she pity's herself. Only does the bare minimum just to get by.

Physiological symptoms - cannot move, very tearful and cries a lot. Occasionally she disassociates with reality - finds herself being in situations where she feels she is watching it on TV from the outside looking in.

Advised she has felt quite low for the last 2 years.

Young person advised she does have friends but does not see them very often.

Goals: to be able to deal with the overwhelming feelings and to feel happier in herself. To feel more motivated to do things and see friends more.

Evidenced-based intervention: We used Behavioural Activation, with looking at problem solving, pros and cons and separating thoughts, feelings, and behaviours as the low-level intervention.

We slowly increased activities and set little tasks to help improve her mood and identified things that contributed to her mood using the ACE log – reflecting on what gave a sense of achievement, closeness and enjoyment.

Treatment feedback - young person had noticed the shift in mood as the sessions went on and she engaged really well and was able to identify the benefits of socialising on her mood. She was open and honest when she had not managed to complete the homework and tasks set, which was useful to reflect on. When young person was completing the Relapse Prevention Plan she stated that by doing the pros and cons activity – comparing if she had done her task to not doing her task, emphasised the rational for Behaviour Activation even more for her, and stated she uses that tool quite regularly to push herself to do things when she lacks motivation.

Start PHQ-9: 14

End PHQ-9: 11

ORS start: 12.9

ORS end: 23.3

IAPT Model:
IPT-A (Interpersonal Psychotherapy for Depressed Adolescents.

Number of sessions:
13 (12 + 1 extra middle phase session)

Biographical data:
Sixteen-year-old male of Indian descent living with Mother and Brother. Father lives in India and little contact with him, however Mother and Father maintain a long distance relationship.

Presentation:
Escalation of depressive symptoms for 3 months including reduced appetite, struggling to sleep/sleeping too much, lack of energy, isolating himself from others, difficulties concentrating in school, often feeling sad, not finding anything fun/enjoyable, fleeting thoughts of self-harm/suicide.

Formulation:

The interplay of the client's depression symptoms, lack of social support and unresolved difficulties with his Father continued to maintain the client's depression.

Therapeutic work:
The aim of treatment using IPT-A was to decrease depressive symptoms and to improve interpersonal functioning. Three phases of therapeutic work completed including assessment/formulation, middle phase, and ending phase. Therapy aimed to provide a space for the client to process and express his past experiences with his Father, whilst considering what opportunities there were in his new role to improve his situation. Middle phase work focussed on helping the client develop his relationship with his Mother and adjust to the circumstances around his Father.

Family work:

Two sessions with Mother through therapy to help gain further understanding of the difficulties, provide psychoeducation around depression and help her to make stringer connections with her son. Mother was supported in accessing her own therapy due to her ongoing difficulties with her husband in India.

Outcome of treatment:

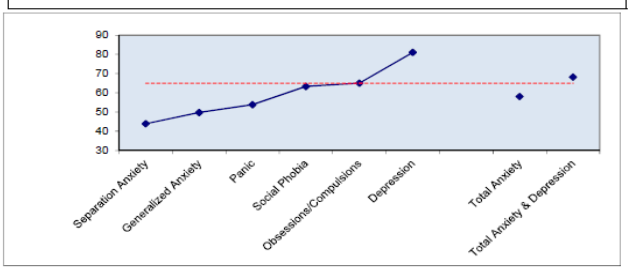
The client made significant symptomatic and interpersonal improvements by the end of treatment, making a full recovery. Communication had improved between YP and Mother and had begun to rely on her for emotional support. Client reported an increase in confidence and was optimistic around his future. The client was no longer experiencing thoughts of harm to self.

Psychometric measures

The Revised Children's Anxiety and Depression Scale (RCADS) was used pre and post treatment and the subscale Low Mood/Depression tracker used throughout therapy. Initial Depression RCADS score was 25Raw/80T, reducing to 3Raw/39T at the end of treatment. Although not problematic at assessment, we also saw a positive reduction in all other categories of the RCADS scores. Symptom tracker scores indicated a steady decrease over the course of therapy, Treatment goals were used and tracked throughout and were achieved to a good level.

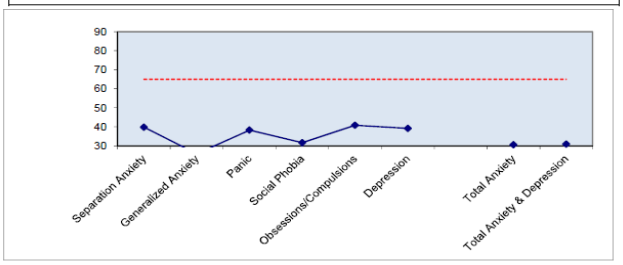
Gender =	boy	(boy or girl)
Grade =	10	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	1	44
Generalized Anxiety	7	50
Panic	5	54
Social Phobia	18	63
Obsessions/Compulsions	9	65
Depression	25	> 80
Total Anxiety	40	58
Total Anxiety & Depression	65	68



Gender =	boy	(boy or girl)
Grade =	10	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	0	40
Generalized Anxiety	0	26
Panic	0	38
Social Phobia	3	32
Obsessions/Compulsions	2	41
Depression	3	39
Total Anxiety	5	31
Total Anxiety & Depression	8	31



What is TAPP?

