Children's COMMISSIONER

Briefing: Children's Mental Healthcare in England

OCTOBER 2017

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Foreword from Anne Longfield OBE, Children's Commissioner for England

Over the last year, the issue most often raised with me has been children's mental health, and it was the top of the list in my consultation with children about my priorities for the year ahead. Many told me about their desperate attempts, sometimes lasting years, to access support, and even primary school children raised concerns about anxiety. I also hear from parents, teachers and carers about their repeated frustrations when trying to get help for children who need it.

I'm very concerned that children's inability to access mental health support leads to a whole range of additional problems, from school exclusions to care placements breaking down to children ending up in the youth justice system. I believe many of these problems could be prevented if children had access to mental health support when they need it. As this briefing shows, early intervention is cost effective - but is currently a postcode lottery of fragmented support depending almost entirely on where a child grows up and which school they attend.

The Government's forthcoming Green Paper presents an opportunity to ensure that proper support, whether it be for low-level issues or chronic conditions, is made readily available for all children who need it. It comes just two years after Ministers promised major reform of the children's mental health system through the 'Future in Mind' programme. But progress in improving children's mental health services has been unacceptably slow, with the Health Secretary himself describing it as the 'weakest area of current [NHS] provision'.

This briefing explains why progress has been limited and sets out some of the changes required to ensure children's mental health services meet demand.

To inform this, I have conducted a thorough examination of the current system of children's mental health care. In particular, I was interested to compare the systems for adult mental health with that for children. The results are shocking. There are enormous disparities. NHS England lays out clear expectations to local areas about what should be provided for adults, backed up by targets and benchmarks on success rates and waiting times. In contrast, there is no monitoring of how many children are seeking mental health treatment, no information on how many are accepted into treatment, how long they will wait or what outcomes they achieve.

There were no children's mental health national targets until last year – now there are nine indicators, but these are not are top priority targets. . At a time when the NHS is under exceptional financial pressure, the system in place makes it all too easy for children's mental health to be ignored.

There has been some welcome progress on areas such as children being held in police cells and the provision of eating disorder services in the community. There has also been a lot of work undertaken in local areas which it is difficult to quantify using national data, but which NHS England estimates has led to an extra 21,000 children receiving CAMHS support since 2015/16. Nevertheless, nearly 60% of local areas are failing to meet NHS England's own benchmarks for local area improvement.

The picture is even bleaker when it comes to early help for children with emerging problems. There is no clear expectation placed on local areas about which services should be provided, or how ill a

child needs to be before they should receive care. No information is collected on which local services are available, and the evidence that has been collected, by myself and a range of other bodies, reveals a postcode lottery of care.

What I want to see is not incremental change, but a wholesale shift in the scale of ambition across Government and the NHS on children's mental health care. I want to see a clear expectation as to what local areas should be providing, with transparency and accountability to ensure this happens.

My message to Government and Parliamentarians is clear: the Green Paper is an opportunity to bring about this seismic change and it must not be missed. Be bold, be brave and do not compromise. We can transform the provision of children's mental health care, and the rewards for doing so are enormous.

Anne Longfield OBE

Children's Commissioner for England

Key Findings from our Research

1. **Our analysis shows just over 200,000 children received CAMHS treatment last year, 2.6% of the age 5-17 population[1].** Comparing this to recent research on the number of children with a mental health condition we estimate that between 1 in 4 and 1 in 5 children with a mental health condition received helped last year[2].
2. **The overwhelming majority of NHS mental health spending goes towards those with the most severe needs.** Our analysis shows that:
    - 38% of NHS spending on children's mental health goes on providing in-patient mental-health care. This is accessed by 0.001% of children aged 5-17[3].
    - 46% of NHS spending goes on providing CAMHS community services, these are accessed by 2.6% of children aged 5-17.
    - 16% of NHS spending goes on providing universal services. This need to support the one in ten children who are thought to have a clinically significant mental health condition but are not accessing CAMHS. It also needs to support a – currently unknown – number of children with lower level needs, who would be less likely to develop a more serious mental health condition if they were provided with timely support.
3. **This is despite the fact that early intervention is much cheaper to deliver[4]:**
    - £5.08 per student – the cost of delivering an emotional resilience program in school
    - £229 per child – the cost of delivering six counselling or group CBT sessions in a school
    - £2,338 – the average cost of a referral to a community CAMHS service
    - £61,000 - the average cost of an admission to an in-patient CAMHS unit=

    And highly cost-effective in preventing conditions escalating:

    The Department of Health estimate that a targeted therapeutic intervention delivered in a school costs about £229 but derives an average lifetime benefit of £7,252[5]. This is cost-benefit ratio of 32-1.
4. **Our research shows that the Government's much vaunted prioritisation of mental health has yet to translate into change at a local level.** The current system for providing children's mental health care is neither transparent nor accountable and the Government have failed both to put clear expectations onto local NHS areas as to what should be provided or to monitor what is provided. In particular, the NHS are still failing to identify:

[1] Figures on those entering treatment taken from the NHS Forward-View Dashboard. Population figures taken from ONS Table SAPE18DT5: Mid-2015 Population Estimates for CCG in England
[2] See page 11
[3] Spending figures from NHS England's CYP Mental Health Services Baselining Report, Jan 2016, population figures as before.
[4] See page 18
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

- How many children are referred to CAMHS but don't receive treatment
- How long children wait from the date they are referred to the date they enter treatment
- How many children drop out of treatment
- Whether the treatment is effective at improving children's mental health

5. **There is a massive discrepancy between children's and adult's mental health. Our analysis shows local areas spend an average of 6% of their mental health budget on children, despite children making up around 20% of the population.** NHS England monitors 39 local measures for adult mental health but only nine for children's mental health.
6. **Most local areas are failing to meet NHS benchmarks for improving services and providing crisis care.**
    - Nearly 60% of local areas are failing to meet NHS standards on improving services
    - Over 55% of local areas are failing to meet NHS standards on providing crisis care in A&E and other settings

Recommendations

The forthcoming Green Paper presents an opportunity to transform children's mental health services. Its ambition should be to bring about a system designed around three principles:

1. A mental health service that is designed for children and built to meet their needs.
2. A service that supports children in the right place at the right time.
3. High quality, evidence based services, from the classroom to hospital care.

In order to achieve this, the Green Paper needs to set clear expectations as to what a child can expect in terms of mental health support and achieve consistency in every area of the country, and whose responsibility it is to provide this. To underpin this, we need a more transparent and accountable system.

Part 1: Transforming Provision

The Green Paper should set out clear expectations as to what a child can expect in terms of mental health support. In particular, it should seek to ensure:

- That every child benefits from teaching and a school environment which helps them build up emotional resilience
- That any child who needs it can access early support for problems when they first start to emerge. This could include parenting support or a short course of therapy.
- That any child with a more serious condition is able to access high-quality, specialist support within clear waiting time standards.
- That when there is a clear clinical need for in-patient care, that children can access this without delay, as close to their home as possible, and for no longer than is necessary. For this to happen, in-patient services needed to be integrated with community services.

In order for this happen, the Green Paper needs to make it clear which bodies are responsible for providing each element of this support with clear expectations placed on:

- Schools
- Local Authorities
- Clinical Commissioning Groups
- NHS England

These organisations need to be held to account on their performance.

