Promoting, protecting and improving our children and young people’s emotional wellbeing and mental health

Doncaster’s Local Transformation Plan

2016 - 2020
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1. Open Letter to children and young people

I am writing to you to explain what changes we have made in this new plan and what the continued offer will be. Last year we developed a Local Transformation Plan that outlined how we were going to change the systems and services for the better. I am delighted to update that things are improving and we will continue to build on this in the new plan, we remain committed to changing things for the better. We strive to ensure that you get the support you need, at the earliest opportunity, provided by the right person or people at the right time.

We are now starting to see some of these big changes taking place and this is a good thing. Staff from different services will work together better to support those who may need it around their emotional wellbeing and/or mental health so that you get the best support possible and not being referred to lots of different services. The community eating disorder and intensive home treatment services are new and something we haven’t had in Doncaster previously. Both will help support young people that need this kind of help and also other professionals that need some advice and guidance.

A big part of the transformation is how services better support schools. What has been amazing is how schools have responded to this. There are now over 80% of schools in Doncaster with a named emotional wellbeing and mental health champion who will act as the lead within the school. They will be well trained and linked in to the community CAMHs workers, each school now has a named CAMHs worker.

We have been working with an organisation called Young Minds to develop a way to include the voice and opinions of children and young people, in all areas. This means we are looking at ways you can help us to commission and then oversee the implementation of services. If you are interested in helping us please let us know.

So what are the big plans for this year? Well there are a few........

1. Continue to work with Young Minds to get the voice and opinions of children and young people.
2. Develop the expertise of staff by training all staff that may have an opportunity to support children and young people.
3. Make sure the new services work by continuously checking them.
4. We are going to have a look at how we currently provide support to Looked after Children, those with Learning Difficulties and those that may enter Youth Justice services and improve them.
5. Check that the outcomes we want to see actually happen.

It is an exciting time and we want you to know that Team Doncaster is absolutely committed to this plan.

Yours sincerely

Damian Allen
Director of Learning Opportunities & Skills
2. Doncaster’s vision for transformation

Our vision sets out the ambition; our mission statement is our statement of purpose as partner organisations. Our values drive the culture of the partner organisations and provide an anchor for everyone against which to test behaviour and delivery.

**Vision**
Team Doncaster will work to secure sustainable improvements in children and young people’s emotional wellbeing and and mental health.

**Mission**
To provide a responsible and transparent partnership in order to bring about whole system transformation, by developing and implementing the Local Transformation Plan.

**Values**
- The needs of our population are paramount
- The partnership will drive forward continuous improvement
- Relationships based on integrity and trust
- Children and young people’s views will be consistently sought, understood and become part of the service delivery model

2.1 We are now a year into the plan and it is pleasing to report that partners are adhering to the mission and values. The profile of the LTP is high and remains a priority for Team Doncaster. It was agreed that it would be helpful to expand on the vision to give greater clarity and detail about what is it Team Doncaster wants to achieve through this plan.

2.2 We want to improve secure sustainable improvements that means children and young people in Doncaster have good mental health and emotional wellbeing.

2.3 We want all children and young people to be emotionally resilient, happy, and confident and to have the best chances possible to succeed in what they want to do.

2.4 For those children and young people that need support, we want to provide this at the earliest possible opportunity, with a clear focus on early intervention and prevention.

2.5 Encourage a more systemic approach where support around emotional wellbeing and mental health will be an add on to what support is already in place and/or being put in place, rather than a hand-off referral.

2.6 The removal of referral thresholds, criteria and written referrals. Support will be part of a systemic approach.

2.7 To develop a participation approach with children, young people and their families in the commissioning and implementing all facets of the plan. The aim is to put children, young people and their families at the heart of the system transformation.

2.8 To remove the stigma of emotional wellbeing and mental health through education and awareness raising.

2.9 To improve the understanding of emotional wellbeing and mental health through a clear workforce strategy, that will offer training and education to every professional working with children, young people and their families. This means that everyone will
understand the importance of good mental health and how to help, or know how to access help when it’s needed.

2.10 We want a specialist service that offers evidence based interventions as part of a systemic approach, with highly qualified staff.

2.11 How will we know that this vision is achieved?

More children, young people and their families will be resilient, happy and confident, with better chances of success
*Evidence – feedback from children, young people and their families through questionnaires, i.e. health related behaviour questionnaire, reduced demand on services and greater educational attainment.*

More children and young people with mental health problems will recover
*Evidence – individual goal setting (where CYP meet their goals).*

Children and young people will have good mental health and emotional wellbeing
*Evidence – routine outcome measures, goal setting, numbers in treatment.*

Children and young people who need support will get this at the earliest opportunity
*Evidence – reduction in numbers seen in specialist CAMHs, numbers seen by consultation and advice workers.*

Support for children and young people is provided by the right person at the right time
*Evidence – numbers seen by consultation and advice workers.*

A quality workforce that is excellent in practice and able to deliver the best evidenced care
*Evidence – numbers accessing training courses, number of referrals into specialist CAMHs, post training findings.*

Fewer children and young people will develop serious mental health problems and those that do are given the best support possible in the community
*Evidence – inpatient admissions, numbers seen by intensive home treatment service.*

The removal of referral thresholds, criteria and written referrals. Support will be part of a systemic approach
*Evidence – number receiving systemic support, number of written referrals.*
3. Introduction

3.1 This document is a refresh of the original Local Transformation Plan (2015-20) submitted in October 2015 which outlined Team Doncaster’s five year vision. The essence of that plan very much remains; with a key focus on Early Intervention and Prevention, whilst strengthening children, young people and their families involvement in all decisions.

3.2 The first plan was signed off by NHS England as having met the criteria in full with identified strengths. A strong needs assessment and good engagement with stakeholders. They commended that the plan was very accessible, transparent and easy to read, clearly describing the services for children and young people, recognising the challenges in Doncaster and directing efforts towards managing these challenges. There were also some recommendations including; baseline data for Local Authority services to be added, stronger governance arrangements and further developed outcomes.

3.3 Lots of good things happened in the first year of the plan, namely the development of a tierless service, new intensive home treatment and community eating disorder teams and the engagement with education. It is important to note though that the transformation of services and ultimately the system is still in its early stages and there is still much to be done. This plan will focus on how we best achieve that, with a greater emphasis on the change model needed to drive change.

3.4 The plan is written to sit alongside the Five Year Forward View for Mental Health (NHSE 2016), the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP), Transforming Care Partnership (TCP) and Doncaster’s Place Based Plan.

3.5 For the purposes of this Local Transformation Plan the partner services will be referred to as Team Doncaster, which is the local partnership name for the following services; Doncaster Clinical Commissioning Group, Doncaster Metropolitan Borough Council, Doncaster Children’s Services Trust and Third Sector partners.
4. Current Commissioning Arrangements

4.1 Doncaster Clinical Commissioning Group, The Local Authority and Children’s Trust moved to a Joint Executive Commissioning (JCEG) arrangement in June 2015 and agreed on two priority areas; one of these being emotional and mental health.

4.2 The JCEG acknowledged that there are many contributing factors that affect emotional and mental health, and aims to evolve the joint commissioning arrangements to a whole system integrated approach to ensure better outcomes. This will span the life of a child, with a clear focus on the 0-1001 days agenda and transition into adult services.

4.3 The aspiration of this plan is that children and young people will be involved in commissioning at all levels and also to be involved in the implementation of services. The work with Young Minds is the first step to doing this from an emotional and mental health perspective.

4.4. Doncaster commissions a number of providers to deliver a range of community and acute services.

<table>
<thead>
<tr>
<th><strong>Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH is a specialist mental health trust offering mental health and community services in Doncaster, Rotherham, North Lincolnshire, North East Lincolnshire and Manchester. As Doncaster’s lead CAMHs provider, RDaSH provides all the elements of the CAMHs provision. This includes specialist CAMHs (including the out of hours service), Looked after Children, Learning Disability and Youth Offending specialist services and the new provision; consultation and advice, intensive home treatment, paediatric liaison and workforce educator. RDaSH act as the lead provider for the new community eating disorder service and the lead for Doncaster for Children and Young People – Increasing Access to Psychological Therapies (CYP-IAPT).</td>
</tr>
<tr>
<td>RDaSH host the ADHD team and provide clinical psychology input in to the autism pathway and diabetes best practice tariff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Doncaster and Bassetlaw Foundation Hospital (DBHFT)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>DBHFT are a hospital Trust that provide a range acute services, including accident and emergency and acute and community paediatrics (inc ADHD and ASD). DBHFT are the lead organisation for autism assessments and therapy services and host the 24/7 crisis support and mental health liaison services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Doncaster Children’s Services Trust (DCST)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>DCST is an independent organisation set up to deliver social care and support services to children, young people and families in Doncaster. It was the first Trust of its kind when established in October 2014 and offers a range of services. These include the Youth Offending service which has its own dedicated CAMHs worker and a forensic psychologist. DCST is leading on a number of innovative development programmes, including Growing Futures, Pause Project and Mockingbird.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Collaboratives</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Help Collaborative groups are local strategic partnership groups and were conceived as a key element of Doncaster’s Early Help Strategy. Collaboratives are fundamentally decision making bodies with the power to make decisions on provision and commissioning of services so as to secure improved outcomes for children and young people aged 0 - 19 years. In so doing, Collaboratives receive needs based assessment of local children and families, performance information of existing service provision and to be able to plan,</td>
</tr>
</tbody>
</table>
source and secure funding, redirect resources and priorities of key agencies in order to achieve improved outcomes. The Collaboratives are empowered to produce a local plan with a focus on reducing inequalities, prioritising prevention and early intervention.

4.5 Doncaster also commissions a range of services that contribute to wider emotional wellbeing and mental health, physical health and care needs for vulnerable and/or hard to reach children and young people.

<table>
<thead>
<tr>
<th>JASP</th>
</tr>
</thead>
<tbody>
<tr>
<td>JASP is a part-time, interim educational provision for key stages 3 and 4 pupils referred by CAMHs who are:</td>
</tr>
<tr>
<td>- experiencing severe and enduring mental health difficulties</td>
</tr>
<tr>
<td>- having difficulty accessing a mainstream education full-time</td>
</tr>
<tr>
<td>- actively involved with CAMHs.</td>
</tr>
<tr>
<td>The aims of the service are to keep this cohort of children and young people engaged in education.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young Minds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Minds is the UK’s leading charity committed to improving the emotional wellbeing and mental health of children and young people.</td>
</tr>
<tr>
<td>Doncaster has commissioned Young Minds over the next five years to build a sustainable participation model with children, young people and families to give them a real voice in how services are commissioned and provided.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>South Yorkshire Eating Disorder Service (SYEDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYEDA are an independent charity that supports a wide range of people from many different backgrounds with a range of eating disorders. They provide therapeutic support, facilitate support groups, offer a befriending service and offer education and training sessions in schools, colleges, to professionals and the wider community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Open Minds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Minds is a local charity that provides a counselling service to children and young people. They offer a range of services which include; counselling, CBT and NLP.</td>
</tr>
</tbody>
</table>
5. Local Investment

5.1 There is a clearly identifiable budget for CAMHs which comprises of funding from Doncaster Clinical Commissioning Group and the Local Authority and is managed by the Strategy and Delivery Manager for Children and Maternity, with CAMHs sitting within this portfolio. Doncaster Clinical Commissioning Group and the Local Authority have maintained a significant financial commitment to CAMHs and will continue to do so. The Local Transformation Plan funding enhances this base level of funding and is helping to support system transformation.

5.2 Doncaster is committed to investing in emotional wellbeing and mental health and the estimated spend in 2016/17 is as follows:

Doncaster Spend

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimated Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist CAMHs:</td>
<td>£1,655,338</td>
</tr>
<tr>
<td>Single Point of Access CAMHs:</td>
<td>£120,000</td>
</tr>
<tr>
<td>Consultation &amp; Advice CAMHs:</td>
<td>£80,000</td>
</tr>
<tr>
<td>Intensive Home Treatment Service:</td>
<td>£220,000</td>
</tr>
<tr>
<td>Paediatric Liaison:</td>
<td>£50,000</td>
</tr>
<tr>
<td>Looked after Children CAMHs:</td>
<td>£80,000</td>
</tr>
<tr>
<td>Learning Disability CAMHs:</td>
<td>£80,000</td>
</tr>
<tr>
<td>Youth Offending Service CAMHs:</td>
<td>£35,000</td>
</tr>
<tr>
<td>CYP-IAPT:</td>
<td>£35,000</td>
</tr>
<tr>
<td>Workforce Educator:</td>
<td>£50,000</td>
</tr>
<tr>
<td>Workforce Strategy:</td>
<td>£100,000</td>
</tr>
<tr>
<td>Autism Pathway:</td>
<td>£516,825</td>
</tr>
<tr>
<td>ADHD:</td>
<td>£200,000</td>
</tr>
<tr>
<td>JASP:</td>
<td>£372,814</td>
</tr>
<tr>
<td>Thrive:</td>
<td>£72,398</td>
</tr>
<tr>
<td>Youth Offending Service Assistant Forensic Psychologist:</td>
<td>£35,000</td>
</tr>
<tr>
<td>Waiting List NHSE Funding*:</td>
<td>£90,000</td>
</tr>
<tr>
<td><strong>Total</strong>:</td>
<td><strong>£3,792,375</strong></td>
</tr>
</tbody>
</table>

*This excludes the potential funding listed in 5.9.
5.3 A breakdown of how this spend will be made against the local priority scheme indicators is below:

<table>
<thead>
<tr>
<th>Local Priority Scheme</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish named emotional wellbeing and mental health leads in schools (internal)</td>
<td>£12,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous consultation and engagement with children, young people and families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment of workforce development lead</td>
<td>£10,000</td>
<td>£10,000</td>
<td>£10,000</td>
<td>£10,000</td>
</tr>
<tr>
<td>Audit and rolling training programme</td>
<td>£35,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHs worker to be embedded in the Early Help Hub</td>
<td>£10,000</td>
<td>£10,000</td>
<td>£10,000</td>
<td>£10,000</td>
</tr>
<tr>
<td>Named CAMHs leads in schools &amp; Primary Care</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
</tr>
<tr>
<td>Supporting self care</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Development of single point of access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further develop evidence base</td>
<td>£18,275</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement all areas of the crisis care concordat</td>
<td>£12,500</td>
<td>£12,500</td>
<td>£12,500</td>
<td>£12,500</td>
</tr>
<tr>
<td>Intensive home treatment service to be provided</td>
<td>£55,000</td>
<td>£55,000</td>
<td>£55,000</td>
<td>£55,000</td>
</tr>
<tr>
<td>Expansion of peer mentoring service</td>
<td></td>
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<tr>
<td>Enhance the current assessment process to include sensitive enquiries</td>
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<tr>
<td>Enhance the current do not attend policy</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Enhance the current do not attend policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop multi-agency teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved community paediatric services (inc ASD and ADHD)</td>
<td>£129,206.25</td>
<td>£129,206.25</td>
<td>£129,206.25</td>
<td>£129,206.25</td>
</tr>
<tr>
<td>Development of domestic violence multi-agency teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of eating disorder community services</td>
<td>£177,966</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The difference between the figures in 5.2 and 5.3 is the spend on other areas not included in the local priority scheme indicators, i.e. specialist CAMHs. Any indicators with no allocated spend will have spend in 2015/16.
5.4 The primary funding sources are:

<table>
<thead>
<tr>
<th>Clinical Commissioning Group</th>
<th>Local Authority</th>
<th>NHS England*</th>
<th>Children’s Services Trust</th>
<th>Collaboratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>£2,385,338</td>
<td>£508,340</td>
<td>£685,000</td>
<td>£35,000</td>
<td>£57,398</td>
</tr>
</tbody>
</table>

* this excludes the potential funding listed in 5.8.

5.5 It should be noted that the above estimates include the majority of funding spent on emotional wellbeing and mental health, however there may be additional funding where detailed information isn’t available. However, this would be limited as we have unpicked several children service block contracts and have a good understanding locally on spend.

5.6 There may be changes to funding that occur in year that we are unable to predict at this stage. There are no reductions to finances planned in year.

5.7 Implementing the Five Year Forward View for Mental Health services sets a trajectory for increased access, which is based on existing prevalence data and allocates funding to this on a national level. This funding will then be allocated locally to support the increase in capacity and system transformation.

5.8 The funding profile for children and young people is as follows:

Therefore it is anticipated that there will be increased levels of funding each year until 2020/21. We are unsure at the point of writing this plan how this will translate locally and what the future levels of funding will be, and/or if commissioning responsibilities will flow down to CCG’s with any additional funding.

5.9 In addition to this, a letter dated 26th September from the National Mental Health Director (NHS England) was sent to CCG accountable officers. This letter announced that an additional £25 million nationally has been identified which can be made available for CCG’s in 2016/17. This funding is in addition to the monies already allocated to CCG’s and brings
forward the expected uplift to baseline funding to meet the published levels set for 2017/18 (£170 million nationally), whilst also providing non-recurrent funding.

As with all allocations of new money, it is critical that we are able to demonstrate the impact of this investment. It is expected that these funds will support CCGs to achieve the following:

- Accelerate their plans and undertake additional activities this year to drive down average waiting times for treatment, and reduce both backlogs of children and young people on waiting lists and length of stay for those in inpatient care.
- Support CCGs to continue to invest in training existing staff through the CYP-IAPT training programme, including sending new staff through the training courses. CYP-IAPT collaboratives are recruiting to training places now, so CCGs should be identifying with their partners the staff to send on the training course and any additional resources required to release staff; and
- Accelerate plans to pump-prime crisis, liaison and home treatment interventions suitable for under 18s, with the goal of minimising inappropriate admissions to inpatient, paediatric or adult mental health wards. This should include working with NHS England specialised commissioning teams to develop integrated pathways.

