Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Children & Young People's Emotional Health & Wellbeing (EHWB) Commissioning and Delivery Strategy

2014 - 2017

The purpose of the Strategy is to help improve the emotional wellbeing and mental health of children and young people (aged < 18) living in Bath & North East Somerset. It focuses on EHWB support services commissioned by the Local Authority and NHS B&NES CCG but also considers services provided in educational settings and by the voluntary sector. The strategy co-ordinates the planning and commissioning of services to ensure that resources in all partner agencies are used in the most effective way to improve children and young people's emotional health.

1. National Context

DoH evidence[1] confirmed that

- The cost of mental health problems to the economy in England has recently been estimated at £105bn, with treatment costs expecting to double in the next 20 years.
- 50% of lifetime diagnosed cases of mental illness start by the age of 14
- Poor mental health in childhood is associated with poor childhood and poor adult outcomes.
- 10% of children at any one time have mental health problems

The 2010 national public health strategy[2] gave equal weight to both mental and physical health and focused on tackling the underlying causes of mental ill-health. The strategy noted;

- Intervening early for children with mental health problems has been shown not only to reduce health costs but also realise larger savings such as improved educational outcomes, reduced unemployment and less crime.
- 25-50% of mental health problems are preventable through interventions in the early years.

[1] *Healthy Lives, Healthy People (Nov 2010) and No Health Without Mental Health (Feb 2011)*
[2] *Healthy Lives, Healthy People (Nov 2010),*

The national strategy expects early intervention and preventative services to be provided by partnership working between the NHS, local government and the third sector.

A number of documents have been published since 2011 which illustrate the government's commitment to improve mental health for all age groups. These include:

- Chief Medical Officer's Annual Report: Our children deserve better: Prevention pays, October 2013 https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays
- NSPCC - Prevention in mind, All babies count: spotlight on Perinatal Mental Health, June 2013 http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html
- Public Health England – How healthy behaviour supports children's wellbeing, August 2013 https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing
- Children and Young People's Mental Health Coalition report 'Overlooked and Forgotten', December 2013 http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/
- Mental health sub-group report of the children's outcomes forum, May 2013 https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results
- Closing the Gap, Priorities for essential change in mental health, January 2014 https://www.gov.uk/government/publications/mental-health-priorities-for-change
- Baby Bonds, Parenting, attachment and a secure base for children, The Sutton Trust, March 2014 http://www.suttontrust.com/researcharchive/baby-bonds/

2. Local Vision

The Children and Young People's Plan (CYPP) 2014-2017 - the commissioning and delivery plan to improve the general health and wellbeing of children and young people across B&NES - outlines the Children's Trust Board's vision and priorities for the period 2014-17.

The vision is:

> *'We want all children and young people to enjoy childhood and to be well prepared for adult life.'*

The CYPP's 3 key outcomes are:

Children and Young People are Safe
Children and Young People are Healthy
Children and Young People have Equal Life Chances

The vision for good mental health for children and young people is**:**

'All children and young people, from birth to their eighteenth birthday, are supported to develop and maintain good mental health, a sense of well-being and emotional resilience. Any children and young people with emotional difficulties and mental health disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.'

Bath & North East Somerset aims to commission and develop services which:

- Help children & young people learn the skills they need to stay emotionally healthy
- Ensure the delivery of a comprehensive range of services to tackle mental health problems before they become entrenched
- Work with adult mental health services to minimise the impact of parental mental ill-health on children and young people
- Identify children & young people who need extra support and provide it as early as possible for as long as it is needed
- Meet children & young people in the most accessible place possible
- Periodically review services to ensure resources are being used in the best possible way

The following commissioning principles are promoted:

Multi-agency working: a key principle of the strategy is that mental health is the 'business' of all agencies, and a joint approach is required to improve children & young people's mental health. There is a commitment to an integrated care pathway for children & young people with emotional and behavioural difficulties which addresses how universal, targeted and specialist services work together to best meet the needs of children, young people and their families. Children & young people may have a 'lead professional' to help coordinate services.