Part 2: Creating an Accountable and Transparent System

Schools

All schools should:

- Establish a positive environment which promotes children's wellbeing
- Teach children of all ages about mental health and wellbeing
- Have a lead professional and a clear mental health policy

- Schools should be an access point for early support for children with emerging problems. such as short courses of therapy. Where possible, this should be provided within the school. The Green Paper should be clear that council and NHS budgets should help to fund these services.
- Where children have more serious needs, schools should be a referral point into specialised services.

The Department for Education should continue to work with bodies such as the Educational Endowment Fund and the Early Intervention Foundation to build-up a clear evidence base for schools and Ofsted should be clear about what they will expect as part of their inspection framework.

Local Authorities

- Low-level mental health issues amongst children should be a clear priority for local authorities, and they should use their public health funding to support early intervention and support for those with emerging needs. Clear statutory guidance should be set outlining a minimum level of provision.
- Local authorities should be required to report on what services they are offering and how much they are spending.

Clinical Commissioning Groups (CCGs)

- NHS England should place a clear expectation on CCGs that they should be providing a comprehensive and integrated package of targeted and specialised provision in their local area. This must include early intervention services.
- This support should include, where appropriate, easy to access, drop-in support provided by the voluntary sector or via online platforms.
- Each CCGs should be required to report on:
    - The number of referrals received to Children and Adolescent Mental Health Services (CAMHS)
    - A measure for assessing these referrals within a clear waiting time
    - The outcome of these referrals, including:
        - What proportion were turned away
        - What proportion were accepted into specialist provision
        - What proportion received some other form of provision
    - For those referrals which are accepted, local areas should report:
        - What proportion of children start treatment:
            - Within one week for urgent referrals
            - Within one month for non-urgent referrals
        - What proportion of children drop out of treatment
        - What proportion of children complete treatment, and what are their treatment outcomes.

        - There should be national NHS standards on waiting times, drop-out rates and the proportion of children accepted into treatment

- The NHS should hold local areas to account to ensure they are spending all the additional funding they have received on children's mental health, that this is not offsetting cuts elsewhere, and that this is combined with effective local transformation plans.
- In 2018 when new data is available on the level of need, clear targets should be set to increase the proportion of NHS funding spent on children's mental health. This should be in line with this level of need and based on the proportion of young people with an identified mental health problem who are accessing treatment.

Briefing: the Children's Mental Health System in England

Background

In November 2014 the Health Select Committee's **report** into children's mental health found that "The lack of reliable and up to date information about children's and adolescents' mental health and CAMHS means that those planning and running CAMHS services have been operating in a fog"[6]. The Committee's finding was backed up by the Government's own mental health taskforce, whose 'Future in Mind' report concluded that "significant gaps in data and information" is one of the major challenges in improving CAMHS services[7].

That Health Select Committee Report is 3 years old this autumn. Since its publication we've had several significant developments: as well as the publication of 'Future in Mind', we've had NHS England's "Five Year Forward View for Mental Health" and major announcements from the Government in March 2015 and January 2017 promising action and extra investment to deliver a 'transformation' in children's mental health.

We are expecting further significant announcements over the next 12-months. The Government have committed to publish a Green Paper on children's mental health this autumn. This should be informed by a thematic review of services currently being undertaken by the Care Quality Commission and Ofsted.

Ahead of the Government's Green Paper the Children's Commissioner's Office has analysed the information which is available on children's mental health to inform Parliamentarians and others explaining:

1. What we know and what we do not know
2. Why gaps exist and why they matter

[6] https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf (p3)
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (p13)

Section 1: What we know and what we don't know

Prevalence

The last nationwide survey of children's mental health was completed in 2004. This survey found that[8]:

- Overall, 9.6% of children aged 5-16 have a mental health disorder, which is comprised of:
    - 7.7% of children aged 5-10 having a mental health disorder
    - 11.5% of children aged 11-16 having a mental health disorder

This is often rounded up to 10% of children, and this assumption of prevalence underpins planning of children's mental health provision at both local and national level[9]. But we don't know whether this assumption is still valid. Since 2000 we have had three nationwide surveys of adult mental health (2000, 2007, 2014) but only one survey amongst children (2004). The adult surveys have shown a steady increase in mental health issues, particularly amongst young women. They have also shown an increase in rates of particular conditions, such as Bi-Polar Disorder or PTSD. These surveys have also added greatly to our knowledge of the risk factors associated with poor mental health, and particularly undiagnosed mental health issues. For example, we know how much greater the prevalence of poor mental health is amongst those living in poverty and we know that certain BME groups are much less likely to be accessing treatment.

Our knowledge of the prevalence rates amongst children is much more limited and the next prevalence study of children is not expected to report until 2018[10].

In the interim, the closest thing we have to a national prevalence study comes from Millennium Cohort Study (MCS), a longitudinal study of over 10,000 children born in the year 2000. The MCS conducted detailed assessments at aged 7, 11 and 14. They found that:

- At age 7, about 7% of both boys and girls have a diagnosable mental health condition.
- At age 11, about 12% of both boys and girls have a diagnosable mental health condition
- At age 14, about 12% of boys and 18% of girls have a diagnosable mental health condition[11].

Overall, these findings suggest that mental health conditions amongst adolescents have increased, with the most significant increase amongst teenage girls. The 2004 prevalence survey found that amongst adolescents, mental health conditions were 30% more common amongst boys than girls[12], while the MCS research found that conditions were 50% more likely amongst girls. When looking at only at depression, the findings were even starker, with 24% of girls being found to be depressed, but only 9% of boys. It is important to note that the MCS findings are in-line with the most recent

[8] http://content.digital.nhs.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf
[9] For example of local level planning see http://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/jsna/cyp-jsna/mental-health-of-children-and-young-people/ for national level uses of this data see the 'Future in Mind' report, above.
[10] http://www.natcen.ac.uk/blog/mental-health-%E2%80%93-how-are-children-and-young-people-affected
[11] www.cls.ioe.ac.uk/shared/get-file.ashx?itemtype=document&id=3338
[12] http://content.digital.nhs.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf

adult prevalence survey (conducted 2014), which found that 26% of females and 9% of males aged 16-24 had a common mental disorder[13].

The MCS findings suggest that prevalence of conditions amongst adolescents is significantly higher than the NHS England had previously estimated. This corresponds with a series of other indications that pressure on children's mental health services are increasing. In January 2017 NHS Digital released figures showing that that the number of A&E admissions amongst children for mental health reasons had doubled in five years[14].

Schools are regularly at the forefront of dealing with mental health issues and a survey of Headteachers conducted last year found that over half thought CAMHS services were poor and 65% had struggled to find mental health support for children who need it[15]. Research from Centre Forum and the Education Policy Institute in 2016 analysed the referrals thresholds set by CAMHS providers and found that "Something has to go drastically wrong before some services will accept a referral; the antithesis of an early intervention approach"[16].

None of these negates the urgent need for a comprehensive and detailed survey of children's mental health needs. In particular, this is needed to identify the levels of lower-level mental health need and the risk factors for poor mental health. The Millennium Cohort Study did enable some analysis of the links between poverty and mental health showing that children growing up in poorer families were more likely to have mental health issues. This complements existing research showing higher prevalence rates amongst certain groups of children. For example, it is estimated that 60% of children in care[17] have a clinically significant mental health condition and that mental health issues are more common amongst LGBT teens[18]. But we are unable to properly compare risk factors or understand how they combine to increase the risk of poor mental health. Improving our understanding of these links is a key aim of the Children's Commissioner's work to assess the levels of childhood vulnerability and how this affects children's outcomes[19]. Understanding these risk factors is also a necessary condition for local areas to be able to make a detailed estimate of the likely level of need in their area and set budgets accordingly.