5.10 In order to secure release of the full additional funding, CCGs will be asked to provide details of how they intend to improve average waiting times for treatment by March 2017. This funding will come down into two payments; the first will be allocated in October 2016 on a fair shares basis, the second payment will be made in January 2017 subject to CCG’s demonstrating progress towards their improvements targets.
5.11 All transformation monies received in 2015/16 were spent on areas identified within the original LTP. A breakdown is as follows:

<table>
<thead>
<tr>
<th>Local Priority Stream</th>
<th>Expected Outcome</th>
<th>Planned Spend</th>
<th>Actual Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local priority stream 1</td>
<td>Establish named mental health and wellbeing leads in schools (internal)</td>
<td>Q3 Oct - Dec 15/16</td>
<td>Q4 Jan - Mar 16</td>
</tr>
<tr>
<td>Local priority stream 2</td>
<td>Continuous consultation and engagement with children, young people and families</td>
<td>Q4 Jan - Mar 16</td>
<td>£90,000</td>
</tr>
<tr>
<td>Local priority stream 3</td>
<td>Appointment of workforce development lead</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£10,000</td>
</tr>
<tr>
<td>Local priority stream 4</td>
<td>Audit and rolling training programme</td>
<td>Q4 Jan - Mar 16</td>
<td>£10,000</td>
</tr>
<tr>
<td>Local priority stream 5</td>
<td>Develop an 'innovation partnership' approach with a local university to deliver an accredited training programme with nationally recognised modules</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£100,000</td>
</tr>
<tr>
<td>Local priority stream 6</td>
<td>CAMHS worker to be embedded in the Early Help Hub</td>
<td>Q4 Jan - Mar 16</td>
<td>£10,000</td>
</tr>
<tr>
<td>Local priority stream 7</td>
<td>Named CAMHS leads in schools &amp; Primary Care</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£20,000</td>
</tr>
<tr>
<td>Local priority stream 8</td>
<td>Supporting self care</td>
<td>Q4 Jan - Mar 16</td>
<td>£40,000</td>
</tr>
<tr>
<td>Local priority stream 9</td>
<td>Development of single point of access</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£50,000</td>
</tr>
<tr>
<td>Local priority stream 10</td>
<td>Further develop evidence base</td>
<td>Q4 Jan - Mar 16</td>
<td>£45,000</td>
</tr>
<tr>
<td>Local priority stream 11</td>
<td>Implement all areas of the crisis care concordat</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£76,306</td>
</tr>
<tr>
<td>Local priority stream 12</td>
<td>Intensive home treatment service to be provided</td>
<td>Q4 Jan - Mar 16</td>
<td>£131,280</td>
</tr>
<tr>
<td>Local priority stream 13</td>
<td>Expansion of peer mentoring service</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£10,541</td>
</tr>
<tr>
<td>Local priority stream 14</td>
<td>Enhance the current assessment process to include sensitive enquiries</td>
<td>Q4 Jan - Mar 16</td>
<td>£5,000</td>
</tr>
<tr>
<td>Local priority stream 15</td>
<td>Enhance the current do not attend policy</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£5,000</td>
</tr>
<tr>
<td>Local priority stream 16</td>
<td>Develop multi-agency teams</td>
<td>Q4 Jan - Mar 16</td>
<td>£5,000</td>
</tr>
<tr>
<td>Local priority stream 17</td>
<td>Improved community paediatric services (inc ASD and ADHD)</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£25,000</td>
</tr>
<tr>
<td>Local priority stream 18</td>
<td>Development of domestic violence multi-agency teams</td>
<td>Q4 Jan - Mar 16</td>
<td>£25,000</td>
</tr>
<tr>
<td>Local priority stream 19</td>
<td>Provision of eating disorder multi-agency services</td>
<td>Q3 Oct - Dec 15/16</td>
<td>£35,000</td>
</tr>
<tr>
<td>Local priority stream 20</td>
<td>Redeploy generic staff currently seeing ED cases now seen by community team to improve access to self harm and crisis and invest underspend from ED funds</td>
<td>Q4 Jan - Mar 16</td>
<td>£35,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>£136,306</td>
</tr>
</tbody>
</table>

5.12 Community Eating Disorder Service Funding
Funding for a community eating disorder service sits within Doncaster CCG’s baseline funding and is as follows:

<table>
<thead>
<tr>
<th>Baseline Allocation</th>
<th>Total Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>£177,966</td>
<td>£177,966</td>
</tr>
</tbody>
</table>

5.13 Commissioners and providers are confident that the full funding allocations will be spent in 2016/17 as per the terms of the Local Transformation Plan.
5.14 Perinatal Mental Health
Another objective within the Five Year Forward View is to increase access to specialist perinatal mental health support. The table below shows total additional funding and how this will be allocated. Doncaster won’t receive any direct local funding until 2019/20, instead additional funding is allocated nationally to support national programmes. However, Doncaster has submitted two bids for STF monies that would bring extra funding into Doncaster until 2019/20.

<table>
<thead>
<tr>
<th>Funding type</th>
<th>2016/17 £m</th>
<th>2017/18 £m</th>
<th>2018/19 £m</th>
<th>2019/20 £m</th>
<th>2020/21 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG baseline allocations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist perinatal mental health</td>
<td></td>
<td></td>
<td></td>
<td>73.5</td>
<td>98.0</td>
</tr>
<tr>
<td>STF monies for allocation (indicative)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal community development fund</td>
<td>5.0</td>
<td>15.0</td>
<td>40.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional CCG funding to be allocated</td>
<td></td>
<td></td>
<td></td>
<td>11.5</td>
<td>22.0</td>
</tr>
<tr>
<td>National programmes (indicative)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother and baby unit development</td>
<td>4.5</td>
<td>10.0</td>
<td>15.0</td>
<td>15.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Workforce development</td>
<td>3.0</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Regional perinatal MH networks</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Other programmes</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Key
- Local Funding
- National Funding
6. Engagement with Stakeholders

6.1 In 2014 Doncaster consulted with lots of its children and young people in preparing the children and young peoples’ plan. The consultation was wide ranging and pulled together by the Youth Council with several key themes emerging. One of the top priority areas was emotional health. Doncaster has a collaborative model of primary schools and children centres being aligned in terms of geography and these groups have consulted with children, young people and families in their areas to understand local need. Again emotional health and wellbeing came out as a key priority. Primarily around the lack of provision for lower level emotional health needs and wellbeing, especially the identification of gaps in mental health provision.

6.2 Building on this are the findings from a children and young people’s democracy event held this year. A collaboration of young people from a variety of settings held an event where four priority areas were discussed; one of these was emotional wellbeing and mental health. The event was a great success and the key findings are as follows:
6.3 Solutions

**Education** – Schools need to do more, currently only offered in PSHE/Citizenship but should weave into other subjects e.g. Drama. More training for teachers/mentors to reduce need on CAMHs.

**Publicity** – More positive publicity needs to be done to stop stigma around Mental Health and CAMHs. Young people suggest running a 'Time to Change' campaign.

**Good Practice** - Other good practice services need to be followed such as E Clinic, Pyramid (Balby Carr).

**Support** - Young people would prefer support from a person they have a relationship with, someone they trust, not necessarily someone from school. Important that the person has the skills & experience in Mental Health. Young people also welcome home services working with all the family and carers.

**Young Minds** - Young people welcomed the 'Young Mind' programme that has been commissioned in Doncaster over the next 5 years.

6.4 Doncaster Public Health co-commissioned a pupil Health-Related Behaviour Questionnaire (HRBQ) in collaboration with Education, at Doncaster Council. The questionnaire was completed by Schools Health Education Unit. This provides useful data to show the impact of strategies in place and informs us about the physical and emotional health and wellbeing of school children in Doncaster, in order to plan for the future. Topics of the questionnaire were as follows, although the content differed depending on age:

- **Emotional Health and Wellbeing**
  - Healthy Eating
  - Physical Activity
  - Dental health
  - Safety
  - Bullying
  - Substance use
  - Relationships and Sexual Health.

6.5 All schools (including those for children with Special Educational Needs) were invited and encouraged to participate during the last term of the academic year 14/15. Initially, 63 primary schools and all 18 secondary schools agreed to take part. However, during the data collection phase, twelve schools (2 secondary and 10 primary) withdrew from the survey or failed to complete before the deadline date for completion. No SEN schools agreed to participate.

6.6 Schools were asked to survey Year 4 and Year 8 pupils as essential and Year 6 and Year 10 pupils as optional, either using an online version of the questionnaire or on paper. Some schools also surveyed Year 3 pupils.

6.7 In total this equates to 2,607 boys and 2,576 girls, a total of 5,183. The pertinent ones for this plan are the ones under the emotional health and wellbeing section. The key findings were as follows:
6.8 Composite self-esteem scores for Primary Schools

<table>
<thead>
<tr>
<th>Level</th>
<th>Values 0-4 (low)</th>
<th>Values 5-9 (medium)</th>
<th>Values 10-14 (med-high)</th>
<th>Values 15-18 (high)</th>
<th>Valid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 Male</td>
<td>5%</td>
<td>21%</td>
<td>42%</td>
<td>32%</td>
<td>656</td>
</tr>
<tr>
<td>Year 4 Female</td>
<td>6%</td>
<td>26%</td>
<td>42%</td>
<td>26%</td>
<td>678</td>
</tr>
<tr>
<td>Year 6 Male</td>
<td>4%</td>
<td>19%</td>
<td>39%</td>
<td>38%</td>
<td>433</td>
</tr>
<tr>
<td>Year 6 Female</td>
<td>5%</td>
<td>22%</td>
<td>37%</td>
<td>36%</td>
<td>419</td>
</tr>
<tr>
<td>All</td>
<td>5%</td>
<td>23%</td>
<td>40%</td>
<td>32%</td>
<td>2208</td>
</tr>
</tbody>
</table>

On the whole the composite responses are quite good, however there are 28% of children asked who have low to medium levels of self-esteem. There is a fairly even split between males and females and across the two year groups.

6.9 Composite resilience score for Primary Schools

<table>
<thead>
<tr>
<th>Level</th>
<th>Values 0-4 (low)</th>
<th>Values 5-9 (medium)</th>
<th>Values 10-14 (med-high)</th>
<th>Values 15-18 (high)</th>
<th>Valid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 Male</td>
<td>5%</td>
<td>21%</td>
<td>42%</td>
<td>32%</td>
<td>576</td>
</tr>
<tr>
<td>Year 4 Female</td>
<td>6%</td>
<td>26%</td>
<td>42%</td>
<td>26%</td>
<td>607</td>
</tr>
<tr>
<td>Year 6 Male</td>
<td>4%</td>
<td>19%</td>
<td>39%</td>
<td>38%</td>
<td>404</td>
</tr>
<tr>
<td>Year 6 Female</td>
<td>5%</td>
<td>22%</td>
<td>37%</td>
<td>36%</td>
<td>396</td>
</tr>
<tr>
<td>All</td>
<td>5%</td>
<td>23%</td>
<td>40%</td>
<td>32%</td>
<td>2002</td>
</tr>
</tbody>
</table>

Again on the whole the composite responses are generally good, however there are over a third of the children asked with a low to medium levels of resilience. Again there is a fairly even split across male and female and year groups.

6.10 Composite self-esteem scores for Secondary Schools

<table>
<thead>
<tr>
<th>Level</th>
<th>Values 0-4 (low)</th>
<th>Values 5-9 (medium)</th>
<th>Values 10-14 (med-high)</th>
<th>Values 15-18 (high)</th>
<th>Valid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 8 Male</td>
<td>5%</td>
<td>15%</td>
<td>35%</td>
<td>44%</td>
<td>623</td>
</tr>
<tr>
<td>Year 8 Female</td>
<td>9%</td>
<td>27%</td>
<td>38%</td>
<td>26%</td>
<td>652</td>
</tr>
<tr>
<td>Year 10 Male</td>
<td>5%</td>
<td>18%</td>
<td>36%</td>
<td>42%</td>
<td>313</td>
</tr>
<tr>
<td>Year 10 Female</td>
<td>8%</td>
<td>27%</td>
<td>39%</td>
<td>25%</td>
<td>314</td>
</tr>
<tr>
<td>All</td>
<td>7%</td>
<td>22%</td>
<td>37%</td>
<td>34%</td>
<td>1956</td>
</tr>
</tbody>
</table>

On the whole the composite responses are quite good, however there are 22% of children asked who have medium levels of self-esteem. However there are still approximately a third of children asked with low to medium levels of self-esteem.

6.11 Composite resilience score for Secondary Schools

<table>
<thead>
<tr>
<th>Level</th>
<th>Values 0-4 (low)</th>
<th>Values 5-9 (medium)</th>
<th>Values 10-14 (med-high)</th>
<th>Values 15-18 (high)</th>
<th>Valid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 8 Male</td>
<td>18%</td>
<td>21%</td>
<td>22%</td>
<td>29%</td>
<td>554</td>
</tr>
<tr>
<td>Year 8 Female</td>
<td>42%</td>
<td>20%</td>
<td>22%</td>
<td>16%</td>
<td>600</td>
</tr>
<tr>
<td>Year 10 Male</td>
<td>34%</td>
<td>24%</td>
<td>22%</td>
<td>20%</td>
<td>274</td>
</tr>
<tr>
<td>Year 10 Female</td>
<td>54%</td>
<td>21%</td>
<td>15%</td>
<td>9%</td>
<td>279</td>
</tr>
<tr>
<td>All</td>
<td>38%</td>
<td>21%</td>
<td>21%</td>
<td>20%</td>
<td>1752</td>
</tr>
</tbody>
</table>
There are some big differences between gender types, with almost half the females asked having a low level of resilience in year 8 and over half in year 10. This is worrying and something that clearly needs to be addressed. This questionnaire suggests that males are more resilient than females.

6.12 The plan is to recommission this questionnaire in 2017 and this is the measurement tool to see if things are improving locally.

6.13 CAMHs asked service users to complete an experience of service and session feedback questionnaire (see appendix 7). The key points were as follows:

- Reporting through experience of service questionnaire (ESQ) forms showed that 74% of parents/ carers felt they were well treated by the people who saw their child.
- The session feedback questionnaire (SFQ) that both service users and parents/ carers felt listened too, talked about what they wanted to talk about, understood the meeting and felt the meeting gave them ideas on what to do, so overall positive feedback.
- There was a general theme of dissatisfaction with the facilities in terms of the waiting area and appointment times.
- There was a reoccurring theme relating to changes in key personnel.

6.14 Throughout 2015/16 there has been a significant amount of engagement with stakeholders to ensure that the LTP was very much a partnership plan, and that it was on every-one’s agenda. This included presentations at all the relevant boards, groups and meetings including those for children, young people and their families. This has been a really helpful exercise as it as helped shape the implementation process through a better understanding of individual service needs within the wider system transformation, in particular with schools.

6.15 The feedback from the vast majority of stakeholders has been positive, which has really helped embed the plan across all areas within the system. We are in a position where there is good ownership and there is a solid base to keep moving forward.

6.16 This is felt particularly strongly in schools as evidenced in 77% of schools nominating an emotional wellbeing and mental health named lead within their school. The named lead acts as the champion and point of reference between schools and other services, i.e. CAMHs locality workers. The response from schools has been extremely positive. There is a clear plan to support those schools yet to nominate with the aim of having 100% nomination by March 2017.

6.17 A series of locality workshops were held with school representatives to develop and agree roles and responsibilities, and what the interface with the new CAMHs locality workers would be, in particular considering the move away from tiers and referral thresholds. All findings were collated and jointly analysed with representatives from schools and agreements have been made on respective roles, responsibilities and the interface. This has been sense checked with children, young people and their families.

6.18 There has been lots of engagement with the CAMHs staff to get their thoughts on how best to support the transformation, which has been really valuable. This work is on-going.
7. Understanding Doncaster’s Need

7.1 The children and young people’s emotional wellbeing and mental health need assessment for Doncaster (2015) was deemed to be a strong needs assessment by NHS England and was the foundation for the original LTP. This needs assessment and information in the following sections sets out the case for change.

### Information Sources
- Emotional wellbeing and mental health needs assessment
- East Midlands Strategic Clinical Network self-assessment toolkit
- Doncaster Safeguarding Children’s Board multi-agency audit of children’s mental health

7.2 Prevalence of key risk factors for mental health
Mental health problems affect about 1 in 10 children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives.

Alarmingly, however, 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early age. The emotional wellbeing of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.

Things that can help keep children and young people mentally well include:

**•** being in good physical health, eating a balanced diet and getting regular exercise

**•** having time and the freedom to play, indoors and outdoors

**•** being part of a family that gets along well most of the time

**•** going to a school that looks after the wellbeing of all its pupils

**•** taking part in local activities for young people

Other factors are also important, including:

**•** feeling loved, trusted, understood, valued and safe

**•** being interested in life and having opportunities to enjoy themselves

**•** being hopeful and optimistic

**•** being able to learn and having opportunities to succeed

**•** accepting who they are and recognising what they are good at

**•** having a sense of belonging in their family, school and community

**•** feeling they have some control over their own life

**•** having the strength to cope when something is wrong (resilience) and the ability to solve problems.

Most children grow up mentally healthy, but surveys suggest that more children and young people have problems with their mental health today than 30 years ago. That’s probably because of changes in the way we live now and how that affects the experience of growing up. (Mental Health Foundation).