Early Intervention: There is a focus on early intervention; in terms of early in the life cycle, early identification of difficulties and early intervention. Hence multi-agency services that promote the mental health of all children & young people (including building resilience) and provide early identification and preventative interventions are commissioned alongside services to meet the needs of children & young people with established or complex problems. Interventions are best provided 'nearest' the child or young person i.e. provided by

practitioners with the 'lowest level of specialism' (but nevertheless with the necessary skills and competencies).

Evidence-based practice: Services should provide mental health care which is based upon the best available evidence, including relevant NICE guidelines.

Addressing inequalities: Services must be provided to children & young people regardless of their ethnicity, gender, sexual orientation and/or religion. All services should pro-actively consider the specific needs of children and young people

- from black and minority ethnic groups (including migrant families),
- with physical and learning disabilities
- who are - or are at risk of becoming - young offenders
- who are - or are at risk of entering - the care system
- who are lesbian, gay, bisexual, transgender or questioning their sexuality
- who are being bullied or discriminated against for other reasons e.g the way they look or their economic circumstances

Service User involvement: All services should have a commitment to increasing the participation of service users, parents and carers in the planning and evaluation of services to ensure that services are designed around the needs of children, young people and their carers as opposed to the needs of individual agencies.

Clear service expectations and outcomes: Services will be commissioned against clear expectations, outputs & outcomes, detailed in service specifications and monitored to ensure compliance and quality.
The following measures of success will be monitored by the group:

- Individual commissioners measuring the effectiveness of commissioned services through monitoring outcome-based service specifications
- Evaluating new pilots or innovative provision
- Feedback from multi-agency staff 'on the ground'
- Monitoring current performance indicators e.g incidence of
  - school exclusions, attendance and attainment,
  - incidence of substance misuse
  - incidence of bullying
  - number and ages of children attending units for behavioural, emotional and social difficulties
- 'Softer' data from Health School Surveys, Pupil Attitude and Attainment Surveys (PASS), Foundation Stage Profile data, referrals to Behaviour & Attendance panels and social media.

3. Promoting and protecting good Mental Health

The Mental Health Foundation[3] believes that good mental health is characterised by a child's ability to fulfil a number of key functions and activities, including:

- The ability to learn
- The ability to feel, express and manage a range of positive and negative emotions
- The ability to form and maintain good relationships with others
- The ability to cope with and manage change and uncertainty

There are a number of 'protective' and 'risk' factors known to be associated with good emotional health:

Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
Easy Temperament adequate nutrition attachment to family above average intelligence school achievement problem solving skills internal locus of control social competence	supportive caring parent family harmony secure and stable family small family size more than two years between siblings responsibility within the family (for child or adult) supportive relationship with other	sense of belonging positive school climate pro-social peer group required responsibility and helpfulness opportunities for some success and recognition of achievement school norms against violence	involvement with significant other person (partner/mentor) availability of opportunities at critical turning points or major life transitions economic security good physical health	sense of connectedness attachment to and networks within the community participation in church or other community group strong cultural identity and ethnic pride access to support services community/cultural norms against violence

[3] **http://www.mentalhealth.org.uk/**

social skills good coping style optimism moral beliefs values positive self-related cognitions physical activity	adult (for a child or adult) strong family norms and morality			

Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children) NB: the following tables list *influences* on the development of mental health problems not the *causes*.

Individual Factors	Family/social factors	School context	Life events and situations	Community and cultural factors
Prenatal brain damage Prematurity birth injury low birth weight, birth complications physical and intellectual disability poor health in infancy insecure attachment in infant/child low intelligence difficult temperament chronic illness	having a teenage mother having a single parent absence of father in childhood large family size antisocial role models (in childhood) family violence and disharmony marital discord in parents poor supervision and monitoring of child low parental involvement in child's activities	Bullying peer rejection poor attachment to school inadequate behaviour management deviant peer group school failure	physical, sexual and emotional abuse school transitions divorce and family break up death of family member physical illness unemployment, homelessness incarceration poverty/ economic insecurity job insecurity	socio-economic disadvantage social or cultural discrimination isolation neighbourhood violence and crime population density and housing conditions lack of support service including transport, shopping, recreational facilities

poor social skills low self-esteem alienation impulsivity alcohol misuse	neglect in childhood long-term parental unemployment criminality in parent parental substance misuse parental mental disorder harsh or inconsistent discipline style social isolation experiencing rejection lack of warmth and affection		unsatisfactory workplace relationships workplace accident/ injury caring for someone with an illness/ disability living in nursing home or aged care hostel war or natural disasters	

Reproduced from: Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and early intervention for mental health-a Monograph, Mental Health and Special Programs branch, Commonwealth Department of Health and Aged Care, Canberra. Quoted in Making it Happen (DH 2001).