Treatment

Treatment for children's mental health is divided into four tiers[20]:

- Tier 1 covers universal provision by non-specialists in universal settings. It includes early intervention and preventative programmes aimed at improving well-being and resilience. Much of this provision is delivered in schools. As the Health Select Committee pointed out in their 2014 report, local authorities should be providing early intervention services through the public health functions which were transferred to them through the Health and Social Care Act.

[13] http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-cmd.pdf
[14] http://www.bbc.co.uk/news/health-38576368
[15] https://www.ascl.org.uk/download.D91C5B0A-72A6-4117-96A9B343E51FB296.html
[16] https://epi.org.uk/wp-content/uploads/2016/05/State-of-the-Nation-report-web.pdf
[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf
[18] http://www.metrocharity.org.uk/sites/default/files/2017-04/National%20Youth%20Chances%20Intergrated%20Report%202016.pdf
[19] https://www.childrenscommissioner.gov.uk/publication/childrens-commissioners-report-on-vulnerability/
[20] http://www.icptoolkit.org/child_and_adolescent_pathways/about_icps/camh_service_tiers.aspx

- Tier 2 is provision for those with less severe issues delivered by mental health practitioners working in universal or primary care settings. This could be counselling or CBT delivered in schools or GP surgeries or counsellors working in schools and youth services. NHS England's model guidance[21] on the provision of Tier 2 recommends commissioning a service that can be accessible from a range of locations and address a range of conditions. But the guidance isn't explicit about who should commission this, rather it suggests that responsibility lies between local authority children's services, local authority public health functions, local Clinical Commissioning Groups and other agencies. Consequently, this support is not consistent across the country.
- Tier 3 is specialist out-patient provision delivered by the CAMHS service, including different disciplines (therapists, psychiatrists etc) to treat persistent and complex mental health treatment. This is all commissioned by local CCGs.
- Tier 4 is in-patient care and some highly specialised care, such as CAMHS for deaf children. This includes specialist in-patient settings for eating disorders and for children who need to be held securely because they pose a significant risk to themselves or others. This is all commissioned nationally by NHS England[22], though some of it is administered by NHS England's seven regional offices.

As part of the transformation agenda following the publication of Future in Mind, local providers have started to move away from using a Tiers model, and further areas are planning to move away from Tiers in the future. We have set out the information in this report by referring to Tiers because we think it is important to distinguish between:

- Universal services for all children
- Targeted provision for children with low-level needs/early intervention
- Specialist provision for children with a diagnosable condition
- In-patient care

Regardless of whether Tiers continue to be used in the future, it is important for us to be able to assess how many children are accessing each type of service.

What do we know about the provision of treatment at each level?

Universal services

This year the Department for Education, in collaboration with NatCen conducted a detailed survey of provision within schools to promote mental-health and well-being. In responding to the survey 73% of schools reported that they had some provision in place to help children develop resilience and emotional well-being (e.g. coping skills, problem-solving or mindfulness)[23]. Overwhelmingly this was funded from school budgets, which are themselves under severe pressure and means that what in-school services we have are at risk

[21] https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-tier-2-3-spec.pdf
[22] Some commissioning will be transferred to lead providers as part of new care models, but NHS England will retain overall responsibility.
[23] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/634725/Supporting_Mental-Health_synthesis_report.pdf

Outside of the school context, no information is collected or published nationally on spending or provision of universal services. In 2014 the Health Select Committee found that early intervention services were, "in many areas suffering from insecure or short term funding, or being cut altogether" they therefore recommended "that, given the importance of early intervention, the DH/NHS England task force should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services"[24]. In response, the Future in Mind report reiterated the importance of early intervention, but didn't conduct any type of audit of current provision. Instead, all seven 'Finance Indicators' published by Public Health England[25] in relation to community children's mental health spending are in fact indicators of local authority spending on children's services or youth justice spending.

Targeted services for those with emerging problems

Again, the DfE and NatCen survey gives us some indication of what provision is in place within schools: 61% of schools in England reported that they offer counselling for children with an identified need for support. Overwhelmingly, this was funded by the schools themselves out of their core budget, though 17% of schools did report receiving some support (financial or otherwise) from local CAMHS services. However, as with universal services, there is no information collected nationally either on provision or funding. This means we don't what, if any, services are being funded by CCGs or through public health funding, or anything about the quality of what services are being provided. Nor do we know how many local areas are following the NHS model guidance in providing an integrated Tier 2 and Tier 3 service.

Specialist outpatient support

There are two possible sources of information on children accessing more specialist services. The first is the Mental Health Services Monthly Statistics (MHSMS), a dataset held by NHS Digital which has national and local level information relating to both adult and children's mental health. The second is the 'Mental Health Forward View Dashboard' (the Dashboard) which was introduced following the 'Future in Mind' reforms and with the aim of showing key indicators which reflect how well local areas are doing at providing mental health

However, both the MHSMS and the Dashboard only record information on children who are accepted into the CAMHS system. Neither capture information on children who are referred into treatment, but whose referral is refused. Having a referral accepted by CAMHS is a threshold that many children will not meet. Overall, NHS England estimates that about 1/3rd of CAMHS referrals are rejected[26], but precise information isn't collected.

In an attempt to understand more about the number of children who are rejected last year the Children's Commissioner's Office conducted a survey of CAMHS providers under the statutory powers bestowed on the Commissioner by the Children's Act 2004. This survey found that 79% of providers reported imposing thresholds on access to services and nearly a third of referrals were

[24] https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf (p3)
[25] https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/0/gid/1938133094/pat/6/par/E12000004/ati/102/are/E06000015/iid/90914/age/173/sex/4
[26] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/08/nhse-camhs-baselining-summary1.pdf (p3)

rejected without a child accessing treatment or being offered treatment[27]. Of particular worry was the regional variation, with one area reporting that 75% of referrals were turned away. Overall, less than 20% of children in the South East were turned down for treatment, but nearly 45% of children in the East of England were turned down.

Similar findings have recently been found by the Educational Policy Institute in their September 2017 Report. Their research indicated that nearly a quarter of referrals (26.3%) to specialist services were not accepted for 2016/17 a significant increase from 2015/16[28] as a result of increasing thresholds across in-patient services[29].

Once a referral is accepted by CAMHS services it is recorded in the Mental Health Services Monthly Statistics (MHSMS), which captures information both on referrals which are accepted by a CAMHS service, and on the number of children entering treatment.

There are several things we can learn from the MHSDS:

- The latest release shows that, during May[30] 2017 there were 344,434 open referrals during the month. This includes children who are in treatment and children who are awaiting treatment.
    - Of these, 160, 046 are referrals within the CAMHS system
    - A further 184,388 are referrals of children to adult mental health services[31]
- There were 42,562 children who had a new referral accepted by CAMHS or adult mental health services during May. This figure includes both first time-referrals and onward referrals (i.e. first into a CAMHS service, and then onto a specialist team) so it does not show how many children were referred into mental health services for the first time.
- 105,824 attended treatment in mental health services during the month. A further 147,929 children were registered as being 'in-contact' with services, but not actually receiving treatment. NHS Digital were not able to tell us what proportion of these children were already accessing treatment and how many were on a waiting list.

Relatively small changes to the MHSDS could give us significant new amounts of information on the CAMHS system. Firstly, it would be helpful if NHS Digital separately recorded the number of referrals into CAMHS, and then onward referrals. So we know how many children are referred into the CAMHS system. This is recorded separately in the underlying data-set[32]. Similarly, it would be helpful if the MHSDS recorded the number of children awaiting their first care contact separately from those who had received care and were awaiting a follow-up. This would show us waiting lists.