7.3 Population and deprivation profile
Doncaster is the largest geographic metropolitan borough in the country with an area of more than 225 square miles. Doncaster has a population of 302,400, of which 72,100 are
children and young people (0-19 years). Children and young people under the age of 20 make up 23.7% of the population of Doncaster, which is similar to the national average (23.8%). The number of children aged 0 to 4 years has slightly declined in 2015 (19,200); this change is different to the regional or national data, which shows an increase. Twelve percent of school children are from minority ethnic groups, which is an increase of over one percent when compared with 2014 (10.9%). (Child health profile (CHP), 2015).

7.4 Doncaster has an equal proportion of male and female children and young people and a homogenous distribution of children can be observed throughout all the age groups (Figure 2).

7.5 Figure 2: Number of children & young people in Doncaster divided by gender and age groups
Source mid 2013 estimate.
### 7.6 Child population in Doncaster (2015)

<table>
<thead>
<tr>
<th></th>
<th>Doncaster</th>
<th>Yorkshire and the Humber</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (age 0 to 4 years) 2013</td>
<td>19,200 (6.3%)</td>
<td>334,100 (6.3%)</td>
<td>3,414,100 (6.3%)</td>
</tr>
<tr>
<td>Children (age 0-19 years) 2013</td>
<td>72,100 (23.7%)</td>
<td>1,278,600 (24.0%)</td>
<td>12,833,200 (23.8%)</td>
</tr>
<tr>
<td>Children (age 0-19 years) in 2020 (projected)</td>
<td>71,400 (23.2%)</td>
<td>1,305,700 (23.6%)</td>
<td>13,325,100 (23.6%)</td>
</tr>
<tr>
<td>School children from minority ethnic groups, 2014</td>
<td>4,782 (12.0%)</td>
<td>150,330 (22.3%)</td>
<td>1,832,995 (27.8%)</td>
</tr>
<tr>
<td>Children living in poverty (age under 16 years) 2012</td>
<td>23.8%</td>
<td>20.8%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Life expectancy at birth, 2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>77.5</td>
<td>78.5</td>
<td>79.4</td>
</tr>
<tr>
<td>Girls</td>
<td>81.7</td>
<td>82.2</td>
<td>83.1</td>
</tr>
</tbody>
</table>

Source: CHP 2015

7.7 Doncaster is ranked the 39th most deprived of the 362 Local Authorities in England with considerable variation between the most affluent wards and the most deprived which number amongst the most deprived neighbourhoods in the United Kingdom.

### 7.8 Children and Adolescent Mental Health Service Data

Based on national prevalence data (ONS mental health of children and young people), the following high level assumptions can be made about the emotional wellbeing and mental health of children and young people in Doncaster aged 5 to 16yrs.

<table>
<thead>
<tr>
<th>All Mental Disorders</th>
<th>Doncaster Population of children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 to 10 5,040</td>
</tr>
<tr>
<td>7.7 % of children aged between 5 to 10 years have a mental disorder</td>
<td>388</td>
</tr>
<tr>
<td>9.6% of children and young people aged between 5 to 16 years have a mental disorder</td>
<td>1,037</td>
</tr>
<tr>
<td>11.5% of young people aged between 11 to 16 years have a mental disorder</td>
<td>605</td>
</tr>
</tbody>
</table>
7.9. The following data shows the key performance areas for CAMHs against key performance indicators. It is useful to note that CAMHs is an integrated service so data is not shown in terms of tiers. The data relates to 2015/16 unless otherwise stated.

7.10 Referral Data
A total of 1,451 referrals were received.

7.11 Number of Urgent Referrals
There were a total of 13 urgent referrals received. The chart below shows the number of those deemed urgent assessed within 24 hours.

7.12 Number on Non-Urgent Referrals
There were a total of 752 referrals that were deemed to be non-urgent. The chart below shows the number that were assessed within 4 weeks.
7.13 Number of assessed children and young people starting treatment with a care plan within 8 weeks of referral
There were a total of 626 assessments completed and the chart below shows the number starting within 8 weeks of referral.

![Number assessed starting treatment with a care plan within 8 weeks](image)

7.14 Number of patients leaving the service in a planned way
A total of 913 patients left the service in 2015/16. The chart below shows how many left in a planned way.

![Number of patients leaving in a planned way](image)

7.15 Number of patients returning to service within 30 days of a planned discharge
16 patients returned into the service within 30 days, this equates to 1.75%.

7.16 Access and Waiting Times
Doncaster on the whole has positive access and waiting times, that compare favourably with the CAMHS benchmarking report (2013).
### Doncaster CAMHS Wait Averages - February 2016

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>24</td>
<td>26.6</td>
<td>25.1</td>
<td>20.4</td>
<td>32.6</td>
<td>32.6</td>
<td>29.8</td>
<td>30.8</td>
<td>22.7</td>
<td>15.1</td>
<td>14.4</td>
<td>34.3</td>
<td>32.3</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>98</td>
<td>58</td>
<td>53</td>
<td>49</td>
<td>49</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>15</td>
<td>14</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>2.8</td>
<td>0.8</td>
<td>1.0</td>
<td>0.8</td>
<td>0.4</td>
<td>0.7</td>
<td>0.7</td>
<td>0.5</td>
<td>1.0</td>
<td>0.7</td>
<td>0.7</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>30</td>
<td>50</td>
<td>50</td>
<td>49</td>
<td>49</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>30</td>
<td>50</td>
<td>50</td>
<td>49</td>
<td>49</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>30</td>
<td>50</td>
<td>50</td>
<td>49</td>
<td>49</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

### CAMHS 212

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>27.1</td>
<td>27.1</td>
<td>30.7</td>
<td>20.8</td>
<td>47</td>
<td>37.9</td>
<td>45</td>
<td>39.9</td>
<td>40</td>
<td>47</td>
<td>48.2</td>
<td>31.9</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Apr - Avg Wait (days)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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</tr>
<tr>
<td>Apr - Number of Patients seen</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

CAMHS 212: General - Longest Treatment: 80 days down from 125 in February
7.17 General Service
The average waiting time for an assessment (non-urgent) is approximately 21 days which is within the 28 day target, and the average length of time for treatment to start is 22 days after assessment, this gives a total of 43 days which equates to 6 weeks. The national benchmark is on average 15 weeks (105 days), with average waiting times increasing consistently since January 2011. This element of the service in terms of access times is performing really well.
7.18 Learning Difficulties
The average waiting time for assessment is 23 days for this element and then a further 36 days for treatment to start. This equates to 59 days and/or 8.4 weeks. This is just over the 56 day target.

7.19 Looked after Children
The average waiting time for assessment is 28 days for this element and then a further 51 days for treatment to start. This equates to 79 days and/or 11 weeks. This is significantly over the 56 day target. This will be the pathway where we will focus the additional funding with the aim of improving capacity to drive down the waiting times to accessing treatment.

7.20 Youth Offending Service
There is a dedicated CAMHs worker based within the Youth Offending Service (YOS) that offers fast track support to young people within the Youth Justice system.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of YP assessed with a mental health need (ASSET)</td>
<td>30</td>
</tr>
<tr>
<td>Number of YP on caseload</td>
<td>86</td>
</tr>
<tr>
<td>Number of YP starting treatment within 8 weeks</td>
<td>13 43%</td>
</tr>
<tr>
<td>Number of consultations with YP</td>
<td>25</td>
</tr>
</tbody>
</table>

7.21 Inpatient (tier 4) admissions & bed days

<table>
<thead>
<tr>
<th>Service</th>
<th>PCT</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute CAMHS</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Adolescent</td>
<td>13</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>7</td>
<td>12</td>
<td>5</td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>5</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>4</td>
<td>9</td>
<td>6</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Complex Learning Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Low Secure</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>PICU</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Medium Secure</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Not known/Not stated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Total patients</td>
<td>33</td>
<td>38</td>
<td>31</td>
<td>17</td>
<td></td>
<td>119</td>
</tr>
</tbody>
</table>
Analysis
There was a slight reduction in the number of admissions in 2014/15 compared to the previous year and very similar number to 2012/13. The number (31) is still a high number regionally and based on additional data from NHS England, Doncaster is the second highest referrer in the region for inpatient services at a rate of 52 per 100,000. This has to be linked to no local home intensive treatment service. When comparing our data to areas that have a home treatment service the number of admissions in these areas is significantly less.

The numbers for 2015/16 are for the first three months of the financial year (Apr – Jun) and if the rates were to stay consistent for the rest of the year, the forecasted annual total would show a significant increase.

The breakdown of data maybe doesn’t give a detailed picture, for example we are aware locally that there were actually six inpatients for eating disorder, however four of these patients will have been in a non-specialist eating disorder service.

The numbers across the services are pretty consistent over the three years, with the following exceptions:
- Increase in acute CAMHs in 2015/16.
- Reduction in admissions for child services.

<table>
<thead>
<tr>
<th>Occupied bed days</th>
<th>PCT</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Acute CAMHS</td>
<td>617</td>
<td>617</td>
</tr>
<tr>
<td>Adolescent</td>
<td>1187</td>
<td>1263</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Child</td>
<td>900</td>
<td>1147</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td>381</td>
<td>181</td>
</tr>
<tr>
<td>Complex Learning Disability</td>
<td>320</td>
<td>632</td>
</tr>
<tr>
<td>Low Secure</td>
<td>347</td>
<td>364</td>
</tr>
<tr>
<td>PICU</td>
<td>24</td>
<td>67</td>
</tr>
<tr>
<td>Medium Secure</td>
<td>243</td>
<td></td>
</tr>
<tr>
<td>Not known/Not stated</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3402</td>
<td>3406</td>
</tr>
</tbody>
</table>
Analysis
Again the numbers are pretty consistent across the three years, with a forecasted significant increase in 2015/16. The average length of stay is approximately 101 days and again this hasn’t really varied over the three years. There have been changes in the number of days though across services:

- Year on year increases for adolescent services
- Year on year increases for learning disability, particularly from 2012/13 to 2013/14
- No days in medium secure.

7.22 Tier 4 Spend

<table>
<thead>
<tr>
<th>Tier 4 Spend</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£2,668,815</td>
<td>£1,581,674</td>
</tr>
</tbody>
</table>

There has been a significant reduction in spend in 2015-16 due to a reduction in admissions.

7.23 Secure Children’s Home
The number of Doncaster young people in a secure children’s home was two. The number in a secure treatment centre was two. This data is provisional and 2014/15 and 2015/16 figures will be finalised in the retrospective annual Youth Justice statistics publications. Note these figures are a monthly snapshot of the custodial population, taken on the last Friday of the month or first Friday of the following month depending on which is nearer to actual month.

7.24 CYP-IAPT
Doncaster Children and Young People’s Mental Health Service (CAMHs) team became part of the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) in October 2012. For the purposes of the application to be a part of CYP-IAPT, the partnership for Doncaster includes North Lincolnshire CAMHs - this was decided due to the smaller team in North Lincolnshire and made the bidding/application process more achievable for both services.

Doncaster is part of the North East Collaborative and is a wave 2 site, joining one year after the initial pilot began, this was alongside several services from Tees, Esk and Wear Valley NHS Trust (TEWV). The North East collaborative is linked to Northumbria University, any training requirements are facilitated/provided through Northumbria University, with an agreement that some of the training would be provided in York rather than Newcastle to reduce the impact of travel (time for students and cost for the partnerships).

The two key areas of transformation and development were as follows:
1. Training
2. Transformation of service.

7.25 Training
The training is delivered at level seven, post graduate diploma level and below is a summary of the training opportunities which Doncaster CAMHs has accessed, along with an update on the trainees:
7.26 Parenting Interventions
- (2012/13) - two places for Doncaster, staff completed the training and delivered Webster Stratton parenting courses
- Both parenting trainees have since left the service, one to pursue private work, the other to work in another CAMHs service
- No further training places requested from the area as this work is already predominantly provided by other services in Doncaster.

7.27 Cognitive Behavioural Therapy (CBT)
- Four trainees have undertaken the CBT training, two in 2012/13, two in the following year (2013/14). The CBT training focuses on interventions for anxiety and depression
- From the four trainees, one person failed an element of the course, one person did not complete due to illness. One person has recently left the service.
- Doncaster CAMHs has identified a further need for another place on the 2015/16 training, given the need and loss of trained workforce. This place was granted.

7.28 Service Lead
- Three staff that had involvement within the Doncaster CAMHs team undertook the service leads training in wave two; not all completed the coursework, but undertook projects to address transformation of services
- No subsequent service leads have been identified from Doncaster to complete the service leads course.

7.29 Supervisor training
- Several clinicians have accessed CYP-IAPT supervision training from Doncaster, there were no staff who had appropriate experience to undertake the formal supervisors training in CBT or Interpersonal Psychotherapy for Adolescents
- A family therapist provided supervision for the systemic family practice course, they have recently left to work within a CAMHs tier 4 unit
- It was hoped to send a CBT therapist to complete the supervisors training this year, but they are on maternity leave.

7.30 Systemic Family Practice (SFP)
- Introduced in 2013/14, branched between systemic practice for eating disorders and systemic practice for self-harm
- Two trainees completed the SFP training, one in each of the areas - eating disorder and self-harm.

7.31 Interpersonal Psychotherapy for Adolescents (IPT-A)
- Introduced to the programme in 2014/15
- One clinician is currently undertaking the training, expected to complete in November 2015.

7.32 Enhanced Evidence Based Practice (EEBP)
- This was introduced in 2014/15, at Graduate Certificate/Advanced Diploma
- One clinician commenced the EEBP course, but withdrew due to personal and work circumstances.
7.33 Transformation
The following, details the aspects of service development which Doncaster CAMHs had agreed to develop as part of the CYP-IAPT application process, alongside a brief summary of the progress to date:

Ensure access and waiting times to treatment do not deteriorate during the training period as a result of this project - there has been no deterioration in waiting times for access to service, remaining constant at 25 to 28 days for a routine referral.

Ensure that the transformation takes account of the diversity and cultural needs of the community you support - on-going development of services takes into consideration the needs of the young people from the Doncaster area and how this changes.

Commit to all Tier 3 CAMHs, and Tier 2 CAMHs who are part of the project, undertaking session by session/frequent outcome monitoring using the CYP-IAPT dataset which is used to guide therapeutic interventions and supervision - the ability to capture routine outcome measures has been developed within the patient records system, there is information available through both raw data and tabulated views for use within supervision. The information gathered also supports clinical decision making processes. Further work is required within the service to fully embed the use and monitoring of routine outcome measures.

Move over the life of the project to accept self-referrals – self-referral has been available for young people to access via the Talking Shop in Doncaster as a drop-in one day a week. Children and young people can also contact the service directly to discuss referrals.

Create a local steering group to steer the project locally to include health and local authority commissioners, NHS and voluntary sector providers - a local steering group was set up initially, as the project has developed and main aspects have been focussed on training places and the development of local pathways. This has now been absorbed into local business division meetings and meetings with commissioners.

Support new partnerships working with your collaboratives as they come on line in future years- we are part of the collaborative steering group, which provides an opportunity for learning and support for new and existing members of the collaborative.

Work with the HEIs to select appropriately skilled trainees and supervisors - recruitment to post graduate courses are fully established and embedded into practice with the Northumbria University.

Ensure that trainees, supervisors and service managers selected to undergo the training can attend training and can undertake the assignments necessary to pass the training - trainees have been supported to attend training as required, post graduate trainees have been fully back-filled within service to allow for the appropriate time and resource to be available for them.

Ensure that the infrastructure and data systems are sufficiently robust to allow data collection of the IAPT data set and ensure data is sent as required - there was financial support to employ a data analyst within the first year of the project, which supported the data capture for the national reporting requirement. The removal of this continues to be challenging for the information department as reporting structures and parameters change.
frequently. This should become easier in the near future as reporting will be delivered through the mental health dataset.

Agree that data sent to the project office becomes the property of the Children and Young People’s IAPT Project - agreed locally.

Receive and transfer all funds in accordance of the objectives of the project, and ensure that, as NHS bodies evolve, that organisations which may follow on in the commissioning role are aware of, understand and accept the commitment to the IAPT project – funding has been made available to the service as per requirement.

Agree to participate in service accreditation to IAPT standards - this is ongoing, service accreditation will be considered through the ‘Delivering With, Delivering Well’ criteria.

7.34 Data collection and analysis
The children and young people’s IAPT data collation and analysis document produced by the CORC central team (July 15) provides a summary of demographic data and service level completeness. Doncaster has mixed results across the board, scoring well in certain areas, i.e. Source of referral record at assessment and completed goal at assessment, and not so well in other areas, i.e. paired goal information and patient satisfaction. This means there is still work to do.

7.35 Perinatal Mental Health
In 2014, the Review of Health services for Looked after Children and Safeguarding in Doncaster, highlighted that:

Perinatal mental health services work well for those expectant women who require support for mild to moderate mental health needs. They are prioritised within the Increased Access to Psychological Treatment service (IAPT) and the adult mental health access team are able to offer rapid assessment. The pathway is less clear for those expectant women or women who require urgent crisis intervention post-delivery, and there is ongoing discussion across health providers on how best to respond to their needs.

There are collective national and local recommendations that highlighted the need for a specialist care pathway to support this client group.

Doncaster CCG commissioned a piece of work to review Mental Health Services in Doncaster that resulted in a report highlighting 26 recommendations. One of the recommendations focused on the requirement to develop specialist care pathways, for example, the current mental health services did not provide care in a co-ordinated way for pregnant women. This meant that their care was fragmented at best. More concerning is that there are not many choices open to women who are experiencing a mental health crisis pre/post birth. This results in either mothers being sent out of area to high cost placements to Mother & Baby Units, or choosing to stay locally and being separated from their babies.