TAPP stands for 'Time Limited Adolescent Psychodynamic Psychotherapy'

Time Limited-TAPP is a brief therapy consisting of 2 parts:

x4 1 hour assessment sessions with a TAPP therapist. This may include time with parents/carers, but mostly time with the young person alone so they can get a sense of what TAPP is like and together to decide a treatment plan.

x16 1-1 therapy sessions, at an agreed time and venue, sessions last for 1 hour every week (though there may be a break in between e.g. if there are school holidays).

TAPP includes the offer of a review meeting 4-6 weeks after the end of treatment. This is an opportunity to meet again with the therapist, to take a slightly more distanced perspective and to think about the thoughts and feelings the young person has after completing the therapy.

Adolescent-The therapy is suitable for young people aged 14+ 

Psychodynamic- This type of therapy recognises the role of growth and development in particular stages of life. 

Teenagers can experience frustrations and barriers that arise during this stage of change, no longer in childhood but not yet entering adulthood, building independence and realising responsibilities, but still in need of understanding, support and direction.

Young people can experience strong emotional responses to friendships, home life, and expectations from education/exam pressure, emerging identity, physical changes, sexuality and uncertainty of how the future may be for them.

Psychotherapy-Through the therapists active listening and confidential discussion, the young person will feel supported to talk through their thoughts and feelings relating to all aspects of life at home, education and their social world.

Supervision

To ensure the therapist gives the right focus and understanding to the young person's needs, the therapist will meet weekly or fortnightly with other TAPP therapists in the service to discuss the sessions. We call this a seminar group. The supervision is confidential.

In addition, the therapist will have monthly group supervision with the TAPP therapists and Professor Stephen Briggs. Stephen offers training and supervision to services providing TAPP.

<u>TAPP Criteria and key points to consider</u>

- Age 14+
- Young Person has asked for support, actively wishes therapy.
- Is this the right time for the young person, are external factors going to be a barrier to sessions, e.g. moving out of area in 6 weeks, about to start exams, significant change about to take place
- Will the young person be able to travel to the appointments; are those around them supportive to get them to the session?
- Does the young person show evidence of taking responsibility for 'self', do they have the ability to be psychologically minded e.g. to be able to reflect on their own internal world, TAPP may not be appropriate for young people with intellectual disabilities
- Has the young person already received other support/psychological therapies, found this did not meet their needs therefore still wanting further help?

TAPP can be particularly helpful for young people who have:

- Confusion and pressure from the social world and therefore TAPP provides the structure, which may be lacking in their social context.
- Anxieties around events in their social worlds e.g. exams/education, changes within family
- Difficulties in relationships (including self-destructive relationships, self-harming behaviour and suicidal ideation)
- Anxieties and difficulties with separation
- Depression. Where the earlier treatment was in a different modality and TAPP is offered as a second treatment.
- When there is an external time-limit
- When presentation is post-trauma
- Transition from CAMHS to Adult Mental Health

Appendix 3

Animal-Assisted Therapy Pilot Initial Outcome Measures and Qualitative Feedback

(April-September 18)

Freud joined our CAMHS team in April 2018. Since his arrival, he has been working with a diverse caseload of young people experiencing difficulties ranging from coping with bereavement, life transitions and attachment difficulties, anxiety and Selective Mutism.

Freud is currently working with a caseload of around twelve young people (September 2018). We have used Animal-Assisted Therapy (AAT) in a number of different ways to work with the individual needs of the young person and their families. We have combined the approach with Interpersonal Psychotherapy, shaping and fading techniques with Selective Mutism and confidence and self-esteem building strategies using agility, dog handling and walking.

Freud is a regular member of our CAMHS young people's participation group Teens for Truth. He enjoys spending time with the group and they report he is a welcomed member. Some of the group members have formed close bonds with him and spend time fussing and playing with him when we meet. We have even been on a group dog walk where the group met for a walk around Wollaton Park.

Here are some case studies including the young people's qualitative feedback and outcome measures.

All photos are included with parental and young person consent for the purpose of this feedback. Photos are taken with all young people who wish to make a photo collection of their time with Freud. They are presented to the young person at the end of the work with a note from Freud.

Case 1

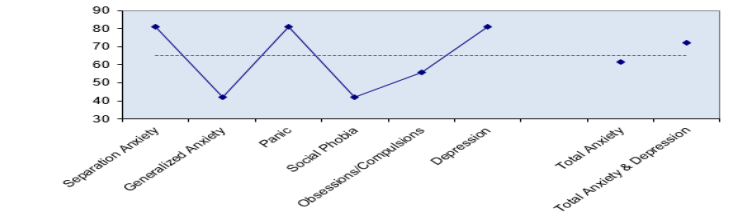
16-year-old male. Experienced significant loss. He had been working with CAMHS prior to being referred to AAT. It was felt he would engage well with AAT due to his love of animals.