More fundamentally, there is a lot of information which is not collected on the MHSDS which could be helpfully collected on a new dataset. This includes:

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[27] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Childrens-Commissioners-Mental-Health-Lightning-Review.pdf

[28] https://epi.org.uk/wp-content/uploads/2017/09/EPI_Access-and-waiting-times_.pdf

[29] https://epi.org.uk/wp-content/uploads/2016/05/State-of-the-Nation-report-web.pdf

[30] http://digital.nhs.uk/catalogue/PUB30060

[31] *NHS Digital have not been able to explain why so many children appear to be getting referred into adult mental health services, and whether this is an issue with the way the data is collected or whether children are being referred into adult services in large numbers.*

[32] http://content.digital.nhs.uk/media/22776/MHSDSv20DataModel/pdf/MHSDS_v2.0_Data_Model.pdf

- The number of children referred for the first time and what proportion of referrals are accepted
- The types of treatment children receive (i.e. talking therapies)
- How long they wait from the referral being made to starting treatment
- Outcomes of treatment

All this information is contained in the mental health statistics for adults.

Again the Children's Commissioner has attempted to address some of these gaps in our knowledge through a survey of CAMHS provider last year, with further research conducted by the Educational Policy Institute this year. Both surveys found waiting times varied considerably between areas – from one provider in the West Midlands with an average waiting time of over 200 days to one in North Wales with an average waiting time of 14 days[33]. The waiting time for an appointment in Tyneside was five times longer than neighbouring Newcastle[34]. Of particular concern was the waiting times experienced by children who were referred with what were classified as 'life threatening conditions', who experienced an average wait of 112 (16 weeks) days before entering treatment.

In contrast there is regular information collected and published for some adult waiting times for mental health. For example, we know that across England, 90% of adults wait less than six weeks to access psychological therapies, regardless of condition. Less than 1% of adults accessing psychological therapies waited more than 18 weeks[35]. We also have different indicators depending on the type of condition, type of service being accessed and indicators on readmission rates.

In an attempt to improve the performance of CAMHS services in 2016 the NHS Forward View Dashboard for Mental Health introduced nine new indicators for monitoring CAMHS treatment at a local and national level. These include the number of children entering CAMHS treatment, spend on CAMHS services, the number of children entering Tier 4 treatment, stays in adult in-patient care and two measures of service improvement.

There are some measures on the dashboard which already appear to be driving improvements. For example, the dashboard records the number of children taken to a police cell as a 'place of safety' under the Mental Health Act, this has consistently fallen over the past year to 35 for the last quarter of 16-17. The Dashboard also shows a steady-fall in the number of children admitted to adult psychiatric wards.

All these indicators are important. In particular, it is helpful for us to get an indication of the number of children within an area entering CAMHS treatment. The latest release, covering January-March 2017, shows that 42,406 children entered CAMHS treatment for the first time. Figures are also available at regional and CCG level, with significant regional variation (see Annex 2). Because first time referrals into the CAMHS system are not collected, it is not possible to compare the number of children entering treatment with the numbers being referred for treatment.

The most useful part of the dashboard for assessing the performance of individual area are the two indicators which show whether local areas are meeting NHS England's benchmarks around CAMHS

[33] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Childrens-Commissioners-Mental-Health-Lightning-Review.pdf (p12)
[34] https://epi.org.uk/wp-content/uploads/2016/05/State-of-the-Nation-report-web.pdf
[35] https://www.england.nhs.uk/mental-health/resources/access-waiting-time/

provisions which were introduced following 'Future in Mind' in 2016. The first of these indicators is a self-assessed indicator of service improvement. Nearly 60% of local NHS areas are failing to meet the expected rate of improvement. The second indicator, also self-assessed is whether a local area is meeting NHS guidelines on providing a CAMHS crisis service out-of-hours to attend to children who present in A&E and other settings. Over half of local areas are failing to meet this benchmark.

The latest version of the Dashboard – covering the final quarter of 2016-17 –introduces additional measures showing waiting times for children with an eating disorder. The Dashboard shows that nearly 70% of urgent referrals start treatment within one week and nearly 80% of routine referrals start treatment within four weeks. Separately, NHS England have told us[36] of a significant increase in the number of children accessing eating disorder treatment, from 1,154 in the 3 months to June 2016, to 1,636 in the same period 2017.

Inpatient care

There are still significant gaps in the information recorded and released which means we do not have information about:

- How many children have to travel out of area to access treatment
- How many children are referred for in-patient treatment but not accepted and why this is.
- For children who do enter treatment, how long do they have to wait for a bed to become available, and what happens to them while they are waiting.

Much of this information on both sectioning and out-of-area placements is collected and published for adults[37]. Some of this information was previously collected and published for children. In 2014, 15% of children requiring a general adolescent bed needed to travel 'out-of-area' but over half of children needing a low-secure bed were sent out of area[38]. For referrals, the latest data we have covers the 2012 to 2013 period and shows a significant rise in referrals over the period. At that time the primary reason for a referral not being accepted was that no suitable bed was available[39]. This data has not been collected or published since 2014.

The Children's Commissioner is currently undertaking two projects in an attempt to increase our understanding of Tier 4 provisions. Using the Commissioner's statutory data access, we have requested information from NHS Digital to enable us analyse the distances children are currently travelling to access Tier 4 beds. We are hoping to complete this analysis later this year to inform NHS England's implementation of the Prime Minister's commitment that by 2021 no child will have to travel 'out-of-area' to access a general Tier 4 bed[40].

Outcomes

For adult mental health treatment, information is recorded and published on whether patients improved after treatment and how many are re-admitted. No information is published on the outcomes children achieve after entering treatment.

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[36] Information provided by NHS England to the Children's Commissioner in correspondence.
[37] https://digital.nhs.uk/catalogue/PUB30021
[38] https://www.kingsfund.org.uk/sites/default/files/media/Margaret%20Murphy%20presentation.pdf
[39] https://www.kingsfund.org.uk/sites/default/files/media/Margaret%20Murphy%20presentation.pdf
[40] https://www.gov.uk/government/speeches/the-shared-society-prime-ministers-speech-at-the-charity-commission-annual-meeting

Spending

The Forward View Dashboard includes a self-reported figure for how much each CCG is spending on CAMHS in absolute terms. We have analysed these returns (see Annex 2) and found that on average each CCG spends 6.3% of their mental health budget, or 0.74% of their overall budget, on children's mental health. Our analysis also shows significant regional variation, with local areas spending from 0.2% to 9% of their mental health budget on children.

Because there are fewer reporting requirements on CAMHS than other areas of NHS spending, there is a strong temptation for CCGs to transfer the additional money the Government have allocated to expanding CAMHS to plug funding gaps in existing services. Research conducted by the charity Young Minds found that only 36% of CCGs spent all the additional funds they were allocated by the Government for CAMHS on CAMHS[41].

In 2015 NHS England estimated that 7% of overall NHS mental health funding[42] goes on children. In addition, some funding comes from local authorities such that overall spending on children's mental health breaks down as follows[43]:

- 38% of spending comes from NHS England and is spent on in-patient and highly specialised care. This is accessed by about 0.001% of children aged 5-17 each year.
- 46% of spending comes from CCGs and is spent on CAMHS services. We estimate this is accessed by 2.6% of children each year.
- 16% of spending comes from local authorities under their public health remit. This includes universal preventive services and support for those with emerging conditions. This is supporting all the children who are not accessing CAMHS.