4. Prevalence of emotional ill-health in Bath and North East Somerset

Symptoms of poor emotional health may differ according to a child's personality, personal history, community and environmental factors. Symptoms include behavioural problems, substance misuse, self-harm, suicide attempts, eating disorders, depression, anxiety, obsessions and psychosis.

There are few reliable estimates of the prevalence of emotional ill-health, particularly for pre-school age children. A government survey in 2004 (Green et al.) found that, at any one time, 1 in 10 children aged 5-16 years old had a clinically diagnosable mental disorder, causing distress to the child or having a considerable impact on the child's daily life and which requiring trained intervention. Prevalence varied by age and gender, and was classified into conduct, emotional, hyperkinetic and less common disorders (ASD, eating disorders, mutism) with some children having more than one disorder. Applying the survey percentages to B&NES child population as estimated in 2011 update:

Table 3:

Total population 5-16 years of age = 20,447

The estimated numbers of affected children are as follows:

NUMBERS	5 to 10			11 to 16			5 to 16		
	male	female	all	male	female	all	male	female	all
Conduct disorder	376	143	517	485	293	773	787	388	1186
Emotional disorder	120	128	253	239	350	586	325	428	757
Hyperkinetic disorder	147	20	169	144	23	164	273	40	307
Less Common e.g. ASD, eating disorders	120	20	137	96	63	164	199	80	266

Local intelligence regarding emotional wellbeing

The Health-Related Behaviour Survey developed by the Schools Health Education Unit (SHEU) is designed for young people of primary and secondary school age. The surveys have been developed by health and education professionals, and cover a wide range of topics. All schools in B&NES are invited to participate when these surveys are carried out every two years.

The Child Health-Related Behaviour Survey in B&NES in 2013 and 2011 asked school children in B&NES a number of questions linked to their wellbeing in terms of satisfaction with life, the extent to which they worry about things and their self-esteem.

Worrying

When the **primary** school pupils in Year 4 and 6 were asked about how much they worried about the following problems:

- School-work/homework
- SATS/tests
- Money problems
- Health problems
- Problems with friends
- Family problems
- The way you look
- Body changes as you grow up
- The environment
- Crime

67% of pupils in 2013 responded that they worry about at least one of the issues listed ‘quite a lot’ or ‘a lot’, this was very similar to 2011 when it was 69%.

In 2013 the issues that were of greatest concern (a lot or quite a lot worried) to primary school pupils were:

- Year 4 females = Problems with friends with 39% of female respondents and family problems with 34%

- Year 4 males = Crime with 29% and SATS with 25%
- Year 6 females = SATS with 32% and problems with friends with 26%
- Year 6 males = Crime with 25% and family problems 23%

When the **secondary** school pupils in Year 8 and 10 were asked about how much they worried about the following problems:

- School-work problems
- Exams and tests
- Health problems
- Career problems
- Problems with friends
- Family problems
- Money problems
- The way you look
- Puberty and growing up
- Being bullied
- Thinking you are gay, lesbian or bisexual

In 2013 68% (64% in 2011) of pupils responded that they worry about at least one of the issues listed ‘quite a lot’ or ‘a lot’, this is higher than the national SHEU rate of 59%.

In 2013 the issues that were of greatest concern (a lot or quite a lot worried) to secondary school pupils were:

- Year 8 females = The way you look with 45% and exams and tests with 41%
- Year 8 males = Exams and tests with 29% and family problems with 20%
- Year 10 females = Exams and tests with 67% and the way you look with 56%
- Year 10 males = Exams and tests with 41% and school work problems with 23%

Self-Esteem

The measurement of self-esteem in the Child Health-Related Behaviour Survey uses a scale based on social confidence and relationships with friends that is derived from the responses to a set of statements taken from a standard self-esteem enquiry method developed by Denis Lawrence (Lawrence,1981):

- Do you feel happy talking to other children at school?
- When you have to say something in front of teachers, do you usually feel uneasy?
- Are there lots of things about yourself you would like to change?
- Do other pupils in the school often fall out with you?
- Do you often feel lonely at school?
- Do you think that other pupils in the school often say nasty things about you?
- When you want to tell a teacher something do you usually feel shy?