He was also struggling to manage his behaviour in school and so it was felt sessions outside would fit much better with the young person's needs.

The loss of his best friend was the most significant, complicated bereavement. We used AAT in combination with a grief focus Interpersonal Psychotherapy. We met at Burnstump Country Park for our sessions and utilised the time by walking, throwing Freud's ball, sitting to complete work and fussing Freud. The young person even taught Freud some tricks with his ball. The bond between them built up quickly and the YP soon started to work with Freud and look forward to his weekly sessions. It was clear each session the YP would arrive with a heightened level of anger and frustration and by the end of the session; he had calmed significantly and could start to access the work around the loss. He reported he noticed this and said he felt a weight was lifted in each session. His symptom tracker scores on the PHQ-9 went from initial scores of around 15-17 to a score of 2-3 suggesting no mood difficulties. His reports using the ORS and SRS rating scales suggested the work helped him to improve his family and social networks and feel more connected to those around him. He reports the work has allowed him to talk about the deceased to his family and close friends and this has helped him process the loss in a more manageable way. In order to work with the YP around ending, as he had bonded so well with Freud, we made a photo book of his time with Freud and he has been invited to our YP group where Freud is a regular member. We have also started to dog walk with the group, which gives the YP access to Freud and walking should he wish to. In our last session, he told me his dad had agreed for him to buy two guinea pigs. He was so excited to have his own pets and have the contact with an animal he had found with Freud. I felt this was his way of replacing the bond with Freud and his family had accommodated this, as they understood how much he had improved since our work together began.

Gender =	boy	(boy or girl)
Grade =	11	(3 - 12 only)

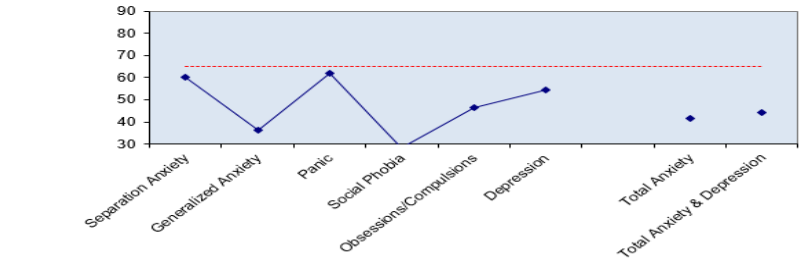
Scales	Raw Scores	T Scores
Separation Anxiety	11	> 80
Generalized Anxiety	4	42
Panic	13	> 80
Social Phobia	7	42
Obsessions/Compulsions	7	56
Depression	26	> 80
Total Anxiety	42	61
Total Anxiety & Depression	68	72



Case 1 Start RCADS

Gender =	boy	(boy or girl)
Grade =	11	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	4	60
Generalized Anxiety	2	36
Panic	7	62
Social Phobia	1	28
Obsessions/Compulsions	4	46
Depression	9	54
Total Anxiety	18	41
Total Anxiety & Depression	27	44



Case 1 End RCADS

Case 2

15-year-old girl. Adopted at 18 months. Sibling adopted when she was 5 years old. Experiencing low mood and difficulties getting along with her sibling and maintaining meaningful friendships. YP suffers from long -term health condition and at times struggles to come to terms with the management of this.

We used AAT in combination with Interpersonal Psychotherapy focusing on strategies to help her maintain relationships that are more meaningful to her. We used Freud as a way for her to connect and be more relaxed in sessions. We met in school and walked to the school field to complete work. The young person enjoyed Freud being there throughout the session, threw his ball and fussed him whilst we completed work. We held a family session in order to work with Freud with both young person and sibling. They both enjoyed this and worked well together. They both led Freud around the agility course and timed each other. They even had a go at the weaves themselves. They raced Freud to his ball and raced one another back. They started to recall things they used to do together when they were a little younger and the young person suggested they should spend more time together as a result. Mum commented they never like spending time together and this had been beneficial. We have agreed a further session with her sibling and mum at the young person's request that again was a pleasant surprise to mum. The young person felt Freud had really helped her work with her brother and she commented she enjoyed seeing how enthusiastic her brother was about spending time with Freud. I felt this bought them together as they had a common interest to start recognising the positives in one another.

Initially her low mood symptom tracker was high scoring up to 22. By session, nine this has decreased to 7 suggesting a large reduction in low mood symptoms. She initially reported struggling with relationships on her ORS. However, she reports feeling more confident and supported within her relationships. The improvement is indicated on her ORS, SRS graph. Initial sessions scored around 20 on ORS compared to 32 by session ten. We have two further sessions remaining. RCADS will be added to this report once our work is complete. She has agreed to join the participation group and sees this as a way of maintaining the relationship she has built with Freud but also to remain involved with CAMHS.

Case 3

14-year-old girl referred through Sharp Clinic for self-harm and low mood. She reported past trauma of witnessing DV, anger outbursts and relationship difficulties in school and with her sibling. She also reported difficulties maintaining peer relationships.