The need for a specialist perinatal mental health service is undisputed. In Doncaster alone we have 4000 live births annually and figures quoted in the Guidance for Commissioners, Perinatal Mental Health Services suggest that for 4000 maternities at least 1,256 will suffer some degree of mental illness during pregnancy or within one year of giving birth and of
those 136 will need intense support from secondary mental health services or admission to hospital.

For 4000 maternities:
- 8 women will experience postpartum psychosis
- 8 women will experience chronic serious mental illness
- 120 women will experience severe depressive illness
- 400-600 women will experience mild-moderate depressive illness and anxiety states
- 120 women will experience Post Traumatic Stress Disorder
- 600-1200 women will experience adjustment disorders and distress.

Practical Mental Health Commissioning Nov 2012

There was the establishment of a working group to look at modifying the Perinatal Mental Health service pathway and as a result, a pilot known as the Doncaster Perinatal Mental Health Advisory Pilot was set up to run for the three months from March to May 2014. The objective of this pilot was to establish the demand for such a service. It was promoted almost exclusively to the maternity department although we did not refuse referrals from other sources such as GPs or other psychiatrists. The purpose of the Advisory Service Pilot was to:
- Determine and evidence the level of need – previously the community mental health team and their midwife appointments saw these ladies separately
- To test a joint pathway developed through the work of the Doncaster Perinatal Mental Health Group.

7.36 Perinatal Advisory Service Pilot

During the three month pilot there were 99 referrals for consideration; each of these referrals was discussed at a multidisciplinary team meeting. Of the 99 referrals 28 were considered to be inappropriate, 36 were felt to require a primary care level of input and were either diverted to their GP or to the IAPT service.

Six clinics were run at Ante-natal Clinics with three women being invited to each clinic. The aim of the clinic was to conduct a thorough psychiatric history, establish the context of the pregnancy and any current or past psychiatric treatment.

The next step has been to commission a further pilot; a psychiatry liaison service. The key findings were inclusive:
- A total of 388 referrals were made to the clinic.

![Marital Status](image.png)
### Reason for referral.

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past history of post natal depression</td>
<td>13</td>
</tr>
<tr>
<td>Previous history of depression</td>
<td>10</td>
</tr>
<tr>
<td>Current depressive episode</td>
<td>7</td>
</tr>
<tr>
<td>Previous history of low mood</td>
<td>6</td>
</tr>
<tr>
<td>Generalised stress /anxiety</td>
<td>6</td>
</tr>
<tr>
<td>Current presentation of low mood.</td>
<td>4</td>
</tr>
<tr>
<td>Medication review</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts of self- harm.</td>
<td>2</td>
</tr>
<tr>
<td>Obsessive compulsive disorder with associated anxiety</td>
<td>2</td>
</tr>
<tr>
<td>History of psychosis</td>
<td>1</td>
</tr>
<tr>
<td>Phobia in relation to medical procedures</td>
<td>1</td>
</tr>
<tr>
<td>History of mental health problems</td>
<td>1</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>57</strong></td>
</tr>
</tbody>
</table>

### Outcome for the patients seen in clinic

It needs to be noted that due to their presenting needs some patients had more than one outcome following their assessment in clinic.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred back to General Practitioner with advice in relation to medicines management</td>
<td>18</td>
</tr>
<tr>
<td>Referred back to General Practitioner with no further advice or follow-up</td>
<td>15</td>
</tr>
<tr>
<td>Referred back to General Practitioner with support plan in place</td>
<td>4</td>
</tr>
<tr>
<td>To continue with input/support from secondary mental health services</td>
<td>4</td>
</tr>
<tr>
<td>Referred to IAPT</td>
<td>14</td>
</tr>
<tr>
<td>Referred for counselling</td>
<td>1</td>
</tr>
<tr>
<td>Referred to social services</td>
<td>1</td>
</tr>
<tr>
<td>Referred to access for secondary mental health services</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding referral made</td>
<td>1</td>
</tr>
<tr>
<td>Referral to secondary mental health services declined</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>

### Findings

- Of the 57 patients seen, only 5 were already known to and in receipt of secondary mental health services, and 2 reported to have made previous suicide attempts, but no current risk was identified
- However, 33 (58%) were either currently or had previously been treated in primary care for mental health problems
- 10 reported to having previously been under the care of secondary mental health services
- 12 were assessed as having previously experienced thoughts of self-harm but with no current risk. Most identified their children or the fact they were pregnant as protective factors
- 3 reported to regular use of cannabis. 2 stated that they had not used it whilst pregnant, 1 reported to still be a regular user. A safeguarding referral was made in relation to these particular women
3 of the women reported to regularly drinking alcohol above the recommended limits, but all stated that they had stopped due to their pregnancy.
• 1 reported to still be smoking during her pregnancy.
• 1 woman reported that she had been violent toward her partner.
• 1 woman reported to have experienced domestic violence but this was whilst with a previous partner.

7.37 Eating Disorders
Estimated incidence for Doncaster has been calculated using data from Micali et al. (2013):

**Anorexia Nervosa**
- Females aged 10-49 years = 13.6 cases per 100,000 population = 11 new cases per year.
- Males aged 10-49 years = 1.3 cases per 100,000 population = 1 new case per year.

**Bulimia Nervosa**
- Females aged 10-49 years = 20.7 cases per 100,000 population = 16 new cases per year.
- Males aged 10-49 years = 1.6 cases per 100,000 population = 1.2 new case per year.

**EDNOS**
- Females aged 10-49 years = 28.4 cases per 100,000 population = 22 new cases per year.
- Males aged 10-49 years = 4.2 cases per 100,000 population = 3.3 new case per year.

The following data reflects CAMHS referrals to the eating disorder pathway. The 2014 data is YTD (as of 16.04.14).

The data suggests an increase in total referrals to the ED pathway since 2011. In 2014, there have been 19 referrals in total in less than four months - the same number of referrals as for the whole of the previous 12 months. The table below outlines the age breakdown.
Confirmed 2014/15 data across the region (for those CCG areas who will be part of the collaborative is as follows:

**Doncaster**
Total number of new cases under 18 years: 34
Total number of new cases over 18 years: 6

**Rotherham**
Total number of new cases under 18 years: 19
Total number of new cases over 18 years: 10

**North Lincolnshire**
Total number of new cases under 18 years: 23
Total number of new cases over 18 years: 20

**Total number of referrals:**
Under 18 years: 76
Total referrals: 112

**7.38 Community Eating Disorder Service**
The new community eating disorder service began in April 2016 and the service is evolving to have all facets of the hub and spoke model. The service is provided across Doncaster, Rotherham and North Lincolnshire. The data below relates to Doncaster only.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of emergency cases received</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of urgent cases received</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Number of non-urgent cases received</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of cases admitted into T4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Seen within access target</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
South Yorkshire Eating Disorder Association have been commissioned to provide the following:

- Raise awareness around eating disorders and how to best support these; and
- Provide education and awareness raising sessions for young people, their parents and professionals.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Raising - Number of professional attending training</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education Sessions - Number of professional attending training</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Training Sessions - Number of professional attending training</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

### 7.39 Out of Hours Service
CAMHs operate an out of hours service 24/7. There were 50 call-outs to the OOH worker during Dec 14 and June 15, which is the highest across the provider patch of Doncaster, Rotherham and Scunthorpe.

### 7.40 Section 136
The following data relates to the number of under 18 year olds on a section 136 who were brought to the 136 suite as a place of safety:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 – 2014</td>
<td>2YP</td>
</tr>
<tr>
<td>2014 – 2015</td>
<td>5YP</td>
</tr>
<tr>
<td>2015 – 2016</td>
<td>3YP</td>
</tr>
</tbody>
</table>

### 7.41 Police Cells
The following data relates to the number of young people where the use of custody as a place of safety. Details as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 – 2013</td>
<td>0YP</td>
</tr>
<tr>
<td>2013 – 2014</td>
<td>2YP</td>
</tr>
<tr>
<td>2014 – 2015</td>
<td>1YP</td>
</tr>
<tr>
<td>2015 – 2016</td>
<td>0YP</td>
</tr>
</tbody>
</table>
7.42 Adult Access Team
The access team are based with an acute setting and see young people and adults aged 16 years old and above with a mental health issue. They saw 15 sixteen year olds, 16 seventeen year olds and 15 eighteen year olds, giving an annual total of 46 young people.

7.43 Perinatal Mental Health
In 2014, the Review of Health services for Looked after Children and Safeguarding in Doncaster, highlighted that:

Perinatal mental health services work well for those expectant women who require support for mild to moderate mental health needs. They are prioritised within the increased access to psychological treatment service (IAPT) and the adult mental health access team are able to offer rapid assessment. The pathway is less clear for those expectant women or women who require urgent crisis intervention post-delivery, and there is ongoing discussion across health providers on how best to respond to their needs.

There are collective national and local recommendations that highlighted the need for a specialist care pathway to support this client group.

Doncaster CCG commissioned a piece of work to review Mental Health Services in Doncaster that resulted in a report highlighting 26 recommendations. One of the recommendations focused on the requirement to develop specialist care pathways, for example, the current mental health services did not provide care in a co-ordinated way for pregnant women. This meant that their care was fragmented at best. More concerning is that there are not many choices open to women who are experiencing a mental health crisis pre/post birth. This results in either mothers being sent out of area to high cost placements to Mother & Baby Units, or choosing to stay locally and being separated from their babies.

The need for a specialist perinatal mental health service is undisputed. In Doncaster alone we have 4000 live births annually and figures quoted in the Guidance for Commissioners, Perinatal Mental Health Services suggest that for 4000 maternities at least 1,256 will suffer some degree of mental illness during pregnancy or within one year of giving birth and of those 136 will need intense support from secondary mental health services or admission to hospital.

For 4000 maternities:

- 8 women will experience postpartum psychosis
- 8 women will experience chronic serious mental illness
- 120 women will experience severe depressive illness
- 400-600 women will experience mild-moderate depressive illness and anxiety states
- 120 women will experience Post Traumatic Stress Disorder
- 600-1200 women will experience adjustment disorders and distress.

Practical Mental Health Commissioning Nov 2012

There was the establishment of a working group to look at modifying the Perinatal Mental Health service pathway and as a result, a pilot known as the Doncaster Perinatal Mental Health Advisory Pilot was set up to run for the three months from March to May 2014. The objective of this pilot was to establish the demand for such a service. It was promoted almost exclusively to the maternity department although we did not refuse referrals from
other sources such as GPs or other psychiatrists. The purpose of the Advisory Service Pilot was to:

- Determine and evidence the level of need – previously the community mental health team and their midwife appointments saw these ladies separately
- To test a joint pathway developed through the work of the Doncaster Perinatal Mental Health Group.

7.44 Childhood Development
The percentage of children achieving a good level of development at the end of reception in Doncaster (53.1%) is lower than the national level (60.4%). During 2013/14, 1,981 children achieved good levels of development (CHP 2015).

Table 3: Percentage of children achieving good level of development at the end of reception (2011-14)

<table>
<thead>
<tr>
<th>Year</th>
<th>No of children achieving good level of development at the end of reception</th>
<th>Percentage of children achieving good level of development at the end of reception in Doncaster (%)</th>
<th>Percentage of children achieving good level of development at the end of reception in England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,997</td>
<td>57.0</td>
<td>59.0</td>
</tr>
<tr>
<td>2012</td>
<td>2,177</td>
<td>62.0</td>
<td>63.5</td>
</tr>
<tr>
<td>2012/13</td>
<td>1,623</td>
<td>43.3</td>
<td>51.7</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,981</td>
<td>53.1</td>
<td>60.4</td>
</tr>
</tbody>
</table>

Source: CHP 2012-15

7.45 Special Education Needs
Doncaster has about 6,386 children who require special educational needs (with or without statement) and this equates to 13.2% of school children (DfE. 2015). The highest percentage of children with SEN in a community from Doncaster was 36.4% while the lowest was 8.6%. A total of 1278 pupils were identified as pupils with SEN during 2014-15; they either had a statement of SEN or an Education, Health or Care Plan.
Pupils with SEN who had a statement were divided into:

- Autism Spectrum Disorder (ASD) 34.70%
- Behavioural, Emotional and Social Difficulties 20.00%
- Speech, Language and Communication Needs 12.70%
- Severe Learning Difficulties (SLD) 10.30%
- Physical Disability (PD) 10.60%
- Others 11.30%

7.46 Schools
Schools are included in the universal offer to children and young people and provide a wide range of services to support children and young people. The support offered to children and young people around emotional health and wellbeing is varied. A recent audit of counselling provision within schools showed there is variance across schools (sample size of 50% of all schools). For full details see Appendix 5. However, the main points were:

- Over half of schools don’t provide face-to-face counselling for a range of emotional health and wellbeing issues
- Approximately 70% didn’t have an external organisation provide face-to-face support
- Training assistants do provide support in some schools, but in the majority of cases where they do provide support, they have had no formal training
- In some schools there is a nominated lead for emotional health and wellbeing
- Schools and CAMHs are not closely configured and don’t have robust systems to enable effective joint working. This means there is very little consultation, advice and guidance provided into schools from CAMHs.

7.47 An emerging theme from recent engagement with schools so far is the requirement for more targeted support for children and young people who seem to be struggling emotionally, and a need for staff training on emotional health including key issues such as self-harm.

7.48 Early Help Offer
Most children, young people and families have a number of basic needs that can be supported through a range of universal services. These services include education, early years, health, housing, youth services, leisure facilities and services provided by voluntary organisations. However, some families have needs which will require additional support to enable them to reach their full potential. In Doncaster the early help offer across services has been patchy with gaps and a lack of co-ordination, in particular services around behaviour issues, risky behaviours, counselling, mentoring and parenting. The Local Medical Committee (LMC), CAMHs and keyworkers from the Stronger Families programme have previously highlighted this as an issue. This has resulted in lots of inappropriate referrals into CAMHs for children and young people who have a behaviour issue rather than mental health. This was identified in the recent audit completed in 2013 (see Appendix 4).
7.49 This was recognised as a big gap and a significant amount of work has been completed over the past year to develop a new early help strategy, which went live on 5th October 2015. A description of the new service is found in section 9, 1.1. (pg 36).

7.50 There is a lack of understanding between universal services and targeted services and CAMHs in terms of thresholds and roles and responsibilities across the emotional wellbeing and mental health agenda. This results in referrals coming into CAMHs that are not appropriate. These are then either returned to the referrer or signposted to another service. In reality not all onward referrals get picked up and those that are returned are back to square one.

7.51 Workforce
Universal staff via the collaboratives and through partner events with CAMHs have identified that staff working in universal services have differing skills, competencies and understanding of the gamut of emotional wellbeing and mental health. Staffs on the whole do not feel confident to identify need early and then provide appropriate guidance and support at an appropriate level.

7.52 Childhood development and school achievements
During 2013/14 just over half of the total children aged under five years achieved a level of good development, this is significantly lower than the national average. Around 50% of young people achieved higher GCSE grades compared to a national average of 56.8%.

7.53 Not in education, employment or training (NEET)
The percentage of young people not in education, employment or training has declined between, 2010-2013. The figures for 2013 shows 5.5% of total young people were NEET.

7.54 Smoking, alcohol and substance misuse
Doncaster has a higher percentage of young people who smoke regularly when compared to the national average. Rates for under 18 year olds for alcohol specific hospital admissions in Doncaster, although being slightly higher, were not statistically different from the national average.

7.55 Looked after children & Homelessness
As of 5th July 2016 there were 504 Looked after Children, the breakdown is as follows:

- Foster Care: 27%
- Home & Hostels: 12%
- Placed with Parents: 55%
- Placed for Adoption: 3%
- Independent Living: 1%
- Placed out of Borough: 2%
<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of LAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3 years</td>
<td>68</td>
</tr>
<tr>
<td>4 – 15 years</td>
<td>333</td>
</tr>
<tr>
<td>16 – 17 years</td>
<td>99</td>
</tr>
<tr>
<td>18 years &amp; over</td>
<td>4</td>
</tr>
</tbody>
</table>

7.56 In 2014 there were 299 children that went missing. Doncaster has a significantly lower rate of family homelessness than the national average.

7.57 Hospital admissions for unintentional and deliberate injuries

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional Injuries (0-14yrs)</td>
<td>520</td>
<td>461</td>
<td>386</td>
</tr>
<tr>
<td>Deliberate Injuries (0-14yrs)</td>
<td>7</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Unintentional Injuries (15-24yrs)</td>
<td>331</td>
<td>272</td>
<td>314</td>
</tr>
<tr>
<td>Deliberate Injuries (0-14yrs)</td>
<td>23</td>
<td>10</td>
<td>21</td>
</tr>
</tbody>
</table>

7.58 Hospital admissions self-harm

The number of children presenting in A&E for self-harming could not be obtained due to the absence of coding for self-harm in A&E. However, children and young people admitted to acute wards via A&E due to deliberate self-harm was obtained and is illustrated in Figure 13. During 2013/14, 130 children and young people were admitted to acute wards due to self-harm whereas the number fell to 109 in 2014/15. The caveat to this data is that it includes alcohol poisoning so it must be interpreted with this consideration.

Figure 13: No of children and young people admitted to acute wards due to self-harm (2013-15).
### 7.59 Suicide

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number admitted to acute wards via A&amp;E or CAMHs for attempted suicide</td>
<td>13</td>
<td>12</td>
<td>27</td>
</tr>
</tbody>
</table>

7.60 Performance data provided for Quarter 1 to Quarter 3 in 2015/2016 identified an increase in the number of children and young people who have been admitted to acute wards via A&E due to attempted suicide as well as there being an increasing number of children and young people being admitted to acute wards via A&E due to deliberate self-harm.

7.61 DSCB wanted to explore this data further to gain a better understanding of those children who attempted to end their life. This is also in line with a recommendation from the recent Ofsted Single Inspection “Undertake a review of those children and young people admitted to hospital for self-harm and attempted suicide to determine reasons that will inform suitable preventative work” (Ofsted, 2015, p40).