- Do you often have to find new friends because your old friends are with someone else?
- Do you usually feel foolish when you talk to your parents?
- Do you think your parents like to hear your ideas?
- Do you think teachers listen to you at school?

When the **primary** school pupils in B&NES were asked these questions in 2013:

- 36% of pupils had a high self-esteem score; this is lower than the SHEU national rate of 42%.
- 24% of pupils had a low self-esteem score; this is very similar to the SHEU national rate of 22%.

In terms of B&NES there has been very little change in the levels of self-esteem reported in primary school children since 2011.

When the **secondary** school pupils in B&NES were asked these questions in 2013:

- 41% (46% in 2011) of pupils had a high self-esteem score; this is very similar to the SHEU national rate of 40%.
- 20% (17% in 2011) of pupils had a low self-esteem score; this is the same as the SHEU national rate.

Bullying

The Child Health-Related Behaviour Survey in 2013 and 2011 asked **primary** school children in B&NES in year 4 and 6 a number of questions about bullying:

- In both 2013 and 2011, 7% of pupils that responded stated that they felt afraid of going to school because of bullying ‘often’ or ‘very often’, this is very similar to the SHEU national rate of 6%.
- In 2013 37% of pupils that responded said that they felt afraid of going to school because of bullying at least ‘sometimes’, this was virtually the same as in 2011, when it was 36%.
- In both 2013 and 2011, 3% of pupils that responded that they think others may fear going to school because of them, this is the same as the SHEU national rate.
- 27% of pupils that responded in 2013 said that they had been bullied at or near school in the last 12 months.
- In 2013, 75% of pupils that responded stated that they thought their school took bullying seriously, while 12% did not think their school took bullying seriously.
- 74% of pupils responded that they have experienced at least one of the negative behaviours listed at least a ‘few times’ in the last month, while 25% said they have done so ‘often’ or ‘every day’.

The Child Health-Related Behaviour Survey in 2013 and 2011 asked **secondary** school children in B&NES in year 8 and 10 a number of questions about bullying:

- In both 2011 and 2013 4% of pupils responded that they feel afraid of going to school because of bullying 'often' or 'very often', very similar to the national SHEU rate of 5%.
- In 2013, 24% (22% in 2011) of pupils responded that they feel afraid of going to school because of bullying at least 'sometimes', very similar to the national SHEU rate of 22%.
- 19% of pupils in 2013 responded that they had been bullied at or near school in the last 12 months (17% in 2011), lower than the national SHEU rate of 31%.
- In 2013, 5% of pupils responded that they had bullied someone else at school in the last 12 months (6% in 201), very similar to the national SHEU rate of 6%.
- In 2013 17% of pupils did not think that their school took bullying seriously (15% in 2011).

A higher proportion (34%) of the secondary school pupils eligible the pupil premium (PP) responded that they felt afraid of going to school because of bullying at least 'sometimes, compared to of non PP pupils (23%).

5. Commissioning

Responsibility for commissioning EHWB services lies with a number of agencies; CCG, Early Years (LA), Youth Service (LA), Schools and Colleges (LA and academies), Specialist Commissioning (National Commissioning Board), Public Health (LA) and Voluntary Sector funding. A model of comprehensive service provision is reproduced in Appendix One.