That leaves just 16% of spending – which we suspect varies considerably across the country – supporting both the children who have a mental health condition but aren't accessing a CAMHS service, and those children at high risk of developing a mental health condition. There is clear evidence that providing these children with more timely support would reduce demand elsewhere on the system.

Anecdotally, we hear from schools and school providers that it is becoming harder for children to access specialist CAMHS services. This may also be behind the steep rise in A&E attendances for MH reasons amongst children. Making specialist services harder to access also increases the strain on universal targeted services, provided by schools and other non-NHS organisations.

This is in spite of the fact that we have clear evidence to show that early intervention is cheap, effective and cost-saving. The cost of providing mental health support is estimated as:

- £5.08 per student – the cost of delivering emotional resilience program in school[44]
- £229 per child – the cost of delivering six counselling or group CBT sessions in a school[45]
- £2,338 – the average cost of a referral to a community CAMHS service[46]

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[41] https://youngminds.org.uk/about-us/media-centre/press-releases/children-s-mental-health-funding-not-going-where-it-should-be/

[42] This figure is different to the 6.36% figure we identify, as it includes spending by NHS England on specialised commissioning, such as children's in-patient treatment or adult forensic services.

[43] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/08/nhse-camhs-baselining-summary1.pdf

[44] https://www.gov.uk/government/news/phe-highlights-8-ways-for-local-areas-to-prevent-mental-ill-health

[45] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

[46] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/08/nhse-camhs-baselining-summary1.pdf (p11)

- £61,000 - the average cost of an admission to an in-patient CAMHS unit[47]

Not only is provision much cheaper if delivered earlier, it is also more (cost) effective:

- Public Health England estimates that every £1 invested in emotional resilience programs in schools has a £5 benefit realised over 3 years.
- The Department of Health's 'Future in Mind' taskforce estimated that a targeted, group-CBT program delivered in a school cost £229 but derived an average lifetime benefit of £7,252[48]. This is cost-benefit ratio of 32-1.

[47] https://static1.squarespace.com/static/58d8d0ffe4fcb5ad94cde63e/t/58ecf71de58c62adea37fa27/1491924766551/BenchmarkingMentalHealthCard2017FINAL.pdf
[48] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Section 2: Why do we know so little? Why does this matter?

Why do we know so little?

Part of the problem in tracking the provision in children's mental health services is the complexity of the system. In-patient care is commissioned nationally by NHS England from a range of NHS, charitable and private providers. Specialist community CAMHS services are commissioned locally by CCGs and then universal services are provided by a mixture of CCGs, local authorities under their public health function, children's services as well as individual schools and colleges. On top of this is a complex regulatory framework. While most areas have an NHS Mental Health Trust, which will be overseen by NHS Improvement as well as the CQC (who will also inspect all in-patient services) other provision may fall under the CQC, or - if delivered in a school - Ofsted, or, in the case of talking therapies provided in non-NHS settings it may not be inspected at all.

This complexity is compounded by a lack of information and transparency. Transparency is needed to ensure that children do not fall between the gaps between services, and responsibility is not passed from one agency to the next.

There is much better data available on adult mental health. This is because there are much clearer expectations of what should be delivered in terms of adult mental health, and performance against these expectations is monitored. While no-one inspects CCGs, NHS England does retain overall responsibility for the commissioning of healthcare, and they do this through measuring performance via a set of indicators. There are over 1900 past and present health indicators published in England to monitor the performance of each area against national benchmarks. But until last year, we had no indicators at all for child mental health. We now have eleven in the NHS England Forward View Dashboard, compared to thirty-nine for adult mental health. NHS indicators play a vital role in reducing the risk of a postcode lottery in service provision. Of particular importance in improving CCG performance are the 'Clinical Commissioning Group Outcomes Indicator Set'[49] these include sixty-five indicators covering health issues as diverse as hip fracture rates to babies born underweight and cancer survival rates. NHS England have now included three adult mental health indicators within the priority indicator set, but there are no child mental health indicators included.

In 2014, the Health Select Committee recommended that "service specifications for Tier 2 and 3 services should set out what reasonable services should be expected to provide". But this recommendation has not yet been implemented. Instead NHS England have published a 'model specification'[50]. This outlines a process whereby the level of need for services is identified by the local authority in the 'Joint Strategic Needs Assessment' and then the CCG commissions Tier 3 services, backed up by universal services provided by other bodies (namely the local authority in its public health function, children's services, GPs and others). In between this are the 'targeted services' which fall under Tier 2. These are services provided to individual children with an identified need. NHS England recommends that the provision of Tier 2 services be 'integrated' with Tier 3 services, but they fail to clarify who should fund these services. Despite the guidance being clear that Tier 2 interventions should

[49] http://content.digital.nhs.uk/catalogue/PUB23691/ccg-ind-mar-17-comm.pdf
[50] https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-tier-2-3-spec.pdf

be provided by mental health professionals, the Government has not placed an expectation on any part of the system to provide it. They provide model commissioning specifications to CCGs should they choose to commission such services, and they say that such services should be integrated with Tier 3 services, but they do not specify how they should be funded. This is the same with all elements of the 'model specification'. They exist to encourage local areas to adopt good practice, but there is no requirement on local areas to follow them, and no monitoring of whether they are adopted.

There is a similar discrepancy with Government attempts to increase use of psychological therapies. For adults, 'The Improving Access to Talking Therapies (IAPT)' programme is provided solely by NHS bodies[51]. The programme intends to improve access to therapy and use clinical evidence to improve outcomes achieved in therapy, it creates standalone IAPT services and IAPT access routes. The programme has evolved over time, first being introduced in 2008, and then refined in 2011 and 2015, when the ambition was set that 1.5m adults a year will access by 2021. To ensure this ambition is realised, NHS England monitor local-level performance in terms of spend on talking therapies, waiting times, treatment completion rate and the number of patients moving to recovery. They also monitor the number of vulnerable groups accessing treatment.

Children weren't included in either of the first two iterations of the IAPT programme. In 2015 NHS England's introduced 'Improving Children's Access to Talking Therapies Programme'[52]. While there is a lot of positive content in this programme, it is fundamentally different from the adults programme in that it seeks to improve existing services, rather than create new standalone services or increase capacity. Because of this, the programme did not include the same level or targets or monitoring as the adult programme.

Why does this matter?

The Government's 2015 strategy Future in Mind concluded that "*A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities*" creates a system "*with the potential for children and young people to fall though the net*"[53]. This risk that children are falling through the gaps between services is of particular concern. There is a wealth of evidence as outlined above, on the problems children face accessing mental health care.

In addition, through the Children's Commissioner helpline for children in care, Help at Hand, we regularly encounter children in urgent need of mental health support.

Together this suggests a crisis in children's mental health, but a crisis where those responsible for the system are operating in the dark, without important information about the scale of the problem. The system in place at present is such that a local area can be refusing 64% of CAMHS referrals, or placing children on indefinite waiting lists or putting in place arrangements such that children regularly fail to enter treatment even after having their referral accepted, and we would not even know.

[51] https://www.england.nhs.uk/mental-health/adults/iapt/
[52] https://www.england.nhs.uk/mental-health/cyp/iapt/
[53] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (p14)

Frustrations with the CAMHS system are not limited to those looking in from the outside. The Secretary of State for Health, Rt. Hon Jeremy Hunt MP described children's mental health services as "possibly the biggest weakness in NHS provision at the moment"[54]. He went on to describe a situation where the NHS was "letting down too many families and not intervening early enough when there is a curable mental health condition, which we can do something about when a child is eight or nine".