7.62 The key objective of this audit was to undertake a ‘deep dive’ into the thresholds, services and support to individual young people who were admitted to an acute ward due to attempting to take their own life.

The DSCB multi-agency audit tool was used in order to measure compliance and quality with the following procedures:

- Assessment and Care of Children and Young People with Mental Health Needs, who are placed in an Acute General Hospital Ward Policy 2015
- Children Living Away from Home (including Privately Fostered Children) 2016
- Working Together to Safeguard Children 2015.

The themed audit day brought together managers/safeguarding leads who were not directly involved in any cases. Practitioners were made aware that a multi-agency audit was taking place and a reflective practitioner questionnaire was sent to those involved for completion. The audit group wanted to explore practitioner views on processes, multi-agency working in Doncaster, participation of young people and what training has been undertaken and what impact this has made to practice.

Questionnaires were sent to parent/carers from CAMHs to inform them of the audit and to seek their views.

A questionnaire for young people was sent to identified practitioners to capture the views of children and young people.
The key findings were as follows:

- In 17 cases the response by the acute hospital was appropriate and timely with referrals to CAMHS evidence. The response from CAMHS was equally appropriate and timely with evidence of referral.
- 13 out of the 18 young people were seen by a qualified CAMHS practitioner within 24 hours of admission to an acute ward, in line with policy. Two other young people (aged 16/17) were seen by the adult crisis teams. Another young person presented at A&E and was going to be admitted (recorded as admitted) but was
taken home by her mother and therefore CAMHs did not have the opportunity to see this young person at point of admission. A follow up appointment took place

- In 17 out of 18 cases auditors were confident that the practitioners knew the signs and risk indicators in terms of self-harm and poor mental health and articulated this well in case records
- 13 out of the 17 assessments evidenced were child focused. The young person’s voice was clearly recorded and quoted; behaviours and observations were evident in CAMHs and DBHFT records
- In 16 cases, a risk management plan and a discharge plan following the admission was evident in both DHBFT and CAMHs records. Plans included for example: removing sharps, tablets, harm minimisation, emojis to show emotions, being with an adult at all times and a follow-up appointment with a psychiatrist within 7 days
- In 14 out of the 18 cases the recording was child focused across agencies records. There was lots of detail about emotions and feelings, good use of “you mentioned, you said” to evidence being child focussed. In addition, DCST and IFST records evidence the signs of safety approach with headings used “what is working and well and what are we worried about” in case recording and supervision
- For those children in T4 services, CAMHs can evidence regular contact with the young person
- In 16 out of the 18 cases there was strong evidence of direct work with the child/young person. The majority of this is in CAMHs records. The types of work evidenced is mainly talking therapies, but there is some evidence of SDQ and RCADS completed with young people, traffic lights, goals signed by young people, mapping around moods, IAPT scores evidence progression.

7.64 There are a number of proposed recommendations for the Quality and Performance Group to consider when formulating the action plan that will inform suitable preventative work:

- There needs to be a multi-agency assessment of holistic needs, not just “current view” at the earliest possible opportunity. We need a whole child and whole family approach for children/young people who are experiencing poor mental health
- Improved attendance at team around the child/family meetings by CAMHs practitioners
- Improved attendance at discharge planning meetings by social workers
- More evidenced-based support and challenge to parents/carers to promote good mental health in children
- More involvement with adult mental health services to support families where there are known parental mental health issues, as there is a strong link with parental mental health and children’s mental health
- All agencies need to increase the use of goal setting and standardised measures to evidence impact and progression
- There needs to be a joint protocol to ensure that children accessing T4 services receive a timely multi-agency assessment (before a discharge meeting) which is implemented and embedded in practice
• Co-ordinated approach to self-harm providing children/young people support in the community
• DBHFT and CCG to ensure the right coding is used, so the performance data is accurate and helps inform services about local need
• CAMHs to ensure that there is robust use of a risk assessment tool, identifying risk to self and others
• RDASH to consider better ways of evidencing work undertaken on electronic case file systems
• CAMHs to evidence case supervision
• DMBC to ensure the Code of Conduct for Working with Children Policy has been shared and understood with education providers
• CAMHs need to reduce DNA appointments and ensure a more inclusive way of engaging young people and hard to reach families
• RDASH to embed sensitive enquiry of trauma, abuse and neglect into practice whilst undertaking assessments
• Consideration given to how young people Post-16 with mental health issues access further education, training and employment
• DSCB to be assured that education providers are aware of and utilising Department of Education (2014) Preventing and Tackling Bullying guidance
• Seeing the child/young person on their own without parents is good practice and will enable the child/young person to speak freely
• Use your electronic systems well to evidence the work undertaken. Use titles, types and subject areas to ensure the information flows
• Ensure supervision and attendance at High Risk Management meetings are clearly documented
• Be clear where your source of information has come from i.e. role/title
• Ensure you gather information for your assessments from the all appropriate health teams
• If you are recommended Early Help support, gain consent and complete an Early Help Enquiry Form.

7.65 Number of Doncaster mental health service users who have dependent children

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Doncaster mental health service users who have dependent children</td>
<td></td>
<td></td>
<td>2090</td>
</tr>
</tbody>
</table>

7.66 Sexual Abuse and Rape Clinic (SARC)
In 2014/15 there were 17 new cases and 14 historic cases. Currently both new and historic cases are seen by Sheffield Children’s Hospital, as we don’t have sufficient numbers locally to enable paediatricians to keep the necessary competencies. There is an agreed local follow-up pathway that works well and we would look to keep this arrangement. There is a gap in that there is no specialised psychology support for this cohort of children and young people. This is something we will look at regionally as part of the five year plan.

7.67 Children in need and child protection
At the time of completing the health needs assessment there were 1,646 Children and Young people who are ‘In Need’ and 420 Children and Young People with a safeguarding plan.
7.68 Domestic Violence
Doncaster Children’s Services Trust (DCST) with Partners has secured funding from the Department for Education (DfE) Innovation Fund to support the transformation of practice to children, young people and families. The DCST project is to specifically focus on Domestic Abuse and the effect this has on children and young people both in the immediate and longer term.

Domestic abuse and violence is a significant feature for children and young people (CYP) in over 30% of all referrals to Doncaster Children’s Services Trust, and is prevalent in police referrals to social care. Currently domestic abuse is not commonly identified by universal and early help services; it is usually first identified by either the police or social care at a relatively high level of risk. At present, most of the responses are focused on either victims or perpetrators, and not on the children and young people in the family. The immediate efforts to reduce short term risk do not necessarily reduce risk in the long term, leading to repeat victimisation with different partners in new relationships, and young people going on to become victims or perpetrators in their adult life. There are very few interventions focused on children and young people, and even fewer focused on the recovery of victims and their children together, in order to achieve sustained reduced risk of victimisation.

7.69 Hospital admissions for mental health
The rate per 100,000 for hospital admissions for mental health (age 0-17 years) has declined from 79.5 in 2010/11 to 53.9 in 2013/14. The rate (per 100,000) for hospital admission for mental health in Doncaster is significantly lower than the England average throughout the period from 2012 to 2015. Hospital admissions for mental health (age 0-17 years) have declined in Doncaster over the past years, 35 people were admitted during 2013/2014.
8. Self-Assessment Toolkit

8.1 A multi-agency team completed the East Midlands Strategic Clinical Network self-assessment toolkit, which has been promoted through the Yorkshire and Humber Strategic Clinical Network. This has been used across the region as a standardised measure. The key findings are as follows:

8.2 Developing the Workforce – 3.33/5 (rating)

Existing Strengths:

- CAMHs clinicians have benefited from the post-graduate diploma level training across three main areas as part of the CYP-IAPT programme. This includes; two staff completing the Webster Stratton parent courses, four trainees undertaking CBT training and three staff completing service leads training
- All staff within CAMHs are trained to practice in a non-discriminatory way
- Multi-agency practitioner training is already being delivered in some schools and this will be the building block to a wider programme. This includes CAMHs, Education Psychology and schools and education.

Areas for development:
The majority of the points under this heading were deemed to be not ready with a complex, complexity rating. Key areas are:

- The need to target the training of health and social care professionals to create a workforce with the appropriate skills, knowledge and values to deliver a full range of evidence based interventions
- Professionals trained to be able to identify mental health problems early and recognise the value and impact of mental health
- Professionals trained on how to provide an environment that supports and builds resilience.

8.3 Resilience, Prevention and Early Intervention for the Mental Wellbeing of Children and Young People – 3.20/5

Existing Strengths:

- The Early Help Strategy for Doncaster is now developed and has been very recently implemented. A joined up early help system will promote the identification of emerging needs and earlier intervention which is based on a whole family approach as promoted by the Stronger Families programme. This will bring better co-ordination and plug a big gap in service provision
- CAMHs are piloting a resilience college model, which aims to meet the needs of children, and young people aged 12-18 years old with emotional distress and mental health problems. This is done through group work and peer support
- There is a current perinatal mental health pilot running which will be evaluated in March 2016. The pilot pathway offers joint case management of care between midwifery, consultant obstetrician and psychiatric care.

Areas for development:
Although this theme scored quite high, a number of the proposals are related to NHSE, PHE and DfE. The ones that relate locally are as follows:

- The development of whole school approaches to promoting emotional wellbeing and mental health
- Supporting self-care by supporting the development of new apps and digital tools.
8.4 Improving Access to Effective Support – 3.14/5

**Existing Strengths:**

- The current CAMHs service adheres to relevant NICE guidelines, including CG158, CG72, CG155, and PH40
- Doncaster already has a shared Tier 2 and 3 services and this is co-located and has many strengths, including excellent access times
- There are some clear access and waiting time standards
- There is a 24/7 out of hours service
- The peer mentoring provision has been held up as an exemplar
- Initial risk assessments ensure high-risk children and young people are seen as a priority. In Doncaster, 100% of those deemed urgent at triage are seen within 24 hours. All referrals are triaged within 24 hours
- There is a strategic link between CAMHs and services for SEND
- There is dedicated learning disabilities provision within core CAMHs
- There are good data systems for collecting data on crisis/home treatment and section 136.

**Areas for development:**
This is the area with the greatest number of proposals locally. Key points are:

- There are a significant number of referrals per annum to CAMHs that should not be referred. In 2014/15 this equated to 24%
- Moving away from the current tiered system of mental health services to investigate other models based on existing best practice
- Enabling single points of access and One-Stop-Shops to become part of the local offer
- Assigning named points of contact in specialist mental health services (CAMHs) for schools, GP practices
- Schools assign names leads for mental health
- Development of joint training programmes
- Implementation of the Crisis Care Concordat
- Implementation of clear evidence based pathways for community based care, including home treatment (tier 3.5) to avoid unnecessary admissions to inpatient care
- Ensure no child or young person (under 18yrs) is detained in a police cell as a place of safety
- There is no community service for eating disorders. Currently an adhoc service is provided in each of the three CCG areas from within core CAMHs.

8.5 Caring for the most Vulnerable – 2.90/5

**Existing Strengths:**

- The current CAMHs service adheres to relevant NICE guidelines, including PH28
- Commissioners and providers across education, health and social care and youth justice systems work together to develop appropriate bespoke care pathways
- The designated lead professional role works well in a number of cases. There is room for improvement but the basics are in place
- There is a specific, multi-agency LAC resource within core CAMHs
- There is a mental health worker placed within the local Youth Offending Service
- In many cases, specialist services (CAMHs) are available to provide advice, rather than see those who need help. The challenge is to get referring services to better use this function as opposed to referring straight into CAMHs’ without any conversations. This links to the named CAMHs roles.
**Areas for development:**
For many of the proposals we have partial implementation locally. The areas, which for development are:

• Mental health assessments should include sensitive enquiry about the possibility of neglect, sexual abuse, including child sexual abuse or exploitation and for those aged 16 yrs and above, routine enquiry
• Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence based services
• For the most vulnerable young people, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services
• Improving care of children who are most excluded from society, i.e. those who are homeless, sexually exploited.

**8.6 To be Accountable and Transparent – 2.40/5**

**Existing Strengths:**

• This was the area with the best performance with a small number of proposals that don’t have full or partial implementation
• There are clear lead commissioner arrangements
• There is a lead accountable commissioning body, this is the CCG
• The Health and Wellbeing Board have strategic oversight of the commissioning of elements of the pathway or offer regarding children and young people’s emotional wellbeing and mental health
• Commissioners ensure quality standards from NICE inform and shape commissioning decisions
• There are systems to monitor access and wait measures against pathway standards that are linked to outcome measures and the delivery of NICE concordant treatment at every step.

**Areas for development:**

• There is currently no single integrated strategic plan for child emotional wellbeing and mental health services across Doncaster
• The work of the lead commissioner is not based upon an agreed plan, agreed by all relevant agencies and with a strong input from children and young people
• Co-commissioning of community mental health inpatient and intensive treatment between local areas and NHSE
• Development of detailed measurement outcomes.
## 9. Workforce

9.1 As part of the needs assessment process we asked partners to collate all available data on activity, workforce and investment for services, which cover the whole gamut of emotional wellbeing and mental health, to give a good understanding of the current workforce. A template was devised by the Yorkshire and Humber Strategic Clinical Network to help standardise reporting, this is the template we used. It is important to note that this data is based on available data only, which may exclude some data.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Number of Practitioner/ Staff in post June 2015</th>
<th>Number of Practitioner/ Staff in post October 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Based Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JASP</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Thrive</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td><strong>Children’s Trust Based Service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Forensic Psychologist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Third Sector</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open Minds</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>NHS Based Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist CAMHs</td>
<td>29.8</td>
<td>15.6</td>
</tr>
<tr>
<td>Consultation &amp; Advice</td>
<td>0</td>
<td>5.5</td>
</tr>
<tr>
<td>Intensive Home Treatment Service</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Paediatric Liaison</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community Eating Disorder Service</td>
<td>1.6</td>
<td>11.9</td>
</tr>
<tr>
<td>Looked after Children CAMHs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Learning Disability CAMHs</td>
<td>2</td>
<td>4.1</td>
</tr>
<tr>
<td>Youth Offending CAMHs</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ADHD</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>Autism</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Single Point of Access CAMHs</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95.40</strong></td>
<td><strong>127.90</strong></td>
</tr>
</tbody>
</table>

9.2 There is a significant increase in practitioners/staff in post in October 2016 as a direct result of the system transformation aims and objectives.

9.3 There has been a deliberate shift of resources from specialist CAMHs to consultation and advice and intensive home treatment to better reflect the needs of the population. The aim being to identify and provide support (as part of a systemic approach) at the earliest stage possible.

9.4 There has been a significant increase in the community eating disorder resource, to reflect the new access and waiting times standards, and the need for a multi-disciplinary approach.

9.5 **Workforce skills audit, development strategy and delivery plan**

The original LTP identified a number of areas that the Borough needs to transform, in order to achieve their ambition to meet the emotional health and wellbeing of children and young people. One of those areas was the need to improve the workforce, with the aim that everyone who works with children, young people and families are ambitious for every child.
or young person to achieve goals that are meaningful and achievable. They will be excellent in practice and able to deliver the best-evidenced care, be committed to partnership working and be respected and valued as professionals. In effect what this means is that this is a good quality equitable offer across the Borough.

9.6 The first step was to commission a workforce audit that would act as the basis for the subsequent strategy. The audit set out to review a range of information regarding current capacity, expectations and skills associated with people engaged in the delivery of emotional health and wellbeing services to children and their families. The approach was to deliver two levels of audit; firstly a simplified questionnaire distributed to the widest possible range of staff in the children’s workforce. This will focus primarily on Primary Care, Health Visiting and School Nursing as well as nominated representatives from Schools. A second layer of skills audit aimed to take a more in-depth and detailed look at the skill set in the CAMHs workforce. This had the intention of understanding the gaps relating to both the highest levels of skills requirements in a range of CAMHs specific core competencies, the ability of CAMHs professionals to use those skills working with and through others, as well as understanding the attitude towards and readiness for change in this core workforce. However, as the audit progressed and the relationship with the pilot schools grew, a deeper dive took place that was further supported by four locality schools events.

9.7 The schools which were engaged at both levels of the skills audit expressed very positive attitudes towards their responsibilities for the emotional health and wellbeing of their students. Every school that was spoken to was engaged in some activity around promoting positive mental health, identifying children with additional needs or providing some level of in house support or guidance.