The young person had four sessions of AAT following work with Sharp. Self-harm had stopped and continued to no longer be an issue for her during our work. She reported Freud helped her by making her laugh and feeling safe around him to talk. She felt the sessions gave her time to think and reflect on what was going well for her. We had initially planned to complete a longer piece of work however, the young person felt she had improved so much over the course of the work, she no longer required further sessions. As the young person did not want a photo of herself with Freud, she opted for a picture of Freud with a message to her to remember her sessions. She reports talking more openly with her mum and spending more time with her and her brother. She feels she is focusing more in school and has made positive choices since recognising the need to change in order to feel better and to feel more connected with those around her.

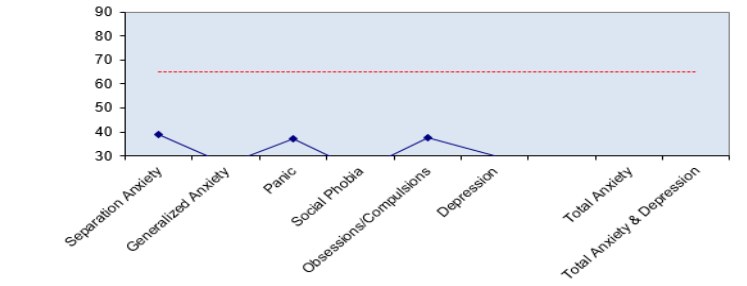
Start RCADS

RCADS Child/Young Person	Raw Score	T Score
Separation Anxiety	3	53
Generalised Anxiety	11	61
Panic	13	79
Social Phobia	8	41
Obsessions / Compulsions	6	57
Depression	20	80
Total Anxiety	41	59
Total Anxiety & Depression	61	66

End RCADS

Gender =	girl	(boy or girl)
Grade =	8	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	0	39
Generalized Anxiety	0	27
Panic	0	37
Social Phobia	0	24
Obsessions/Compulsions	1	38
Depression	0	30
Total Anxiety	1	27
Total Anxiety & Depression	1	26



Case 4

13-year-old girl. Struggling to manage the changes in her relationships that occurred at the same time as at the loss of her grandmother suddenly. Young person was finding it hard to maintain her relationships at home and in school as a result to finding processing changes in her family relationships hard to manage. We used IPT-A and AAT together due to the young person having a passion for animals. She took to Freud straight away and fussed him during our sessions. Her feedback on Freud said she really liked him being around, as she felt comforted by him and found him funny. The young person has made lots of progress using the combination of AAT sessions using IPT-A and family sessions to help both young person and family talk about the loss but also the changes in the family that followed. This has helped her to feel more settled within her family relationships, communicate her own needs and has helped her to feel more able to navigate her friendships in school due to feeling more settled overall.

We would meet at school and walk to a nearby park. The young person likes sitting on the skate park when no one was around and throwing Freud's ball in to the skate bowl so he would chase it and bring it back to her. She reports it was a distraction from what she was talking about as sometimes she found it difficult to talk about her family difficulties, but felt Freud helped make this feel lighter and allowed her to talk more freely.

Her verbal reports regarding the improvements to her relationships and mood are really positive. She feels her sleep and appetite has improved and she is spending more time with her family. Her RCADS show a positive change in her symptoms of anxiety and depression.

I have agreed one further maintenance session with the young person in order to check on progress now she is back in school and to complete her ending photographs for her to keep. She is currently actively encouraging parents to purchase a dog like Freud.

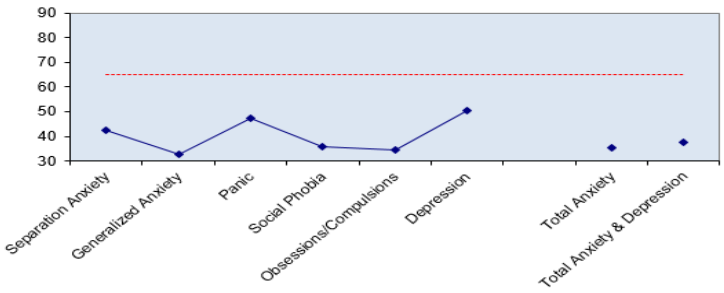
Case 4 Start RCADS

RCADS Child/Young Person	Raw Score	T Score
Separation Anxiety	5	57
Generalised Anxiety	11	61
Panic	8	58
Social Phobia	20	64
Obsessions / Compulsions	4	47
Depression	18	76
Total Anxiety	48	60
Total Anxiety & Depression	66	65

Case 4 End RCADS

Gender =	girl	(boy or girl)
Grade =	7	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	1	43
Generalized Anxiety	2	33
Panic	4	47
Social Phobia	6	36
Obsessions/Compulsions	0	35
Depression	8	50
Total Anxiety	13	35
Total Anxiety & Depression	21	38



Appendix 4

Teens for Truth support and participation group update 2018

The group helped design the mental health passport, thinking about what would be engaging for young people. This has been implemented and used by practitioners with young people and their families. They also provided feedback on other ways of getting the young person's voice and journey such as use of computer based downloadable versions, which are available to download as a resource on the website. They also talked about apps and how they may be useful but expensive.