[54] https://www.hsj.co.uk/sectors/mental-health/hunt-vows-to-act-on-nhss-biggest-area-of-weakness/7011628.article?blocktitle=&contentID=

Annex 1: The Performance of Local Areas

CCG Name	Improvement Benchmarks[i]	Crisis Care Benchmarks[ii]	% of children aged 5-17 accessing CAMHS during 2016-17[iii]	CAMHS Spend Per Child (under 18)[iv]	% of CCG Budget Spent on CAMHS[v]
England Average	**n/a**	**n/a**	**2.62%**	**£49**	**0.74%**
NHS Airedale, Wharfedale and Craven	30.0%	Fully compliant	2.42%	£37	0.61%
NHS Ashford	70.0%	Partially compliant	3.40%	£49	0.87%
NHS Aylesbury Vale	90.0%	Fully compliant	2.84%	£39	0.71%
NHS Barking and Dagenham	15.0%	Fully compliant	2.71%	£69	1.36%
NHS Barnet	95.0%	Partially compliant	4.05%	£58	1.11%
NHS Barnsley	95.0%	Partially compliant	4.70%	£84	1.00%
NHS Basildon and Brentwood	70.0%	Fully compliant	2.63%	£43	0.76%
NHS Bassetlaw	100.0%	Partially compliant	2.62%	£55	0.78%
NHS Bath and North East Somerset	90.0%	Fully compliant	2.13%	£71	1.06%
NHS Bedfordshire	85.0%	Fully compliant	1.30%	£65	1.32%
NHS Bexley	95.0%	Partially compliant	1.83%	£49	0.91%
NHS Birmingham CrossCity	90.0%	Fully compliant	1.27%	£49	0.91%
NHS Birmingham South and Central	90.0%	Fully compliant	1.92%	£92	1.13%
NHS Blackburn with Darwen	80.0%	Partially compliant	0.22%	£47	0.72%
NHS Blackpool	70.0%	Partially compliant	4.22%	£69	0.69%
NHS Bolton	85.0%	Partially compliant	2.86%	£51	0.76%
NHS Bracknell and Ascot	90.0%	Fully compliant	1.64%	£44	0.90%

NHS Bradford City	80.0%	Fully compliant	1.35%	£30	0.51%
NHS Bradford Districts	80.0%	Fully compliant	2.03%	£41	0.73%
NHS Brent	95.0%	Fully compliant	2.61%	£34	0.58%
NHS Brighton and Hove	35.0%	Partially compliant	2.65%	£23	0.31%
NHS Bristol	95.0%	Partially compliant	0.09%	£59	0.95%
NHS Bromley	40.0%	Not compliant	1.92%	£47	0.77%
NHS Bury	90.0%	Partially compliant	2.81%	£45	0.68%
NHS Calderdale	90.0%	Partially compliant	1.62%	£34	0.49%
NHS Cambridgeshire and Peterborough	35.0%	Fully compliant	2.18%	£45	0.85%
NHS Camden	95.0%	Partially compliant	3.02%	£124	1.49%
NHS Cannock Chase	35.0%	Partially compliant	8.59%	£71	1.35%
NHS Canterbury and Coastal	70.0%	Partially compliant	3.51%	£60	0.79%
NHS Castle Point and Rochford	80.0%	Partially compliant	2.65%	£33	0.43%
NHS Central London (Westminster)	95.0%	Partially compliant	3.46%	£28	0.27%
NHS Central Manchester	90.0%	Partially compliant	5.22%	£60	0.84%
NHS Chiltern	90.0%	Fully compliant	2.18%	£41	0.84%
NHS Chorley and South Ribble	30.0%	Partially compliant	0.39%	£38	0.53%
NHS City and Hackney	90.0%	Fully compliant	1.99%	£79	1.19%
NHS Coastal West Sussex	95.0%	Fully compliant	2.26%	£45	0.55%
NHS Corby	20.0%	Partially compliant	5.03%	£61	0.93%
NHS Coventry and Rugby	25.0%	Fully compliant	2.70%	£44	0.72%
NHS Crawley	45.0%	Fully compliant	1.78%	£28	0.46%
NHS Croydon	50.0%	Fully compliant	2.41%	£43	0.92%
NHS Cumbria	85.0%	Partially compliant	0.26%	£53	0.67%

NHS Darlington	90.0%	Fully compliant	5.76%	£70	0.96%
NHS Dartford, Gravesham and Swanley	20.0%	Partially compliant	3.07%	£42	0.70%
NHS Doncaster	85.0%	Partially compliant	1.56%	£49	0.65%
NHS Dorset	40.0%	Partially compliant	3.96%	£69	0.84%
NHS Dudley	85.0%	Fully compliant	0.64%	£64	0.94%
NHS Durham Dales, Easington and Sedgefield	90.0%	Fully compliant	8.66%	£71	0.77%
NHS Ealing	35.0%	Partially compliant	1.66%	£29	0.48%
NHS East and North Hertfordshire	90.0%	Fully compliant	2.03%	£54	0.91%
NHS East Lancashire	80.0%	Partially compliant	0.25%	£57	0.79%
NHS East Leicestershire and Rutland	35.0%	Fully compliant	2.50%	£27	0.43%
NHS East Riding of Yorkshire	95.0%	Fully compliant	2.45%	£49	0.75%
NHS East Staffordshire	35.0%	Partially compliant	7.63%	£25	0.44%
NHS East Surrey	90.0%	Fully compliant	1.16%	£47	1.04%
NHS Eastbourne, Hailsham and Seaford	50.0%	Fully compliant	4.14%	£12	0.14%
NHS Eastern Cheshire	90.0%	Partially compliant	1.43%	£47	0.66%
NHS Enfield	40.0%	Partially compliant	2.03%	£2	0.05%
NHS Erewash	95.0%	Fully compliant	3.10%	£43	0.58%
NHS Fareham and Gosport	90.0%	Partially compliant	2.89%	£45	0.70%
NHS Fylde & Wyre	80.0%	Partially compliant	0.53%	£39	0.48%
NHS Gloucestershire	95.0%	Fully compliant	2.82%	£60	0.89%
NHS Great Yarmouth and Waveney	30.0%	Partially compliant	3.90%	£22	0.26%
NHS Greater Huddersfield	90.0%	Partially compliant	1.85%	£28	0.44%
NHS Greater Preston	30.0%	Partially compliant	0.38%	£31	0.45%