**Findings Summary - Schools**

<table>
<thead>
<tr>
<th>Findings Summary - Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schools welcome the opportunity to work more closely with CAMHs professionals in the new model</td>
</tr>
<tr>
<td>Most expertise in schools is vested in a small number of pastoral support staff</td>
</tr>
<tr>
<td>A small number of schools have excellent systems and processes in place. They promote positive mental health, have access to and use tools to identify additional needs and training and expertise in delivering bespoke interventions, and work closely and effectively in collaboration with external professionals including CAMHs</td>
</tr>
<tr>
<td>Skills across all areas of emotional health and wellbeing needs are variable. Coupled with pockets of excellent practice are low levels of understanding and skills. There is also an acknowledgement that much activity in this area is driven by guesswork and well-meaning</td>
</tr>
<tr>
<td>There are no standards for the systems and processes that should be in place to underpin the activity schools engage in to identify and intervene to meet need</td>
</tr>
<tr>
<td>Generally, interventions in schools are applied inconsistently and lack structure and evidence base</td>
</tr>
<tr>
<td>The point at which schools individually exhaust their competence and confidence and turn to external support varies significantly. Specialist schools in particular, though not exclusively, have very high levels of skill and support infrastructure and use these to support high levels of emotional health and wellbeing needs before contacting CAMHs for specialist support and advice</td>
</tr>
<tr>
<td>Schools acknowledge they use tools and techniques that have been developed for one set of needs and applying them to others (e.g. Lego therapy for communication deficits) or they make educated guesses as to what interventions could be applied in particular circumstances</td>
</tr>
<tr>
<td>There is limited sharing of practice or knowledge between schools. Emotional Health and Wellbeing Leads in schools have no systems or processes in place for engaging formally with each other across schools</td>
</tr>
<tr>
<td>Whilst some schools have very positive relationships with the CAMHs service these were often built on one-to-one relationships or where schools had specific skills or competencies that enabled them to engage with CAMHs in a ‘CAMHs Language’</td>
</tr>
</tbody>
</table>

51
9.8 The wider workforce were consulted with the key findings as follows:

<table>
<thead>
<tr>
<th>Findings Summary – Wider Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>All parts of the ‘Team Doncaster’ offer for children and young people acknowledged that prevention activity was better, cheaper and more effective over the whole life cycle. All partners in this audit reinforced the view that delivering interventions at the earliest possible stage was the best way to meet the needs of children and young people.</td>
</tr>
<tr>
<td>Many services in the Borough, particularly those already addressing other high impact needs, have excellent systems and processes in place to promote positive mental health and provide meaningful interventions to support children and young people with emotional health and wellbeing needs. Such services may be better placed to address higher level emotional health and wellbeing needs through access to increased skills training and higher end consultation and advice from specialist practitioners in CAMHs.</td>
</tr>
<tr>
<td>There is an absence of services in the Borough where young people can receive counselling support to work through particular issues with impartial and independent experts.</td>
</tr>
<tr>
<td>GPs in Primary Care do not feel they have the time or skills to deal with high levels of emotional health and wellbeing need. They note a perceptible increase in numbers of children and young people presenting with emotional health and wellbeing issues.</td>
</tr>
<tr>
<td>GPs recognise that they don’t have (and can’t establish in short consultations) meaningful enough relationships with children and families to be able to make a huge impact on the experience of the child or young person.</td>
</tr>
<tr>
<td>GPs, Health Visitors, School Nurses and the wider workforce struggle to easily identify the sources of advice, information and support available to children, young people and their families as these are not centrally collated, collected or presented.</td>
</tr>
<tr>
<td>There may be scope to investigate the provision of some emotional health and wellbeing support for children and young people in primary care settings.</td>
</tr>
<tr>
<td>School Nurses in partnership with schools Emotional Health and Wellbeing Leads sometimes struggle with gaining access to suitable space within the school estate to deliver emotional health and wellbeing services.</td>
</tr>
<tr>
<td>Schools are able to specify in an annual plan the key areas they require School Nursing services to focus on. Many schools identify emotional health and wellbeing as one of those areas, not all schools do so.</td>
</tr>
<tr>
<td>School Nursing, Health Visiting and CAMHs are all managed within a single business unit. This provides considerable opportunity for increasing the amount and efficacy of joint working and significant coordination or effort across the disciplines in order to facilitate the objective of improved whole-child outcomes.</td>
</tr>
<tr>
<td>School Nursing and Health Visiting services receive large numbers of referrals into their services, there are concerns about how best to identify the ones with the greatest need for emotional health and wellbeing support.</td>
</tr>
<tr>
<td>There has been significant investment in developing skills and understanding around ‘attachment’ within the Health Visiting workforce and those they work closely with including the Early Help Hub.</td>
</tr>
<tr>
<td>The Early Help Hub is a key part of the system for meeting the emotional health and wellbeing needs of Children and Young People in the Borough and increasing capability within the hub to deal with emotional health and wellbeing needs will address need more quickly.</td>
</tr>
<tr>
<td>The Early Help Assessment (previously the CAF) is often seen solely as a tool for assuring referral threshold criteria. However, it is actually an actual assessment tool that could help ensure consistency and improved communication across the Borough.</td>
</tr>
<tr>
<td>There is an opportunity to enhance further the delivery of an emotional health and wellbeing offer amongst Health Visitors and School Nurses through the provision of additional skills and access to consultation and advice from CAMHs practitioners.</td>
</tr>
<tr>
<td>A focus on developing the CAMHs offer into schools could be complimented strongly with a primary mental health consultation and advice offer into nurseries and children’s centres. This could focus on early resilience training and the development of competencies in recognising and providing support for emotional health and wellbeing needs.</td>
</tr>
</tbody>
</table>
9.9 An audit was completed on the CAMHs workforce. The key findings were as follows:

<table>
<thead>
<tr>
<th>Findings Summary - CAMHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Support Workers provide a valuable and innovative role within the service</td>
</tr>
<tr>
<td>There is a broad range of professions, roles and qualifications represented within the service</td>
</tr>
<tr>
<td>The service has struggled in the past to retain qualified CBT practitioners. Not all CAMHs staff are trained to the necessary level in CBT</td>
</tr>
<tr>
<td>The service skill mix seems heavily skewed towards professional roles with limited scope for support roles including those at an associate practitioner level</td>
</tr>
<tr>
<td>Within the service training needs are not clearly identified nor recorded consistently</td>
</tr>
<tr>
<td>Within the service there is little evidence to show how individual staff member’s training or development is driven by the needs of the service</td>
</tr>
<tr>
<td>The Trust-wide ‘Training Needs Analysis’ has identified within it a range of courses relevant to the future needs of CAMHs staff. Many of these courses have been commissioned through Health Education England (Yorkshire and the Humber). These include Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Mindfulness, Motivational Interviewing, Leading Structured Groups, Family Intervention training and Training to Support Carers</td>
</tr>
<tr>
<td>CAMHs staff would benefit from increased levels of skill in Cognitive Behavioural Therapy, Mentalisation Based Therapy, Family Therapy and Mindfulness</td>
</tr>
<tr>
<td>CAMHs staff require support and development to be able to deliver interventions through others, especially in providing advice and guidance to others working with children and young people without the need to see the individual themselves</td>
</tr>
<tr>
<td>Some effort needs to be invested in ensuring that all CAMHs staff including the non-clinical admin, clerical and managerial staffs are fully engaged in the new service arrangements. That they are clear about their role within it, the skills and competencies they will be expected to have to ensure safe, effective and evidence based interventions to children and with and through others</td>
</tr>
<tr>
<td>Some CAMHs staff will be already skilled to deliver training to groups of non-CAMHs staff in the Borough. There is, however, a need to ensure that all staff who may be called upon to deliver such training are skilled at providing training to groups</td>
</tr>
<tr>
<td>As the service develops staff will need further support to ensure they continue to develop and adapt to the changing needs of the children and young people of the Borough</td>
</tr>
</tbody>
</table>
9.10 There are a series of recommendations that come directly from the above key findings.

## Impact Area

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Workforce Impact Area</th>
<th>Which Groups of staff?</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Promoting Positive Mental Health</strong></td>
<td>Schools, Health Visitors, School Nurses, Early Help Hub, Children’s Centres</td>
<td>Schools with CAMHS support and advice</td>
</tr>
</tbody>
</table>

### Development of an easily accessible and searchable self service advice and information portal.
Staff across children’s services are able to share and showcase their best practice increasing knowledge, expertise and confidence across children’s services. This will contain a repository of best practice examples of tools and techniques for promoting and delivering to improve Emotional Health and Wellbeing in Children and Young People. Would also include signposting for external advice and support including where schools might start with receiving assistance with commissioning external support.

### Development of an invitation only (private) professionals network:
An online self-organised network of individuals across the range of children’s services sharing their own knowledge and seeking advice and support from other peers. With the addition of CAMHS staff this could also then become a repository of qualified best practice with responses to questions and their answers being curated and/or moderated by CAMHS. As with recommendation 1 this could be integrated into the ‘Care4Doncaster’ portal.

### Development of a Doncaster-wide Promoting emotional well-being and positive mental health course:
Such a course would be widely accessible and, with the support of senior leaders across the Borough, widely accessed by a broad range of staff from the widest possible range of children’s services. Benefits will be maximised by not limiting the course solely to those with an interest in emotional health and wellbeing. The focus of the course would be on: Spotting early signs of a mental health issue in children and young people, confidence helping a young person experiencing mental ill health. Providing early help, protecting from harm, preventing a MH issue getting worse, assisting with recovering faster from a period of ongoing mental ill health and acting to reduce the stigma associated with mental health issues.

### Development and delivery of a model of motivational interviewing/ brief interventions techniques training:
Rolling out a series of basic and higher level training in these areas would maximise the impact of every contact with a child or young person and provide the basis for a CBT based common thread through the Borough.

### Increase in the availability of counselling skill in schools:
Development of a Doncaster Schools’ Counselling offer in line with the DfE recommendations

### Development and delivery of a series of shared learning opportunities for specific needs:
Conduct disorders, Anxiety, Depression, Hyperkinetic disorders, Attachment disorders, Eating disorders, Substance misuse, Deliberate self-harm, Post-traumatic stress Staff across the system have increased confidence in dealing with the highest need areas.

### Delivery of shared learning opportunities for meeting higher needs:
Working with staff across the Borough to increase skills in dealing with children with higher end emotional health and wellbeing needs

### Training others: Increasing skills, knowledge and competence at sharing specific tools and techniques relating to emotional health and wellbeing in children in young people through delivery of training to others either one-to-one or group training

### Delivering through others: Increasing skills, knowledge and competence at sharing specific tools and techniques relating to emotional health and wellbeing in children in young people through delivery of training to others either through one-to-one or group training

### Cognitive Behavioural Therapy:
There should be a high level of skills and expertise in competent use of CBT with children and young people across the range of CAMHS professionals.

### CAMHS - Specific higher level interventions: Additional level skill training in Mentalisation Based Therapy, Family Therapy and Mindfulness

### Adapting to and dealing with ‘Change’:
Investing in organisational development initiatives in support of the changes will enable the rapid change mobilisation required of CAMHS staff as the schools pilots take off, are modified and evaluated and the final roll out begins through 2017

### Doncaster should consider the development, or adoption, of a core competency framework for schools staff in leading on or delivering emotional health and wellbeing in schools:
There is, just published by the Yorkshire and Humber Children’s Workforce Leads Group, a Professional Capabilities Framework for the Wider Children’s Workforce: early intervention and prevention. It addresses many of the same issues regarding the diverse skills and competencies identified amongst pastoral support staff and Emotional Health and Wellbeing leads in schools.
10. Key Objectives

The above needs assessment is extensive and gives an excellent overall picture of need. However, there was a need to drill down and pick out some key areas of need, which in turn will allow us to identify the key objectives. The original LTP outlines the key issues and key objectives. For the purposes of this updated LTP we will only include the key objectives.

Support Universal Services
By creating provision to specifically support universal services. This will include named CAMHs workers for schools, Primary Care and a Primary Mental Health Worker within the Early Help Hub. The development of an enhanced single point of access.

Development of Intensive Home Treatment Provision
By implementing a new home treatment service that acts as an alternative to inpatient services and has a key role in pre-crisis and enables step down from acute/inpatient services.

Caring for the Most Vulnerable
To dismantle barriers and reach out to children and young people in need through better assessment and an integrated flexible system that provides services in a way that are evidence based.

Implement the Crisis Care Concordat
We will implement all aspects of the concordat, in particular the embedding of a new 24/7 helpline, ensuring no child or young person is placed in a Police cell as a place of safety and by creating a new liaison provision within an acute hospital setting.

Eating Disorders
By creating a new community service to reflect local need.

Children, Young People and Families have a Voice
By developing sustainable methods to effectively engage with our children, young people and their families so they have a voice and shape what services are provided.
## 11. Outcomes

<table>
<thead>
<tr>
<th>Local Priority Scheme</th>
<th>Outcome</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish named emotional wellbeing and mental health leads in schools (internal)</td>
<td>Better educational attendance and attainment.</td>
<td>Attendance registers and GCSE scores Number of exclusions</td>
</tr>
<tr>
<td>Continuous consultation and engagement with children, young people and families</td>
<td>Commissioning and service delivery decisions are shaped by children, young people and their families</td>
<td>Children and young people involved in commissioning and on task and finish groups</td>
</tr>
<tr>
<td>Appointment of workforce development lead</td>
<td>Workforce that has the skills and capabilities to meet the emotional wellbeing and mental health needs of children and young people</td>
<td>Workforce competency questionnaire</td>
</tr>
<tr>
<td>Audit and rolling training programme</td>
<td>Workforce that has the skills and capabilities to meet the emotional wellbeing and mental health needs of children and young people</td>
<td>Workforce competency questionnaire</td>
</tr>
<tr>
<td>CAMHS worker to be embedded in the Early Help Hub</td>
<td>Effective MDT triage and children and young people being seen by the right person at the right time</td>
<td>Reduction in referrals Increase in systemic work</td>
</tr>
<tr>
<td>Named CAMHS leads in schools &amp; Primary Care</td>
<td>Improved emotional wellbeing and mental health of children and young people</td>
<td>Health behaviour questionnaire</td>
</tr>
<tr>
<td>Supporting self care</td>
<td>Less children and young people requiring external support Improved resilience</td>
<td>Referrals into CAMHS Referrals into Early Help Hub Health behaviour questionnaire (resilience score)</td>
</tr>
<tr>
<td>Development of single point of access</td>
<td>Effective MDT triage and children and young people being seen by the right person at the right time</td>
<td>Reduction in referrals Increase in systemic work</td>
</tr>
<tr>
<td>Further develop evidence base</td>
<td>Increase in staff’s competencies to deliver evidence based interventions</td>
<td>Number of CYP-IAPT trained professionals within CAMHs</td>
</tr>
<tr>
<td>Implement all areas of the crisis care concordat</td>
<td>Reduction in children and young people presenting in crisis Improved resilience</td>
<td>Attendees at A&amp;E, Section 136 Health behaviour questionnaire (resilience score)</td>
</tr>
<tr>
<td>Intensive home treatment service to be provided</td>
<td>Children and young people are better supported at home</td>
<td>Reduction in tier 4 admissions</td>
</tr>
<tr>
<td>Expansion of peer mentoring service</td>
<td>Effective transition</td>
<td>YH transition toolkit benchmarking tool</td>
</tr>
<tr>
<td>Enhance the current</td>
<td>Children and young people’s</td>
<td>CAMHS assessment</td>
</tr>
<tr>
<td>Assessment Process to Include Sensitive Enquiries</td>
<td>Levels of Need Are Identified</td>
<td>Documentation</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Enhance the Current Do Not Attend Policy</td>
<td>No Child or Young Person is Discharged for Non Attendance</td>
<td>DNA Rates</td>
</tr>
<tr>
<td>Develop Multi-Agency Teams</td>
<td>Children and Young People Being Seen by the Right Person at the Right Time</td>
<td>Service Provision Breakdown</td>
</tr>
<tr>
<td>Improved Community Paediatric Services (Inc ASD and ADHD)</td>
<td>Effective Assessment and Discharge Services</td>
<td>Community Paediatric Performance Dashboard</td>
</tr>
<tr>
<td>Development of Domestic Violence Multi-Agency Teams</td>
<td>Reduction in Domestic Abuse Rates</td>
<td>Growing Futures Performance Metrics</td>
</tr>
<tr>
<td>Provision of Eating Disorder Community Services</td>
<td>Services Began on 1st March 2016 and This Will Be a Phased Evolution of Service. Consultant Psychiatry Post is Only New Post Vacant. SYEDA Are Delivering Education Sessions</td>
<td>Reduction in Tier 4 Eating Disorder Admissions</td>
</tr>
</tbody>
</table>
12. Transformation Plan & Updates: areas for change, how this will be delivered in 2016/17 and progress made in 2015/16

The following are the priority areas for implementation in 2016/17. This section offers the detail on how and why these priorities will be implemented, and gives an update on any progress made in 2015/16.

12.1 Resilience, Prevention and Early Intervention for the Mental Wellbeing of Children and Young People

Aim:
To act early to prevent harm by investing in universal services, supporting families and those who care for children, building resilience through to adulthood. We also want to develop and implement strategies that support self-care.

A local task and finish group has been set up to lead on the implementation of this area of the LTP. Membership has been agreed and initial meetings held. Membership is at the right level and there is an underlying philosophy of accountability.

12.2 Support universal services

Why is this a priority?
The lack of a co-ordinated early help offer has led to high levels of inappropriate referrals into CAMHs and therefore children and young people not being seen by the right person at the right time. There are gaps in universal service workforce expertise around emotional wellbeing and mental health and significant variance in links between education and CAMHs and Primary Care and CAMHs. There is a single point of access into CAMHs but not to the wider emotional wellbeing and mental health services.

How will we do this:

• Named mental health leads in schools/academies
• Create a single point of access in the Children and Families Hub
• Move CAMHs duty functions into the Children and Families Hub.

By creating provision specifically to support universal services. This will include named CAMHs workers for schools, named CAMHs workers for Primary Care. Further detail of this new model called Consultation and Advice Service (CAS) is found in 12.5

The second element is to create a true single point of access, to build on the year one work of embedding a CAMHs worker within the Early Help Hub. The worker has made good links and added value to the Early Help Hub which we now want to build upon to create a true single point of access for emotional wellbeing and mental health, early help and social care. Originally there was to be 1WTE CAMHs worker within the Early Help Hub, but now as we look to bring together through one front door, we will be committing a greater CAMHs resource. This will include the duty resource and functions moving to the hub. There is clinical agreement from CAMHs and we are exploring as a partnership how best to integrate this.