They also had input into if an exercise group would be useful for CAMHS to run to improve mental health/wellbeing. A practitioner who was interested in designing and implementing an exercise and fitness group to help children and young people with emotional wellbeing. The group provided feedback on how useful they thought this project would be for some young people. They also advised on how some young people would find this setting difficult and ways this could be managed.

Discussions re the CHI form

The group feedback on the CHI form. They felt the CHI form could be made more user friendly and more appropriate for CAMHS as a whole. They have provided alternative questions for the CHI form and voted on which questions they found useful and how this could be scored out of 10 rather than the current format.

Discussions re the website and what could be improved

The young people attempted to complete a self-referral using the BEMH website to see how user friendly the website was. They provided feedback on this and are very keen to become involved in the new design, as they felt strongly about this being accessible to all young people and families and less confusing.

Publicity material for CAMHS

They were asked to think of how to break down the barriers both from a point of view of young people not knowing about CAMHS but also stigma around mental health. They came up with some really useful ideas around having straightforward, easy to read leaflets discussing the difficulties we can help support and having straightforward ways of contacting CAMHS. They also provide ideas such as restroom posters and small cards similar to Kooth cards. The leaflets have been created with teens for Truth input around wording and being straightforward and restroom leaflets have also been taken forward.

Next Steps Project

They provided feedback on the idea itself, how this could work and during evaluation provided feedback on how to engage young people in the take up of the service.

CAMHS Citywide Team Day on Participation

They attended a CAMHS team day, which went really well. This highlighted the importance to the young people and to participation as a whole for CAMHS and the young people. They were able to reach practitioners in terms of them thinking about referring young people to the group and ways they could help support young people who may be anxious about meeting new people and practitioners. They were also able to share with practitioners what they get themselves from attending the group in terms friendship, improved self-esteem and confidence.

They discussed what would be useful around parent participation

They discussed what they felt would be useful around parent participation and how CAMHS could involve parents more. The practitioners who are leading on parent participation took on board this and the feedback used to help support this project.

They discussed what they would want in a CAMHS practitioner

They discussed what they feel are the important qualities and competencies in a CAMHS practitioner. This has helped to shape the person specification for the role.

Key Themes

Participation means everyone being involved. The group are keen to expand as they find the group very useful for their own needs in terms of confidence building and self-esteem. They feel by supporting staff to encourage participation, our group will also be able to evolve and develop further, which would be more meaningful to CAMHS and to the young people.

Overall, their feedback has been listened to and they have felt a sense of worth as practitioners, managers have got back to them about updates etc.

Martina Hayhoe and Heather Kelly

CAMHS Practitioners and Teens for Truth group leads

October 2018.

Appendix 5

Participation Summary Report (October 2018)

In order to deliver best practice, Targeted CAMHS have enrolled to be a Young Minds Trailblazer; part of 'Amplified, a NHS England funded programme to develop the participation of children, young people and their families at every level of the mental health system.

A whole organisation participation plan focussing children and young people was previously developed by the service. The Trailblazer action plan is currently being developed to embed the participation and co-production with parents and carers within the service with the support from Young Minds.

The overview shows our current participation and the ideas to be developed. Since July 2018 the service have gained the views on participation from the community, children young people, service users, parents/carers and families.

In order to gain views parents and carers we launched a **'Your Voice'** campaign and the community were invited to give their views of the service, on what participation looked like to them. In addition, we sought the community's views and attended the Splendour festival at Wollaton Park.

Here we gained the views of 120 + members of the community, on mental health, CAMHS, participation and event feedback. The main themes from their voices were:

- *"Young people parents/carers wanted to get involved.*
- *Parents sometimes need support too.*
- *CAMHS needed to have more presence in the community and in schools.*
- *Young people and families wanted a say in the service they received.*
- *More transparency.*
- *Putting a human face to CAMHS made the service seem more transparent and accessible.*
- *Talking about mental health was good"*

The feedback enabled the service to develop many ideas of further innovation, particularly The Open Door pre Choice Assessment session, which is held now held monthly. This is to break down the barriers about what to expect from their assessment process and coming into a CAMH service and helping the community to see 'a face to CAMHS'.

The Parents in Mind Group has also been developed to embed participation from parents and carers into the service. This is a group for parents run by parents that offers peer support and a focus group to look at helping shape the CAMHS service with co-production. It is also a forum for discussions and to develop ideas including a community garden idea. The group are also aiding the development of a questionnaire to gain parent/carer feedback and involvement once their child has completed their time with CAMHS. Young Minds are also supporting this work and are offering free participation training to our workforce and young people and parent/carers group. This will also be an opportunity to look at the Trailblazer action plan and develop it further with co-production from our service user groups.

The importance of having a presence in schools and the community has come from service users, the community, parents and MH2K. The community/schools events are listed in the overview. Parents in Mind and the Teens 4 Truth group have also developed the leaflets for these events.