NHS Greenwich	45.0%	Partially compliant	1.93%	£48	0.84%
NHS Guildford and Waverley	40.0%	Fully compliant	1.00%	£38	0.66%
NHS Halton	90.0%	Partially compliant	2.66%	£61	0.79%
NHS Hambleton, Richmondshire and Whitby	25.0%	Fully compliant	4.12%	£46	0.68%
NHS Hammersmith and Fulham	95.0%	Partially compliant	3.09%	£85	1.08%
NHS Hardwick	95.0%	Fully compliant	0.49%	£20	0.27%
NHS Haringey	100.0%	Partially compliant	3.09%	£50	0.86%
NHS Harrogate and Rural District	25.0%	Fully compliant	3.36%	£35	0.53%
NHS Harrow	95.0%	Partially compliant	2.14%	£27	0.51%
NHS Hartlepool and Stockton-on-Tees	40.0%	Fully compliant	8.38%	£104	1.44%
NHS Hastings and Rother	50.0%	Fully compliant	4.84%	£11	0.13%
NHS Havering	15.0%	Fully compliant	4.65%	£45	0.61%
NHS Herefordshire	45.0%	Fully compliant	3.26%	£47	0.74%
NHS Herts Valleys	90.0%	Fully compliant	2.06%	£48	0.87%
NHS Heywood, Middleton and Rochdale	90.0%	Partially compliant	2.67%	£65	0.94%
NHS High Weald Lewes Havens	45.0%	Partially compliant	3.34%	£68	1.04%
NHS Hillingdon	100.0%	Fully compliant	1.56%	£21	0.42%
NHS Horsham and Mid Sussex	45.0%	Fully compliant	1.83%	£24	0.45%
NHS Hounslow	45.0%	Partially compliant	2.79%	£17	0.31%
NHS Hull	85.0%	Fully compliant	3.13%	£66	0.92%
NHS Ipswich and East Suffolk	40.0%	Partially compliant	2.15%	£53	0.91%
NHS Isle of Wight	20.0%	Partially compliant	0.05%	£78	0.82%
NHS Islington	95.0%	Partially compliant	0.51%	£48	0.56%
NHS Kernow	25.0%	Not compliant	3.02%	£58	0.84%

NHS Kingston	50.0%	Fully compliant	2.14%	£35	0.53%
NHS Knowsley	35.0%	Partially compliant	1.65%	£44	0.48%
NHS Lambeth	35.0%	Not compliant	2.86%	£62	0.82%
NHS Lancashire North	80.0%	Partially compliant	0.46%	£35	0.48%
NHS Leeds North	90.0%	Partially compliant	0.87%	£47	0.70%
NHS Leeds South and East	90.0%	Partially compliant	0.77%	£65	0.90%
NHS Leeds West	90.0%	Partially compliant	0.89%	£50	0.65%
NHS Leicester City	35.0%	Fully compliant	2.06%	£28	0.46%
NHS Lewisham	50.0%	Fully compliant	2.71%	£32	0.50%
NHS Lincolnshire East	50.0%	Partially compliant	2.53%	£46	0.51%
NHS Lincolnshire West	50.0%	Partially compliant	2.29%	£37	0.51%
NHS Liverpool	70.0%	Partially compliant	2.89%	£78	0.81%
NHS Luton	85.0%	Fully compliant	1.46%	£63	1.44%
NHS Mansfield and Ashfield	100.0%	Partially compliant	2.59%	£45	0.64%
NHS Medway	25.0%	Partially compliant	2.41%	£30	0.52%
NHS Merton	85.0%	Fully compliant	3.15%	£48	0.81%
NHS Mid Essex	80.0%	Fully compliant	2.55%	£32	0.60%
NHS Milton Keynes	90.0%	Fully compliant	1.27%	£42	0.91%
NHS Nene	70.0%	Partially compliant	3.91%	£55	1.01%
NHS Newark & Sherwood	100.0%	Partially compliant	3.13%	£39	0.50%
NHS Newbury and District	45.0%	Fully compliant	1.41%	£57	0.95%
NHS Newcastle Gateshead	95.0%	Partially compliant	5.11%	£82	1.08%
NHS Newham	40.0%	Partially compliant	2.37%	£43	0.74%
NHS North & West Reading	45.0%	Fully compliant	1.43%	£58	0.96%

NHS North Derbyshire	95.0%	Fully compliant	0.24%	£12	0.13%
NHS North Durham	40.0%	Fully compliant	7.90%	£61	0.71%
NHS North East Essex	30.0%	Fully compliant	3.23%	£43	0.61%
NHS North East Hampshire and Farnham	85.0%	Partially compliant	2.04%	£53	0.84%
NHS North East Lincolnshire	100.0%	Partially compliant	2.12%	£75	1.10%
NHS North Hampshire	90.0%	Partially compliant	2.64%	£41	0.81%
NHS North Kirklees	40.0%	Partially compliant	1.49%	£27	0.50%
NHS North Lincolnshire	90.0%	Partially compliant	1.67%	£45	0.70%
NHS North Manchester	40.0%	Partially compliant	6.15%	£49	0.60%
NHS North Norfolk	30.0%	Fully compliant	1.80%	£25	0.32%
NHS North Somerset	95.0%	Not compliant	0.16%	£44	0.71%
NHS North Staffordshire	80.0%	Not compliant	4.40%	£38	0.56%
NHS North Tyneside	90.0%	Partially compliant	0.60%	£63	0.85%
NHS North West Surrey	90.0%	Fully compliant	0.63%	£46	0.74%
NHS Northern, Eastern and Western Devon	75.0%	Partially compliant	1.62%	£111	1.72%
NHS Northumberland	90.0%	Partially compliant	5.79%	£66	0.78%
NHS Norwich	80.0%	Fully compliant	1.95%	£31	0.46%
NHS Nottingham City	50.0%	Partially compliant	1.55%	£49	0.66%
NHS Nottingham North and East	100.0%	Partially compliant	2.72%	£43	0.64%
NHS Nottingham West	100.0%	Partially compliant	2.24%	£41	0.66%
NHS Oldham	90.0%	Partially compliant	2.11%	£42	0.66%
NHS Oxfordshire	45.0%	Fully compliant	3.70%	£45	0.74%
NHS Portsmouth	90.0%	Partially compliant	2.15%	£58	0.83%
NHS Redbridge	15.0%	Fully compliant	2.25%	£29	0.56%

NHS Redditch and Bromsgrove	40.0%	Fully compliant	1.91%	£40	0.66%
NHS Richmond	50.0%	Fully compliant	2.13%	£39	0.67%
NHS Rotherham	70.0%	Partially compliant	1.95%	£49	0.67%
NHS Rushcliffe	100.0%	Partially compliant	2.70%	£51	0.74%
NHS Salford	35.0%	Partially compliant	4.85%	£49	0.60%
NHS Sandwell and West Birmingham	75.0%	Partially compliant	1.43%	£28	0.45%
NHS Scarborough and Ryedale	25.0%	Fully compliant	5.19%	£55	0.63%
NHS Sheffield	45.0%	Fully compliant	3.01%	£35	0.49%
NHS Shropshire	85.0%	Partially compliant	0.24%	£33	0.47%
NHS Slough	90.0%	Fully compliant	0.93%	£40	0.91%
NHS Solihull	50.0%	Fully compliant	3.48%	£7	0.11%
NHS Somerset	45.0%	Fully compliant	2.55%	£40	0.61%
NHS South Cheshire	40.0%	Fully compliant	0.92%	£33	0.49%
NHS South Devon and Torbay	40.0%	Fully compliant	1.35%	£66	0.85%
NHS South East Staffordshire and Seisdon Peninsula	35.0%	Partially compliant	7.24%	£52	1.06%
NHS South Eastern Hampshire	90.0%	Partially compliant	3.54%	£49	0.73%
NHS South Gloucestershire	85.0%	Partially compliant	0.12%	£22	0.46%
NHS South Kent Coast	20.0%	Partially compliant	3.79%	£56	0.81%
NHS South Lincolnshire	50.0%	Partially compliant	2.61%	£41	0.51%
NHS South Manchester	90.0%	Partially compliant	7.49%	£86	1.11%
NHS South Norfolk	80.0%	Fully compliant	1.50%	£54	1.02%
NHS South Reading	45.0%	Fully compliant	1.48%	£64	1.00%
NHS South Sefton	40.0%	Partially compliant	2.14%	£81	1.05%