There is an aspiration that the joint resource between CAMHs and social care will start to facilitate better working relationships and joint visits.
All schools in Doncaster have been asked to identify a emotional wellbeing and mental health lead/champion in schools. This lead will work alongside the school nursing team and schools pastoral support staff to develop internal pathways and systems, that ensure children and young people are supported at the earliest opportunity by the professional who is best placed to do so. Through increased understanding of and increased competencies in emotional wellbeing and mental health these staff will be able to better identify need and then tailor support quickly and effectively. This will be underpinned by regular CAMHs consultations and the training support.

Progress to Date:
A letter has been sent out to all schools/academies in the Borough from the Assistant Director for Education, asking for nominations for named emotional wellbeing and mental health leads. The current number of schools who have responded is really positive. A breakdown per locality is as follows:

- North 23/35 - 66%
- East 19/27 - 70%
- South 31/37 - 84%
- Central 23/26 - 88%

101/125 schools in total

**Response rate 81%**

Interestingly the overall KPI target for March 2017 is 75% so already we have achieved this. The plan to engage with the other schools that have yet to nominate is that once the new consultation and advice model is implemented, schools/academies will sell it to their colleagues as they realise the benefits. There is a fairly even split between the schools and academies that haven’t responded and work is ongoing to engage with these.

Work is ongoing with the 14 pilot schools and we are delighted with how this is progressing. There are representatives from some pilot schools on the respective task and finish groups that are charged with overseeing the implementation.

The (1WTE) CAMHs worker sits within the Early Help Hub (which is to link with the multi-agency safeguarding hub) to become the Children and Families Hub and has established some good joint working relationships and sharing of skills and information. This work is ongoing and the hub manager and CAMHs clinical lead for this area are working through how best to incorporate the duty functions and the overall CAMHs resource within the new hub.

**Progress rating: Very Good**

Plans for 2016/17

- To work towards 100% of schools having a nominated mental health lead
- Development of children and families hub.
12.3 Apps and Digital Tools
Why is this a priority?
We know that children and young people value digital support, but there is not a co-ordinated and validated offer locally. Currently support for emotional wellbeing and mental health predominantly comes from CAMHs.

How will we do this:
• Work with the local expert reference group to review existing tools and trial new ones.

The champions that are being developed through the work commissioned with Young Minds will identify 15 children and young people that want to become champions (These champions will become an expert reference group for this area of work).

Progress to Date:
Young Minds have established local links (see section 4.3) and are in the process of recruiting Youth Participation Champions, who will act as the expert reference group in terms of this area of work.

An options paper has been developed with some possible digital options and will be discussed with the expert reference group.

Progress Rating: Good

Plans for 2016/17
• Expert reference group to lead on decision of which digital option to use

12.4 Perinatal mental health
Why is this a priority?
There are 1,256 women in Doncaster who are likely to suffer from some degree of mental illness during pregnancy or within one year of giving birth.

How will we do this:
• By learning from a local pilot and national guidance
• By submitting two bids for STF funding to develop a high quality specialist perinatal mental health service.

This proposal is designed to develop consistent high quality specialist perinatal mental health services across the Doncaster and Bassetlaw Hospitals NHS Foundation Trust footprint with the intention of improving infrastructure, workforce development and clinical capacity to achieve improved patient experience and outcomes.

This proposal will create a standardised offer across Doncaster which improves consistency and continuity of care.

The proposal has two elements:

Specialist Perinatal Mental Health Service for complex presentations
A stepped care model approach with most women being supported in primary care, with access to advice or referral to specialist services for the most complex presentations. It will
cover any woman identified as requiring mental health support during pregnancy or up to 1 year post delivery.

The pathway will:

- Be delivered by a team of specialist midwife, and dedicated mental health staff who will assess, support, provide advice (including non-complex prescribing) and sign posting
- Access to a Consultant Psychiatrist will be via the relevant locality service
- Include primary care, IAPT, peer support, voluntary services and social prescribing
- Enable rapid access to secondary mental health services for anyone with an identified need
- Ensure there is a named professional who has oversight of the women’s care across local providers.

The service would take a lead role in the training and educating of partner professionals, leading to increased knowledge and awareness resulting in more women being identified and supported to access appropriate services. There is a definite need within the local population for a service supporting the woman and her family, recognising that mental health can deteriorate (as well as improve) during pregnancy and for the first year after birth. National reports around PNMH, including MBRRACE, highlight the risks and the long term health benefits for our community.

The impact of this service for women will be a quality experience where care is:
- Person centred
- Co-ordinated/not fragmented
- Efficient/ownership by all stakeholders (not passing the baton)
- Inclusive and collaborative.

Training will be delivered initially to all staff and subsequently will become embedded practice with pathways and guidelines supporting both women, families, primary care and staff ensuring that PNMH is everyone’s business. Seconding clinical midwives to the team will ensure sustainability succession planning and continuity. See Appendix 2 for specialist perinatal MH pathway.

Specialist Health Visiting intervention in line with attachment pathway
As a Call to Action Early Implementer Site RDaSH piloted an enhanced universal model of antenatal and postnatal assessment focusing on promoting perinatal mental health and parent child attachment to support the emotional wellbeing of the whole family and provide a nurturing environment for the infant in line with the recommendations of the 1001 Days strategy.

Building on this we propose a dedicated team drawn from the existing workforce to receive training to provide targeted specialist intervention for families who are beyond preventative interventions and require additional support in line with the multi-agency Attachment Pathway. See Appendix 3 for attachment mental health pathway.

This proposal will build on the growing range of commissioning proposals which are being developed across the STP footprint, and would utilise good practice which has evolved and the learning’s from the Doncaster Perinatal Mental Health Pilot.

The engagement and involvement of women with mental health issues in the perinatal period and their families will be vital to ensure that these new services meet needs effectively, and
women (and fathers) have the best possible opportunity to develop a health emotional bond with their child during pregnancy and in the first year of life.

By the end of 2018/19 we propose to have in place an agreed multi-agency specification, with clear interfaces across services, and pathway of care for expanded model of specialist community provision designed to impact on quality and health outcomes.

The second bid is a regional one across the STP footprint, that will develop consistent high quality specialist perinatal mental health services across South Yorkshire and Bassetlaw (STP), with the intention of improving infrastructure, workforce development and clinical capacity to achieve improved patient outcomes. The vision is to create a standardised offer across the patch which improves consistency and continuity of care. The workforce has five work streams.

**Progress to Date:**
Due to pilot ending there is now no specialist community service to support parents experiencing perinatal mental health problems. Two bids have been submitted to the STF perinatal community development fund.

**Progress Rating: Satisfactory**

**Plans for 2016/17**
- Await the outcome of the STF bids
- If successful, implement the new programme(s).

### 1. Promoting Resilience

**Are we on-track?**
When you consider progress against the original milestones above, it is encouraging to see that progress is being made, often before we expected it to, i.e. named school leads.

We are confident that we are on-track to achieve the remaining milestones.
12.5 Improving Access to Effective Support

Aim:
To change how care is delivered and build it around the needs of children, young people and their families. We will move away from a system of care delivered in terms of what services, organisations provide, to ensure that children and young people have early access to the right support at the right time in the right place.
A local task and finish group has been set up to lead on the implementation of this area of the LTP. Membership has been agreed and initial meetings held. Membership is at the right level and there is an underlying philosophy of accountability.

12.6 Move away from the current tiered system of mental health services

Why is this a priority?
There is variance in the skills and competencies of staff in universal services (including schools and Primary Care). There is very little consultation with CAMHs prior to referral and a high number of inappropriate referrals.

How we will do this:

• By having new CAMHs workers based within the community who act as dedicated named contact points for all schools and GP practices
• CAMHs locality workers providing advice, support and guidance to professionals already working with children and young people in a systemic approach
• Removal of written referrals into CAMHs with access via the consultation and advice service
• Removal of referral thresholds.

By having additional new locality/community based CAMHs workers that provide consultation, advice and guidance to professionals already working with children and young people in a systemic way. There is a worker in each of the localities and they will provide easier access into support. The key driver behind this is to provide support to those children and young people that have previously failed to meet thresholds and been left without support. The new functions will come under the consultation and advice service (CAS) and new branding is now to be explored.

The role of these workers will be to discuss and provide advice and guidance on the management of cases, including consultation, co-working or liaison, in a systemic way, there is a need to move away from the hands off referral culture. This will mean that no child from these settings should be referred into CAMHs without a discussion with the named CAS locality worker. The aspiration is to totally remove written referrals into CAMHs, whereby entry into the service comes only through consultation and co-working or self-referral. A further aim of the consultation model is that cases (as appropriate) will be led by the most appropriate person, be this carer or professional, supported by the CAS worker. In practice this will mean the development of joint assessments, better awareness of roles and responsibilities across the range of services and effective communication. We would expect over the forthcoming years that the number of joint assessments go down and the number of consultations goes up.

The longer term aspiration is to provide support to children and young people at the earliest possible stage, which will reduce the numbers needing specialist CAMHs input. This will then allow over time a redeployment of resources from specialist CAMHs to the consultation and advice service and LAC.
The model is as follows:

**School/School Mental Health Champion**
- Identify Possible Mental Health Concerns
- Discuss with Young Person/Family
- Agree plan/set up network meeting to consider issues
- Access appropriate services e.g. Educational Psychology

**School Champion Contact Designated CAMHs Consultation Team**
- CAMHs offer direct consultation based on known information from school and consider school plan

Underpinning this will be the development and implementation of a local joint training plan, whilst being very aware of any national developments via the schools pilot programme. Doncaster was unsuccessful in the bid but has decided to implement the pilot with the interested schools locally. Clinicians within respective services, including CAMHs and Education Psychology will develop training programmes with named education leads.

The evolution of this will be the expansion into a wider community mental health provision, that builds upon not only the above but also the newly implemented Early Help Hub and built into the redesigns of community nursing and therapy services, which we will be completing in 2016.

**Progress to Date:**
There has been lots of ongoing engagement with stakeholders at both strategic and operational levels to ensure the new consultation and advice functions fit within the wider system. In Spring, roles and responsibilities for both the CAMHs locality workers and school staff were agreed.

This has been the main area of focus in 2015/16 and we are pleased to update that the new functions of consultation, advice and guidance are in place, the move to a more systemic way of working across agencies has begun. There are currently 4WTE CAMHs consultation and advice workers with Doncaster split into four localities, each locality has a named worker, supported by two floating staff (holiday cover etc). The staff will share resource and expertise to best meet need. The initial feedback from schools and other professionals has been very
The new offer began with the new academic year and will be tested and evolved over the next six months with the aim of removing referral thresholds and written referrals into CAMHs by the Summer of 2017. Referrals will be replaced by requests for collaborative working (in a systemic manner) and will mean a continuation of support rather than a hand off referral. The aim of which is to truly remove tiers and access to support.

Progress Rating: Good

**Plans for 2016/17**

- Continue to embed the new consultation and advice functions
- Recruit final 1WTE to model
- Monitor effectiveness and allow for a flexible approach to service development
- Move to no thresholds.

12.7 Ensure the support and intervention for young people in the mental health concordat are implemented.

**Why is this a priority?**
Children and young people in Doncaster were admitted to hospital for attempted suicide and we have others in crisis. All elements of the Crisis Care Concordat are not currently being implemented.

**How will we do this:**

- New 24/7 all age crisis hub
- CAMHs interface and liaison nurse placed in acute hospital setting
- Liaison and diversion service to be aware of CYP services
- Explore options of regional section 136 suite and crisis accommodation.

By implementing the Crisis Care Concordat, there has already been lots of work done in this area and in many cases provision is already in place; a section 136 suite that is appropriate for assessment of children and young people, a 16 year old plus street triage system and a 24/7 out of hours CAMHs provision. However, there is still much to do.

The crisis hub went live in September 2015 and is evolving to an all age service that will interlink with the paediatric liaison nurse and CAMHs out of hours service, to provide 24/7 support for those young people in crisis. A recent audit showed that there is a need for improvements and these recommendations will be implemented.

A CAMHs interface and liaison nurse will be responsible for providing specialist nursing skills and knowledge, liaison and case management of complex cases between CAMHs and paediatric wards, A&E and inpatient providers. This post will sit within the intensive home treatment provision and provide face to face assessments for those in crisis within the four hour targets. They will link closely to the out of hour’s service and offer advice, guidance and training to paediatric wards and A&E. The out of hour’s service will be given some additional resource to increase the rota to support the achievement of the four hour face-to-face targets. In response to the announcement of non-recurrent pump-prime investment in all age 24/7 liaison mental health services, we will continue to work with adult colleagues to map out the current provision across all ages, which will include the new CAMHs interface and liaison
nurse, compare current provision to the model service specification and then commission a service to meet the requirements. It would seem likely that the CAMHs interface and liaison nurse will form part of this service moving forward.

The local liaison and diversion service are in the process of identifying any gaps in their knowledge of children and young people services and will present these to the emotional wellbeing and mental health strategy group to help facilitate a training plan. This can and will be done locally by services as part of a relationship and service awareness building initiative.

The thoughts and discussions around the regional provision of suitable accommodation for Children and Young People have been ongoing. Doncaster supported Sheffield in a successful funding bid to develop a regional Section 136 suite. Sheffield are now developing this service with a few to Doncaster (and potentially others in South Yorkshire) spot purchasing beds per annum.

We are now solely exploring a local solution to short-term crisis beds as the regional option wasn’t going to be as effective. We are exploring the option of training foster carer(s) to provide intensive support to children and young people in crisis across mental health, substance misuse, social care and youth offending. This will be a joint commissioning arrangement. The intensive home treatment service will provide in-reach to the foster carers as required. We are aiming for a solution by April 2017.

Progress to Date:
The 24/7 crisis support helpline went live in September and audit was completed after one year to look at any issues. There were some areas for development that will be worked through and reviewed over the next six months.

We have completed with partners a mapping of current psychiatry liaison services for all ages, that details current pathways and resources. This will now shape decisions moving forward to ensure we move towards a core 24 service. The actions are held on the local Crisis Care Concordat action plan.

The CAMHs interface and liaison function has been detailed in the service specification and the model of delivery is clear. There is agreement from the acute provider on the model and an agreement with the provider in terms of the relevant governance arrangements etc. This service is now up and running with a focus of developing collaborative working and providing direct CAMHs support in the acute setting.

The liaison and diversion service has identified gaps in their knowledge of Children and Young People services and a training plan has been agreed and is being facilitated. Local services are supporting the liaison and diversion service around their understanding. This work is developing and ongoing.

We have local systems in place that mean no Child or Young Person will be detained in a police cell as a place of safety from 1st January 2016. This has been communicated via regional meetings and the regional work will further enhance the local provision.

Progress Rating: Good

Plans for 2016/17

- Implement recommendations from crisis hub audit
- Embed the liaison functions within the acute paediatric and A&E hospital setting
12.8 Development of intensive home treatment provision

Why is this a priority?
We have high numbers of children and young people referred into inpatient services with an average length of stay of approximately 101 days. We are high when compared to our neighbours regionally and currently do not have an intensive home treatment service.

How will we do this:

- Developing and implementing a new intensive home treatment service to act as an alternative to tier 4 provision.

By developing and implementing a new home treatment service that acts as an alternative to inpatient services, has a key role in pre-crisis care and enables step down from acute/inpatient services. Locally this will be a multi-disciplinary team consisting of clinical psychology, senior mental health nurses (self-sufficient and prescribers), social worker and peer mentors. The service will provide the same support as if a child was in an acute setting but at home or in the community, i.e. twice daily visits to check on physical and psychological condition (as appropriate), support parents/carers to manage medications at home and providing 24/7 on call support. The service will provide direct support to acute paediatric wards and A&E and provide peer support to the CAMHs interface and liaison nurse. A large portion of the recurrent funding will be used to commission this resource and initial costs are detailed in the tracker.

Progress to Date:
The service specification is complete and funding arrangements have all been agreed. The intensive home treatment service will offer an alternative to tier 4. The service provider proposed a model of working that was agreed by the Mental Health Strategy Group in July. They have visited other intensive home treatment services to help their thinking.

Most posts were initially recruited to but the senior post and social worker post are still vacant. These are currently out to advert.

The service made a phased implementation from September and currently has nine on the caseload.

The service is currently recording its data manually as the relevant KPIs need adding to the providers system (redmine).

**Progress Rating: Satisfactory**
12.9 Promote best practice in transition

Why is this a priority?
Transition remains a problem for some young people; in particular it isn’t started early enough.

How will we do this:
- Implementing model specification for transition
- Work with YH SCN to develop guidance documents for transition
- Add resource to peer mentoring service.

By implementing the model specification for transitions from CAMHs developed by NHS England, continuing to work with the Yorkshire and Humber Strategic Clinical Network on developing guidance for commissioners and provider toolkit on transition and building on the current peer mentoring provision we have in Doncaster that has been held up as an exemplar.

Doncaster CAMHs employ peer support workers who themselves have a live experience of mental health problems. The role includes supporting young people and their families in the process of transition through to adult services, to provide continuity and advocacy. The peer support workers attend transition meetings with service users with adult care coordinators to provide information about the process and assist the family and young person to manage any concerns and anxieties they may have. The role also involves assisting young people who may be anxious about discharge from the service and helping them to make the transition back to Primary Care. The workers help young people to meet personal, social and educational goals supporting them to access college and school (attending college with them short term as part of a reintegration care plan) and become more active in the community. Peer support workers are also mental health promotion advocates and are key to service developments and consultation to ensure service users voices are heard. They have presented workshops in schools and colleges and are key to development as peer facilitators in the recovery college being implemented in CAMHs assisting young people through personal experience to manage anxiety and stigma.

The posts have offered opportunities to people who have mental health issues to address their own reintegration into employment. Posts are flexible in terms of part time or full time hours dependent on the needs of the workers and their own mental health and are substantive NHS contracts. Peer Support Workers have since graduated to gain IAPT posts and training to band 6 practitioner level via university, paramedics and project leads in non-NHS community projects.