There has been one focussed Team Day around participation where young peoples from MH2k, Teens 4 truth and Trans 4 Me gave the team feedback on their views on the importance of participation for young people, they also gave ideas on how to improve the service and how to gain further participation from young people and their families. The action plan is constantly being developed by the ideas of the CAMHS community to improve the service and embed participation.

<u>"Your Voice" Splendour Report</u>

Through the community stand at the festival, Targeted CAMHS gained the views of our young people, parents, carers and community.

We talked and engaged with over 120 people, children, young people, parents, carers, families and professionals.

<u>Below are some examples of the feedback:</u>

"Participation is really important; to ask the views of parents and carers and young people helps with transparency" social worker and parent.

"We need to work together, we know our kids and you know how to help" parent.

"Love this stall, great idea, making CAMHS more human, a face, more approachable" YP with Parent.

"*Well done CAMHS, I would love to get involved in a parent support group, it is hard when you're a lone parent"* parent.

"What a good idea to come into the community to ask our views" YP.

"Knowing what's happening, what to expect from the services" Family.

<u>Main themes from the engagement of our community:</u>

5 main themes were highlighted:

- Both parents/carers and young people would like the choice to participate, get involved with shaping their care; particularly decision making and support groups; working together.
- CAMHS presence has been received well in the community and more presence is needed to help break down barriers and reduce stigma (a human face)
- It is essential CAMHS have more presence in schools/ more awareness/assemblies/teacher awareness
- More transparency about the service that is offered
- Easier access

This feedback helped with informing and developing our further service development in line with embedding meaningful participation, including:

- The Open Door Drop in Sessions (pre choice assessment: session explaining what to expect/transparency etc.)
- Facilitation of a parents support and focus participation group
- Presence/stands at community events
- Stands at school parent's evenings

From this work, Targeted CAMHS have now:

- Developed a parent/carer support and participation group
- Have planned more events in the community including a series of workshops in the community and stalls at different events prompting a face for CAMHS and tackling stigma, such as having a stall at the up and coming Ruby Wax event at the Play House in October 2018.

Appendix 6

MH:2K Nottingham & Nottinghamshire - Big Showcase

10th May 2018

About MH:2K

About MH:2K

- **MH:2K is a pioneering youth-led model for engaging young people in conversations about mental health in their local area.**
- MH:2K helps decision-makers and researchers to gain deeper understanding of mental health issues in their area and new insights about effective solutions for prevention, support and services.
- MH:2K is delivered by **Involve**, a leading charity working in the field of participation, and social enterprise **Leaders Unlocked**.
- In 2016-2017, we piloted MH:2K in Oldham. In 2017-2018, we are running it in Birmingham, Central Lancashire, North Tyneside, and Nottingham and Nottinghamshire. The project also now has a National Advisory Panel.
- MH:2K in Nottingham & Nottinghamshire is supported by the Wellcome Trust People Award, Nottingham City Council, Nottinghamshire County Council, and Clinical Commissioning Groups.

How it works

- **Recruitment:** of a core team of young people as 'Citizen Researchers'
- **Design Days:** to explore key national and local information and determine which mental health issues are most significant for their area.
- **Roadshow:** The Citizen Researchers co-design and co-deliver workshops to engage at least 500 other young people in the topics identified.
- **Results Day:** The Citizen Researchers help analyse and extract key findings. They work with local decision-makers on recommendations for change.
- **Big Showcase:** The Citizen Researchers present their findings and recommendations to key stakeholders and discuss next steps.
- **Local Advisory Panel** of key local decision-makers and stakeholders informs the project throughout.

What we did in Nottingham & Nottinghamshire

- We recruited **29** motivated young adults with diverse backgrounds and life experiences to become the MH:2K Citizen Researchers.
- The group selected 5 key priorities to address through the pilot:
  - Stigma and Public Awareness;
  - Treatment and Therapies;
  - Education and Prevention;
  - Cultures, Genders and Minorities;
  - Family, Friends and Carers
- The team designed and delivered their Roadshow events to schools, colleges and community groups across Nottingham & Nottinghamshire.
- The Roadshow reached **647 young people**. There **were 30 events at 15 different organisations.**

Our Local Advisory Panel

- **Elizabeth Allcock**, Service Improvement Facilitator for Quality, Governance and Patient Experience, Nottinghamshire Healthcare NHS Foundation Trust
- **Kate Allen, Consultant in Public Health**, Children's Integrated Commissioning Hub and Public Health Nottinghamshire
- **Pav Ayoub,** Senior Practitioner, Countywide Team, Nottinghamshire Youth Service
- **Pom Bhogal**, Youth Service Manager, Children, Families and Cultural Services, Nottinghamshire County Council
- **Hayley Bipin**, Commissioning Officer (Children), Nottingham City CCG
- **Jane Caro**, Citywide Targeted CAMHS Manager, Early Help Services
- **Brodie Colton,** Young person representative
- **Helene Denness,** Consultant in Public Health, Nottingham City Council
- **Lucy Hawkin**, Schools Health Hub Coordinator & Young Minds Local Delivery Lead
- **Lucy Peel**, Programme Lead, Children and Young People's Mental Health and Wellbeing (Nottinghamshire and Nottingham City)
- **Nichola Reed**, Public Health and Commissioning Manager