Table 4: Services currently (September 14) commissioned to support the Emotional Health of Children and Young People

Preventative ←----------→*Specialist/Corrective*				
Age	*Universal, open access*	*Targeted preventative*	*Targeted management of complex needs*	*Crisis management*
preschool	Maternity Services, Health Visitors, Children's Centres, GPs, FIS, Play rangers, Nurseries and Early Years Education Settings,	Health Visitors (Universal Plus and Universal Partnership Plus) Family Nurse Partnership, SENCOs, Educational Psychologists, Parenting Support (Incredible Years), PCAMHS, Speech and	Infant Mental Health Service, Southside Family Project, Early Support, Bath Opportunity Playgroup, Community Paediatricians, Lifetime, Learning Disability Nursing Service, Flying Start, Specialist Child	CAMHS

		Language Service, Early Relationships Support, Therapeutic Play, Flying Start, Bright Beginnings.	and Family Support Team,	
primary	FIS, Play rangers, Full time education, Pastoral Care, GPs, School Nurses, Learning to Lead, Director of Public Health Award for schools, PHSE, SEAL approaches,	Educational Psychologists, SENCOs, Young Carers Group, Shout Out (advocacy services), Parenting Support (Incredible Years), Transition Support, Speech and Language Service, PCAMHS, Antibullying (Zap?), Primary school counselling, Nuture Outreach	Special Schools, The Link, CAMHS, 117 Project, Southside Family Project, Community Paediatricians, Learning Disability Nursing Service, Lifetime, Specialist Child and Family Support Team, Behaviour and Attendance Panels.	CAMHS
Secondary + colleges	FIS, Full time education, PHSE, SEAL approaches, GPs, School Nurses, College Nurses, Pastoral Care, Learning to Lead, Director of Public Health Award for schools/colleges	Youth Services (Connect), Clinic on the Move, SENCOs, Compass, Speech and Language Service, Mentoring Plus, Educational Psychologists, Young Carers Group, Shout Out (advocacy services, Parenting Support (strengthening families, strengthening communities), Speech and Language Service, PCAMHS including counselling, Antibullying (ZAP), LGBT support.	Special Schools, Project 28, Youth Offending Service, CAMHS, Young Parents Support, 117 Project, Community Paediatricians, Learning Disability Nursing Service, Lifetime, CASH Clinic, Specialist Child and Family Support Team, The Link, Behaviour and Attendance Panels.	CAMHS

6. **Funding**

B&NES is served by all elements of the model outlined in Appendix 1. Children's services are detailed above (Table 4) and are provided by a range of organisations including the LA, Sirona, Oxford Health NHS Foundation Trust and smaller voluntary organisations.

Both the Local Authority and the NHS Clinical Commissioning Group make significant contributions to EHWB services e.g. funding for Health Visitors, School Nurses, Paediatricians, Youth Services, Substance Misuse Services, Children Centres, Play, School Inclusion, Parenting etc. Additional funding for EHWB services e.g. counselling is provided from individual and pooled school/Academy budgets.

Funding to implement the EHWB strategy, including the primary and specialist CAMHS services is mainly committed until March 2017. Some of the services currently provided are fixed term pilots ending before March 2017.

Commissioners generally work with fully committed budgets and the current economic situation is only likely to lead to a reduction in national and local government funding.

So the main scope for improving services to children and young people is likely to come from:

- **Better identification of need**
- **Earlier intervention to support need**
- **Increased joint commissioning to pool resources and create coordinated services which present as 'seamless' pathways for children and their families.**

7. Governance

- The EHWB Strategy Group acts as a sub-group for the Children's Trust Board and are required to produce 6 monthly reports to the Children's Trust Board, LSCB and Health and Wellbeing Board as well as an annual review of performance.
- There are strong links to the Local Safeguarding Children's Board (LSCB) with the EHWB group's social care representative also being a member of the LSCB
- There are links to the Suicide Prevention Strategy Group and the Self-Harm Steering Group via the Mental Health representative from Public Health. Some actions from the Suicide Prevention Strategy Action Plan form part of the Action Plan for the EHWB Strategy.
- The current Suicide Prevention Strategic Plan and Action Plan can be viewed here: http://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/suicide-prevention-strategy-2012

8. Action Plans

Previous Action Plans

There have been 6 previous EHWB strategic action plans for Bath and North East Somerset, the last one dated 2012-2014. Significant progress has been made in the priorities identified within the previous strategies:

Table 5:

Previous priorities and actions	Achievements to date
Development of services to meet the PSA target for comprehensive CAMHS (24 hour cover, access for all 16-17 year olds and access for children & young people with a learning disability)	In 2010 the specialist CAMH service was re-commissioned and is now provided by Oxford Health NHS Foundation Trust (OHFT). This service has 24 hour cover, access for children up to 18 years old and a specialist LD service. The current contract runs until March 2017.
Development within specialist CAMHS to provide more focussed, shorter term support for some mental health problems leading to a reduction in waiting times to access the service	In Dec 2011 from OHFT indicate that 89% of referrals (ytd) were assessed within 4 weeks and 93% are assessed within 8 week. By Nov 2012 this had risen again to 95% assessed within 4 weeks of referral. Due to increasing demand, by July 2014 the % being assessed within 4 weeks had fallen, but 100% of routine referrals to both PCAMHS and CAMHS were assessed within 8 weeks.
Strengthening of consultation and support to non-specialist services by the specialist CAMHS team	In 2009/10 Extended Schools money funded mental health awareness training provided by specialist CAMHS. In 2010/11 there was significant additional support provided via the TaMHS (Targeted Mental Health in Schools) project to self-selected schools. Multi-agency training has been, and will continue to be provided by OHFT as part of the commissioned CAMHS and PCAMHS services. During 13/14 OHFT increased its support and consultation to the school nurses and pastoral staff in targeted secondary schools.
To reduce the number of children & young people with mental health difficulties inappropriately admitted to a general paediatric or adult mental health ward and reduce the length of	There were no local under 18 year olds admitted to adult wards in the 2013/14 (unless by patient choice). Since April 2013 inpatient beds have been commissioned by NHS England

stay as inpatients	(as opposed to local commissioners) who recognise there is a national shortage of CAMHS beds and are in the process of commissioning more. Nevertheless since April 2013 no children or young people have needed to go 'out of area' to access generic inpatient beds.
To work with Early Years strategy group to ensure that infant mental health services are delivered as part of the development of Children's Centres	Early Relationship support from Sirona has become well established, with clinical supervision provided by specialist CAMHS, who now provide a more specialist infant mental health service. As an Early Implementer Site for the new national healthy child programme, health visitors have received additional training in how to promote attachment - both before and after birth. Closer links are being forged with the maternity services to enable vulnerable families to be identified and supported by Children's Centres as soon as possible. From April 2015 Health Visitors will offer an antenatal promotional interview with all pregnant women. This includes reflecting on the importance of attachment and sensitive parenting.
To have a clearer focus of children & young people with very challenging behaviour, particularly young offenders and children in care or those at risk of becoming offenders or children in care.	The OSCA service (Outreach Service for Children and Adolescents) from OHFT maintains close links with the Youth Offending Service. YOS also have access to a Sirona nurse who has some mental health expertise. A Speech and Language therapist is commissioned by the CCG to 'up-skill' the YOS staff. Specialist CAMHS supports LAC as and when they are referred and provide consultation for social workers to discuss individual children and young people anytime during office hours.
To develop improved needs assessment, health profiling and performance/outcome information in order to better target services and service improvement	Alongside the more traditional measures of social and economic disadvantage, and school attainment, absence, exclusions, etc. additional local data is being collected via the SHEU survey in schools. Many

	schools also now use PASS surveys (some funded by TaMHS) which highlight attitudes to school and levels of self-esteem. School and college nurses and the Director of Public Health Awards coordinator use as much data as possible to identify whole school, group or individual pupil interventions. Outcome measures are beginning to be used routinely in some services. OHFT is in the process of identifying the most appropriate measures for their services – it is an pilot for the national children's IAPT which has extensive data requirements including outcome measures. The technology to collect these routinely is being embedded in the service.
To continue to improve the EHWB pathway, ensuring that routes to access services are made clear to all potential referrers	Periodic audits of services are undertaken to check gaps in service provision. The PCAMHS/CAMHS service is now accessed using one referral route which simplifies and streamlines access to all OHFT's services. Referral criteria and routes are well publicised and each GP practice has received written information about the PCAMHS service and how to refer. Opinions about the service from PCAMHS/CAMHS stakeholders are due to be collected, summarised and considered by OHFT.
To increase the participation of children, young people and their families to influence service delivery	Service user evaluation and participation in developments are a requirement in all service specification. The extent and impact of participation is monitored at least annually. OHFT has an active children and young person participation group which regularly contributes to the development of services.

Appendix 1