NHS South Tees	40.0%	Fully compliant	7.85%	£90	1.13%
NHS South Tyneside	90.0%	Partially compliant	6.05%	£135	1.57%
NHS South Warwickshire	20.0%	Fully compliant	2.77%	£37	0.50%
NHS South West Lincolnshire	50.0%	Partially compliant	2.61%	£36	0.51%
NHS South Worcestershire	40.0%	Fully compliant	1.80%	£43	0.64%
NHS Southampton	80.0%	Not compliant	2.29%	£85	1.17%
NHS Southend	80.0%	Partially compliant	3.26%	£33	0.54%
NHS Southern Derbyshire	45.0%	Fully compliant	2.66%	£44	0.66%
NHS Southport and Formby	40.0%	Partially compliant	3.40%	£41	0.49%
NHS Southwark	90.0%	Partially compliant	3.30%	£46	0.70%
NHS St Helens	40.0%	Partially compliant	1.80%	£54	0.61%
NHS Stafford and Surrounds	35.0%	Partially compliant	8.84%	£47	0.90%
NHS Stockport	35.0%	Partially compliant	1.91%	£11	0.15%
NHS Stoke on Trent	80.0%	Not compliant	5.07%	£49	0.72%
NHS Sunderland	90.0%	Fully compliant	5.45%	£93	0.97%
NHS Surrey Downs	40.0%	Fully compliant	0.78%	£31	0.60%
NHS Surrey Heath	90.0%	Partially compliant	1.63%	£48	0.83%
NHS Sutton	45.0%	Fully compliant	4.06%	£52	0.87%
NHS Swale	20.0%	Partially compliant	3.27%	£55	0.90%
NHS Swindon	85.0%	Fully compliant	2.19%	£47	0.88%
NHS Tameside and Glossop	40.0%	Partially compliant	1.74%	£7	0.10%
NHS Telford and Wrekin	80.0%	Fully compliant	0.23%	£55	0.92%
NHS Thanet	70.0%	Partially compliant	4.93%	£70	0.98%
NHS Thurrock	80.0%	Fully compliant	2.47%	£35	0.69%

NHS Tower Hamlets	40.0%	Partially compliant	2.71%	£55	0.86%
NHS Trafford	90.0%	Not compliant	0.65%	£40	0.63%
NHS Vale of York	25.0%	Fully compliant	3.34%	£50	0.76%
NHS Vale Royal	40.0%	Fully compliant	1.05%	£50	0.75%
NHS Wakefield	100.0%	Partially compliant	2.81%	£66	0.79%
NHS Walsall	30.0%	Fully compliant	0.71%	£48	0.73%
NHS Waltham Forest	100.0%	Fully compliant	3.86%	£45	0.74%
NHS Wandsworth	100.0%	Fully compliant	3.55%	£68	0.86%
NHS Warrington	85.0%	Partially compliant	1.71%	£46	0.74%
NHS Warwickshire North	25.0%	Fully compliant	3.05%	£88	1.53%
NHS West Cheshire	85.0%	Not compliant	1.21%	£48	0.64%
NHS West Essex	80.0%	Fully compliant	2.72%	£49	0.85%
NHS West Hampshire	90.0%	Partially compliant	2.87%	£43	0.67%
NHS West Kent	75.0%	Partially compliant	2.02%	£41	0.73%
NHS West Lancashire	30.0%	Partially compliant	0.37%	£48	0.70%
NHS West Leicestershire	85.0%	Fully compliant	2.76%	£36	0.58%
NHS West London	95.0%	Partially compliant	3.25%	£11	0.12%
NHS West Norfolk	75.0%	Fully compliant	2.03%	£69	0.95%
NHS West Suffolk	90.0%	Partially compliant	2.13%	£47	0.73%
NHS Wigan Borough	80.0%	Fully compliant	1.42%	£50	0.66%
NHS Wiltshire	40.0%	Partially compliant	1.95%	£54	0.95%
NHS Windsor, Ascot and Maidenhead	90.0%	Fully compliant	1.78%	£50	0.89%
NHS Wirral	75.0%	Partially compliant	1.29%	£71	0.97%
NHS Wokingham	40.0%	Fully compliant	1.25%	£50	0.95%

NHS Wolverhampton	30.0%	Fully compliant	2.08%	£80	1.33%
NHS Wyre Forest	40.0%	Fully compliant	2.30%	£54	0.66%

A note on the data in Annex 1: All figures provided by the individual CCGs to NHS England as part of a statutory data collection. The information presented here is based the on quarterly data collections during 16-17.

[1] This data is taken from CYP(i) on the NHS Mental Health Five Year Forward Dashboard. At a CCG level this indicator shows the % score against a self-assessed data collection which forms the Children and Young People's Mental Health Services (CYPMH) CCG IAF Mental Health Transformation. For further information about this indicator please see page 11

[2] This data is taken from CYP (vi) on the NHS Mental Health Five Year Forward Dashboard. At a CCG level this indicator shows the answer given by the CCG to a self-assessed data return as part of the CCG IAF mental health transformation indicator question: Are CCGs implementing an agreed improvement plan for crisis response for children?

[3] This data is taken from CYP(ii) on the NHS Mental Health Five Year Forward Dashboard. NHS England provide the following caveats concerning the data:
Figures presented here for children and young people accessing mental health services are known to be underreported. This may mean that there are geographical patches including a number of CCGs in which no data is currently being recorded, or there are many areas in which the actual levels of activity will be underreported.
These statistics are classified as experimental and should be used with caution. Experimental statistics are new official statistics undergoing evaluation.

[4] Figures concerning spend have been taken from NHS Mental Health Five Year Forward Dashboard aCYP(vii). Population figures have been worked out from ONS figures: Table SAPE18DT5: Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, Persons (National Statistics).

[5] Data configured using spend figures from aCYP(vii) and total mental health spend from NHS Mental Health Five Year Forward Dashboard bCYP(vii). Figures for eating disorders are not included

Annex 2: Further Work the Children's Commissioner's Office is undertaking on Children's Mental Health

In-Patient Mental Health Care for Children

The Prime Minister has promised that by 2021 no child will have to travel 'out-of-area' to access general in-patient mental health care. We have requested data from NHS Digital and NHS England to enable us to assess:

- How far children are currently travelling to access treatment
- Which areas of the country have particular problems with provision
- Which specialisms require additional provision
- Will NHS England's current plans to expand bed capacity meet the Prime Minister's pledge

Secure Mental Health Care for Children

We have requested data from NHS England to assess the number of children who require sectioning. We also hope to be able to identify:

- How long these children wait to be assessed
- How long they wait to be found a suitable bed
- Where these children are being referred from, and where they are discharged to.

Social Media and the Well-Being of Younger Children

We will be conducting focus groups to examine the relationship between the social media use of 8-12 year olds and their wellbeing. In particular, we want to explore:

- The use and awareness of social media amongst this age group
- The relationship between familial social media use and children's use
- The perceived and actual role it plays in friendships and family relationships
- How their use of social media, or other's use, impacts their day
- How social media improves or distorts children's understanding of the wider world

Further work we are scoping

Early Intervention Support and the Role of Schools

We are currently scoping work looking at what low-level and early-intervention support is available for children and the role of schools in supporting children. Further details to be announced.

Other related work

Secure Children's Home Network

We will be looking at the number of children placed in secure children's homes on welfare grounds. As with in-patient mental health care, we want to understand whether current provision is acceptable and how long children wait for safe and suitable accommodation. We also want to assess what information is recorded on the mental health status of children entering secure children's homes on welfare grounds.

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