Findings and recommendations

Stigma and public awareness

Stigma and public awareness:
Key findings

- **There is a general lack of awareness of mental health** among young people, parents, professionals, and within the education system.
- **There is not enough training for schools, the workplace and professionals** in the correct use of language and terminology around mental health.
- This leads to young people **being left unsupported, their problems escalating, and an inaccurate picture** of how mental health is really affecting them.
- **There is an urgent need for greater promotion of the services** available to young people and how to access them.
- **Within some cultures, religions and ethnic groups,** there is a lack of understanding that mental health affects everybody, including young males.

Stigma and public awareness:
Our recommendations

1. **Provide compulsory education on mental health from a young age**, and deliver training for teachers and parents in how to support young people. Even using the terms in more positive way can help to reduce stigma and normalise conversations.
2. **Harness social media as a positive tool to promote an accurate and well-informed portrayal** of mental health. E.g. Kooth are currently piloting this service using Instagram.
3. **Use proven methods, like posters on the back of toilet doors and anonymous helplines,** to direct young people to the best place for help, without the fear of exposure in public. Get young people involved in developing these promotional materials.
4. **Target religious groups and cultural spaces** to bridge the gap in knowledge and awareness through the community.
5. **Carry out youth-led campaigns and projects like MH2K** to build positive momentum. Use peer-to-peer support groups, youth-led workshops and assemblies.

Treatment and therapies

Treatment and therapies:
Key findings

- Young people face barriers when trying to access services due to **long waiting times, assessment periods, insufficient duration of treatment and the transition** from child to adult provision.
- Some professionals **aren't trained well enough in how to communicate with young people** and how to support them.
- **Access to services is restricted,** with unrealistic hours, opening times which don't correlate with school times, and locations which may be too far to travel to if unaccompanied.
- Some young people feel that **the type of treatment they are given is not suited** to them or the professional they are seen by isn't someone they feel comfortable with, and they are not offered an alternative.
- **The transition from child services to post-18 services** is not smooth or reliable enough. The waiting time and consistency of care isn't followed through meaning some young people are falling through the system.

Treatment and therapies:
Our recommendations

1. **Offer 24/7 helpline support and drop-in sessions** which are open at suitable times that don't clash with school/college hours.
2. **Use staff members from teams across mental health services** to ensure better coverage when some areas are facing high demand. Ensure that flexible staffing is being used effectively.
3. Put an end to only offering limited weeks of treatment and make it a **continuous assessment which reduces the pressure and stress** on the young person to 'feel better' within just 6 weeks for some issues.
4. I**nclude young people when training professionals**, and allow them to help educate teachers/counsellors about how to communicate with young people, making it more powerful.
5. **Use spaces where young people feel comfortable**, like community centres and youth centres, rather than clinical/hospitalised spaces which can be daunting and off-putting.

Education and prevention

Education and prevention:
Key findings

- **There is not enough privacy when seeking help in schools**, e.g. announcements to see the school counsellor are made publicly in front of other students, and you have to leave during lessons. This results in students shying away from seeking help in the first place.
- Many teachers that deal with students on a daily basis **do not know how to spot the signs or what to do** – only pastoral staff seem to know what to do.
- **It's hard to seek help in schools** as staff members don't explain the process properly or the circumstances in which parents have to get involved. Looking at leaflets and posters can make your problems more public.
- **There is too much focus on exams and academic achievement**, which is very stressful and counterproductive, making young people more anxious with no opportunity for a break or relaxation.

Education and prevention:
Our recommendations

1. **Make it possible to arrange appointments in a confidential way**, e.g. creating an online appointment system and booking with an arranged location to make it feel less daunting and make the first step easier.
2. **Provide a basic training day for all members of staff on mental health** and how to advise young people, create more informal situations with staff, so students feel more comfortable approaching and talking to them.
3. **Improve the accessibility of services**, and how information is distributed, keeping things clear and simple. Use private processes e.g. emailing mental health information to all students rather than leaflets on a public notice board.
4. **Set up peer support groups across year groups**. Set up older students to work with younger students who may not as comfortable with a teacher or adult.
5. **Reduce exam pressure and increase extracurricular activities.** Make person-specific revision plans, instead of setting unachievable goals which can be overwhelming. Educate parents on how much pressure is appropriate. Support session like yoga, mindfulness, opportunities for talking about self-care and ways we look after ourselves in times of stress.

Cultures, genders and minorities

Cultures, minorities and genders: Key findings

There **isn't enough mental health education for religious groups and ethnic minorities** through religious buildings, community centres, and faith schools. Some young people are having to live a 'double life' between western values and their own background.
Support systems are put into place **without full consideration of how young people actually feel about accessing the facilities**. Often, they're not advertised well enough therefore young people don't know enough about them.
Teachers are not trained on the subject of LGBTQ+ or knowledgeable enough about how to deal with homophobic bullying and discrimination.
Young males and some ethnic minorities are particularly affected by **addictions to drugs, alcohol, gambling, social media, gaming, and pornography** which are having a detrimental effect on young people's lives.
There is still a **huge problem with the stigma of mental health for young males**. They are constantly told to 'man up' and 'real men don't cry' which leads to them not expressing their feelings or seeking help.

Cultures, minorities and genders: Our recommendations

1. **School counsellors to be accessible to all students** during school hours, through online services and drop-ins. There should be safe spaces that students feel comfortable in, and counselling must be private and confidential.
2. **Work with the voluntary sector to provide earlier intervention.** Services need to be actively promoted within voluntary sector settings, religious centres, community centres and faith schools. Councils and services need to use their voluntary sector links more effectively.
3. **Use accessible means like street stalls to defeat ideas of masculinity from an early age** and raise awareness of topics like identity and equality. Prioritising work with males.
4. **Bullying should be taken more seriously at schools, particularly homophobic/ transphobic bullying.** Teachers need specific LGBTQ+ training in order to understand their students.
5. **Run PSHE/Citizenship** lessons to address the consequences of drug use, addictions, coping mechanisms and spotting the signs of MH**.**
6. Run specialist education programmes that **address masculinity and mental health in football clubs/sports clubs/air cadets/drama clubs etc**

Family, friends and carers

Family, friends and carers:
Key findings

- **Young people face feelings of isolation** due to racism, homophobia, or the pressure of figuring out identity. “Being isolated is probably one of the worst things you can feel, if you let out your feelings, you worry that you will push friends, family and carers away.”
- **Young people are afraid of being seen as different**, as they are under so much peer pressure. There is pressure to fit in, look good, and do things they don’t want to do. Many think they are abnormal, whilst everyone else around them is ok.
- **Many young people feel they cannot communicate** with their friends and family about . They feel that no one can relate to their problems.
- **Parents did not have this much exposure to mental health** when they were growing up. This results in huge gaps in their relationships with their children, who might be silently suffering.
- **Within the school environment, people are afraid of being judged by others**, and feel like there is nowhere they can go. This is largely due to the services offered in schools which are lacking in anonymity, not giving the young people the confidence to seek help.

Family, friends and carers:
Our recommendations

1. **Offer young people more choice of professionals to see and speak to**, in terms of age/gender/culture etc. This way they are more likely to open up and feel comfortable.
2. **Create an online booking system for school counsellors.** This way friends/ other students won’t know that you’re going to see the nurse/counsellor, therefore reducing the fear, anxiety and pressure of coming forward.
3. **Invite parents to compulsory talks throughout the school years**, not just in sixth form – providing information to reduce family pressures and make the whole family more at ease with talking about mental health.
4. **Run PHSE in schools to engage friendship groups** – include self-confidence, self-esteem, and self-belief workshops as well as providing the basis facts on mental health services.
5. **Consider innovative ways to engage parents. Y**oung people feel their parents wouldn’t be able to support them with their mental health due to the lack of understanding and knowledge, so an MH2K-style engagement project could piloted to engage/educate parents and carers directly.

Nottingham City Council

CAMHS
Child & Adolescent Mental Health Services

Appendix 7

Today's Date:	**Monday 29 October 2018**	Weeks Away:	Date of:	Surplus/Deficit Wait Time:
Next available Choice:		3.14	20 November 2018	**2.86**
Next available Choice if all waiting were booked into next available slots:		4.14	27 November 2018	**1.86**
Next Available Joint BEH/CAMHS Choice:		5.00	03 December 2018	**1.00**
Next Available Joint BEH/CAMHS Choice if all were booked in:		5.00	03 December 2018	**1.00**
Next Available Joint Community/Targeted CAMHS assessment:		3.00	19 November 2018	**3.00**
Next Available Joint Community/Targeted CAMHS assessment if all were booked in:		6.43	13 December 2018	**-0.43**
Next available Consultation:		1.29	07 November 2018	**4.71**
Next available Consultation if all were booked in:		12.29	23 January 2019	**-6.29**
Next Available Partnership:		6.43	13 December 2018	**1.57**
		Number:		
No. awaiting Choice in CAPA tray:		12		
No. awaiting Consultation in CAPA tray:		16		
No. awaiting Joint BEH/CAMHS choice in CAPA tray:		0		
No. awaiting Joint community CAMHS/CAMHS assessment in CAPA tray:		7		
No. awaiting Partnership:				

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Children's Partnership Board Forward Plan

25th March 2020

CYPP Priority: Supporting Achievement and Academic Attainment
Safeguarding Board Annual Report and Business Plan
Update on Exclusions / Managed Moves
Nottingham Schools Trust Update
Update on Young Carers
Update on Whole Life Disability Service
Partners Update: Nottinghamshire Police

Please contact Debbie Hemsley if you have any suggestions for future items for the forward plan: Debbie.hemsley@nottinghamcity.gov.uk

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