Plans for 2016/17
- Recruit to final posts
- Add to redmine and start to provide information electronically
- Implement the full model of delivery
- Closely monitor delivery
- Review service after six months of full delivery.

Progress to Date:
CAMHs have just completed a transition benchmarking exercise which will be reviewed in November, with a subsequent action plan. The benchmarking tool was from the Yorkshire and Humber Clinical Network developed toolkit.

The peer mentoring functions are being reviewed with a view to seeing how these can be expanded. Funding for any subsequent training is available.
**Progress Rating: Satisfactory**

### Plans for 2016/17
- Review transition benchmark findings
- Peer mentoring service to be reviewed with a view to expanding.

### 12.10 Eating disorder community service

#### Why is this a priority?
There has been a year on year increase in referrals into CAMHs for eating disorders as well as an increase in those accessing inpatient services.

#### How will we do this:
- New community eating disorder service adhering to access and waiting time standards
- Robustly evaluate the new model.

By implementing access and waiting time standards for children and young people with an eating disorder (NHS England) regionally in conjunction with Rotherham and North Lincolnshire (which gives a total population of approximately 727,000). The need and prevalence across the three areas is identified in section six and although falls below the numbers needed to maintain staff competencies, we feel that there is an unmet need that would take it above this minimum number. Agreement has been made locally that Rotherham will be the lead commissioner on this and provisional meetings and workshops have taken place to discuss the guidance and how best this can be implemented across the three areas.

We will commission an external research agency to develop and complete a robust service model evaluation after 18 months that will shape future commissioning decisions.
Progress to Date:
The three commissioners have agreed a local service specification based upon the *Access and Waiting Time Standard for Children and Young People with an Eating Disorder*, and contract and procurement routes have been agreed and established. Rotherham is the lead commissioner on this. The service specification has been agreed and there is a clear implementation plan to underpin delivery.

The phased delivery started on 1st March, the diagram below shows the proposed model and capacity across the three areas.

All vacancies for Doncaster have been filled except the consultant psychiatrist, which failed to get any suitable applicants when first advertised. It is back out to advert. It is important to note the service is achieving the prescribed access and waiting standards at this point, albeit without the full multi-agency resource in place.

Data is currently being collected and provided manually until added to redmine.

RDaSH (main provider) have sub-contracted SYEDA to provide the early help, prevention and education elements of the service specification, this is a new area in Doncaster so we are keen to understand need and impact. The new resource in SYEDA is 2WTE and these are an education and training manager and education worker. Performance to date is outlined in 4.41.

Doncaster has led on the commissioning of an evaluation study of the new community eating disorder model. Pacec have been awarded the contract and have been in contact with RDaSH to begin developing the evaluation framework. This work commenced on 1st March 2016 and they are liaising with the CEDS providers and local commissioners in terms of setting up the evaluation framework. The evaluation will be completed at 16 months with an evaluation report submitted to commissioners at 18 months.

*Progress Rating: Good*

**Plans for 2016/17**
- Recruit to the psychiatry post
- Add to redmine and start to provide information electronically
- Review service delivery after six months of starting
- Continue to raise awareness via SYEDA
- Work with acute provider to develop links between community and acute.
Are we on-track?
There has been some slippage in a couple of areas, namely the intensive home treatment service and crisis hub going live (with paediatric expertise), however there are clear reasons for this and recommendations/solutions to remedy them.

We are confident that we are on-track to achieve the remaining milestones.

12.11 Caring for the most Vulnerable
Aim:
To dismantle barriers and reach out to children and young people in need, through a flexible integrated system that provides services in a way that they feel safe and are evidence based.

A local task and finish group has been set up to lead on the implementation of this area of the LTP. Membership has been agreed and initial meetings held. Membership is at the right level and there is an underlying philosophy of accountability.

12.12 Trauma focused care
Why is this a priority?
There is a need for greater awareness of the impact of trauma, abuse and/or neglect on mental health. CAMHs assessments do not routinely include sensitive enquiry about the possibility of neglect and sexual abuse (including CSE). There is variance in staff’s competencies in working with vulnerable children and young people.

How will we do this:
• Audit of current practice, skills and competencies
• Enhanced training package for staff working with vulnerable CYP.

By providing an enhanced training package for staff working with vulnerable children and young people, which would lead to greater professional awareness of the impact of trauma, abuse and/or neglect on mental health, in particular existing CAMHs and Social Care staff. Running alongside, there will be changes made to current mental health assessments to include sensitive enquiry about the possibility of neglect, sexual abuse, including CSE for those aged 16 years and above as routine practice. A small amount of funding is allocated for the development if new resources and staff training. Those with an identified need will then
be referred onto appropriate services with ongoing support mechanisms in place. A CAMHs worker will sit within the local multi-agency safeguarding hub.

CAMHs are currently involved in the local follow-up pathway for children and young people where there is suspected sexual abuse and rape (SARC) and this works well. However, there is a gap regarding direct and specialised psychology/psychiatry support and this is something we are looking at regionally.

There is likelihood that all SARC assessments (both forensic and non-forensic) will be commissioned by NHSE in the future.

**Progress to Date:**
The audit of current practice was has been completed and there are some recommendations, that will be implemented by the provider. These will be reviewed after six months.

There is still an intention to look at the provision of specialised psychology/psychiatry support for Children and Young People where there is suspected sexual abuse, this will happen in year three.

**Progress Rating: Satisfactory**

**Plans for 2016/17**
- Implement the audit recommendations.

12.13 Make sure that children and young people or their parents who do not attend appointments are not discharged from services, rather actively followed up

**Why is this a priority?**
DNA rates for 2014/15 were 9.5% and the current policy, whilst robust, needs modification so that no child or young person leaves service because of DNAs.

**How will we do this:**
- Build on current policy and ensure staff compliance.

By building on the current policy to make it more robust so that children, young people or their parents who do not attend are not discharged from services, no matter how many times they DNA. There will be a clear expectation that reasons for non-engagement are to be actively followed up.

**Progress to Date:**
This was implemented and has been finalised through the new service specification and contract. The provider is currently amending policies and procedures and we have asked for an audit on staff’s compliance to the policy. This audit has been completed and the findings and recommendations will shape future thinking.

**Progress rating: Good**

**Plans for 2016/17**
- Implement the audit recommendations.
12.14 Develop multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. Improve the care of children and young people who are most excluded from society, i.e. those sexually exploited, homeless or in contact with the youth justice system.

Why is this a priority?
There is variance in the provision across services.

How will we do this:
- Build on multi-agency approach.

By building on the multi-agency approach we already have to make support more accessible. We currently have good systems for Looked after Children and those in the Youth Justice system but outside of this there are no agreed mechanisms. We will change this by increasing the expertise with CAMHS and the capacity that is gained will allow CAMHS workers to move out to join multi-agency teams, i.e. Youth housing and support services and youth services. Doncaster does not have a gang culture. Doncaster does though, have high levels of poverty and deprivation meaning for some children and young people they are more at risk. Ensuring we have flexible multi-agency teams will ensure these children and young people are identified and supported.

Progress to Date:
The plan is to develop these teams by March 2019, so no work done on this to date.

Progress Rating: n/a

12.15 Learning Disability specialist provision

Why is this a priority?
The care and treatment review guidance and policy are not currently being implemented locally.

How will we do this:
- Ensure we are CTR compliant
- Review the current pathway provision for LD CAMHS.

By improving the universal offer to children and young people with a learning disability and ensuring compliance to the care and treatment review policy and guidance. A review of the current pathway will be completed which will shape future commissioning decisions.

Secondly we are committed to the implementation of new practice that ensures we are compliant with the care and treatment review guidance and policy. The post admission review mentioned before provides a good platform for us to work through how best to do this, supported by adult and specialised colleagues.

Progress to Date:
Local systems have been set up for Children and Young People that are compliant with the mandated guidance and policy; this was completed by November 2015. To date there have been no requests for a CTR. To ensure best practice a local MOU underpinned by a policy has been completed and agreed by specialised commissioning.

In addition, Doncaster has led on the development of a regional MOU to ensure that each
area in Yorkshire has access to an independent clinical expert. This will be achieved through a like for like agreement on sharing this resource across the patch.

Progress Rating: Very Good

Plans for 2016/17

- Monitor effectiveness of local CTR arrangements
- Implement the regional MOU
- Review the current pathway for LD CAMHs.

3. Caring for the most vulnerable

Are we on-track?
The enhanced training package has slipped due to the slightly later start of the workforce educator that will lead on this work.

The next areas of work will be to map out the current provision for LAC, LD and YOS pathways with the aim to improve these services in 2016/17.

12.16 To be Accountable and Transparent
Aim:
To drive improvements in the delivery of care and standards of performance, to ensure we have a much better understanding of how we get the best outcomes for children, young people and their families.

12.17 Lead Commissioner arrangements
Why is this a priority?
To ensure we have a strategic lead and a figurehead to co-ordinate.

How will we do this:
- Designated lead commissioner.

Doncaster Clinical Commissioning Group (DCCG) is the lead commissioner for the development and implementation of our local transformation plan supported by partners. We have an established emotional wellbeing and mental health strategy group chaired by the
Chief Nurse in DCCG with appropriate senior membership and it is functioning well. Through a collaborative approach this group led on the development of the plan.

The emotional wellbeing and mental health strategy group will be the accountable group for the implementation and direct oversight of the plan, feeding any issues up to two strategic boards; Health and Wellbeing Board and Children and Families Strategic Partnership Board who will monitor the overall performance of the plan (Appendix 8). In addition to feeding into these groups, the Emotional wellbeing and mental health Board will link directly to the Children and Families Commissioning Group and report into the Safeguarding Children’s Board and Children.

The diagram below illustrates the governance structure

The terms of reference for the Emotional wellbeing and mental health Group (Appendix 1) outline the purpose and functions of the group in detail.

**Progress to Date:**
The lead commissioner remains in place and the Emotional wellbeing and mental health Strategy Group continue to have direct oversight of the LTP implementation. There are two task and finish groups that sit under the strategy group that are leading on the detailed implementation. The lead commissioner chairs these meetings and feeds directly into the Strategy Group and Health and Wellbeing Board. There is good representation and accountability across partners.

The Mental Health Strategy Group feeds directly into the Joint Executive Commissioning Group where all commissioning decisions are made. The ultimate accountable group is the Health and Wellbeing Board.

**Progress Rating: Very Good**
12.18 Collaboration with specialist commissioners

Why is this a priority?
To reduce any duplication in commissioning and to ensure that services locally, regionally and nationally are commissioned to meet need.

How will we do this:
- Collaborative working.

DCCG is committed to working with specialised commissioning and we have identified the following key themes and issues arising from commissioning of CAMHs Tier 4. These will be listed below. It is important to note that Doncaster has considered all key themes and issues and has factored all the following into our thinking about the refreshed plan. It is the desire of Doncaster to work closely with specialised commissioning to find solutions.

Clearly determine from the plans CCG T4 CAMHs capacity requirements, all CCGs to include spend and activity analysis for 2014/15.
Evidence that whatever is being considered will have some impact on rate of admissions currently going into inpatient beds (% expected) or that because the service is well established and working effectively, that this position will remain relatively static. The introduction of the intensive home treatment service will have a direct impact on this. Doncaster would like to explore the opportunity of working collaboratively on measuring this and initial discussions have taken place. The hope for Doncaster is that this will facilitate discussions regarding the flow down of tier 4 financial savings, to help our local ability to meet the Future in Mind principles.

Consideration of intensive support teams to support ED cases and prevent need for admission but also consideration of in-reach into paediatric wards for those on medical stabilisation – what measures would be in place to evidence the success of this? This is under consideration, initial thinking is:

ED Clinics where full assessment can take place and care planned to suit and accommodate the needs of the individual.

Crisis intervention 24/7 either by increasing what is there or setting it up, to support YP with a view to managing the crisis and where possible to reducing the need for admission.

Learning Disability is an area of significant growth and given the nature and complexity between health and social care, how will this be addressed, as whilst the numbers are relatively small, these young people present significant challenges to the system. Robust and comprehensive community teams required to provide crisis support, prevent the need for admission and support reduced lengths of stay to those who need to be admitted (taking views of transforming care into consideration). Theme emerging around inadequate LD /ASD/ CAMHS provision in Tier 2/3 and is a priority to address given the requirement to develop alternatives to inpatient provision in partnership with Local Authority, CCGs and NHS England.

Perinatal – consideration of community provision either by increasing what is currently available or by setting up a new service.
Plans should address step down from Tier 4 facilities, where often there is a lack of provision in residential settings, day care, and intensive community support/wrap around to support discharge.

Also similar for the ever increasing number of young people with autism, what treatment services are available/planned?

All plans to reference Secure CAMHS Outreach Service, currently commissioned by NHS England, potential for commissioning by CCGs going forward and funding stream to support. There should be more robust engagement and collaborative working between specialised NHS England mental health commissioners and CCG commissioners to ensure we commission whole systems pathways of care, in CAMHs and adult services.

Themes emerging on workforce planning - risks of not securing sufficient clinical CAMHs and mental health experienced clinicians (evidenced by closure of some CAMHs inpatient beds due to staffing shortages, particularly RMNs).

Progress to Date:
The lead commissioner plays an active role in Yorkshire and Humber Clinical Network and has regular communication with regional specialised commissioners. This includes chairing the Mental Health Commissioners Steering Group. There is a direct link both ways and we are confident that there is strong and efficient collaboration.

Progress Rating: Very Good

### Plans for 2016/17

- Continue to work closely with specialised commissioning
- Explore collaboratively the savings to NHSE from reductions in T4 admissions and if these can flow down
- Community Eating Disorder Service to provide in-reach into acute settings and work closely with the home intensive treatment service to reduce T4 admissions
- Ensure effective 24/7 crisis support
- Look to continue to bolster ADHD and ASD community support
- Ensure social care respond to requests from T4 settings to support step down.

12.19 Engagement

**Why is this a priority?**

This plan is for our children and young people, to improve their outcomes around emotional wellbeing and mental health and as such we must provide the services they need. Only through effective sustained engagement can we provide the services they need in a way they want.

**How will we do this:**

- Giving Children, Young People and their families a voice
- Commission organisation to lead on this piece of work
- Develop sustainable model.

By implementing our shared ethos of giving children, young people and their families a view in shaping commissioning decisions. We will commission an external organisation to develop and implement a plan of continuous engagement and consultation throughout the life of the
plan to make sure that children, young people and their families have a real voice. We will also use this avenue as another medium to sense check ideas and to gauge whether things are improving.

A duty of the strategy groups is to develop consultation with local stakeholders and ensure these views are fed into the local delivery planning process. Service users/carers to be involved by either direct involvement in the group on appropriate issues, or via discussions with user groups.

**Progress to Date:**
Young Minds won the contract and began working on 1st March 2016. Local links have been established and this work is starting to move forward at a pace. The aim is to have 15 mental health champions that help shape the evolution of future LTP’s and to test implementation ideas. The model will ensure that at the end of the LTP (Young Minds have a four year contract) Doncaster has a sustainable model for engagement and young people participation. Work is progressing as per the work plan/schedule with no concerns.

**Progress Rating: Satisfactory**

**Plans for 2016/17**
- 15 mental health champions to be recruited and actively start to shape commissioning and service delivery
- Continue to develop a sustainable participation approach.

**12.20 Local Offer**
**Why is this a priority?**
To make sure everyone knows about the plan, it’s aims, objectives and intentions.

**How will we do this:**
We will publish the Local Transformation Plan electronically on the following websites:
- Doncaster Clinical Commissioning Group
- Doncaster Metropolitan Borough Council
- National Health England
- Doncaster Local Offer
- Doncaster Safeguarding Children’s Board
- Doncaster Council for Voluntary Services.

**Progress to Date:**
The Local Transformation Plan was sensed checked locally and was felt to be Child and Young Person friendly, this was backed up by the Yorkshire and Humber Strategic Clinical Network. It and the data collection template were published on the following websites as per the mandate, published on the following websites:
- Doncaster Clinical Commissioning Group – published 4th December 2016
- Doncaster Metropolitan Borough Council – published 4th December 2016
- Doncaster Local Offer – published 11th December 2016
- Doncaster Council for Voluntary Services – published 11th December 2016

The two outstanding sites are as follows:
- Doncaster Safeguarding Children’s Board – the board want to have the presentation on the LTP before ageing to publish. This is booked in for 21st April. We are in the final stages of getting it uploaded
• NHS England – DCCG communications lead in discussion with NHSE counterpart about this.

**Progress Rating: Good**

### Plans for 2016/17

- Update all sites with the refreshed LTP.

#### 12.21 Commissioning and procurement

**Why is this a priority?**

To ensure we act within the regulations and to commission services compliant with Health and Social Care Act and Equality Act.

**How will we do this:**

- Adherence to NHS procurement regulation
- Adherence to Equality Act
- Adherence to Health and Social Care Act.

The NHS Procurement Regulations 2013 currently sets out the framework within which the healthcare system should be managed and makes it clear that commissioners must seek to obtain services from those providers best placed to meet the best interest of the patient; market development being one of the key principles by which the NHS reform programme aiming to ensure that patients are at the centre of driving change.

This requires Doncaster CCG as a commissioner to understand not only the quality and characteristics of current local providers, but also those of potential future providers, who might be known or not known at the present time. In order to be able to demonstrate that this is the case, we need to have a process for the systematic analysis of relevant healthcare markets, and a means of applying the intelligence gathered through such analyses into the commissioning process, informing service reviews, procurement and tendering processes, the creation of options for choice, the development of plurality in service provision, market testing and the assessments of contestability.

Choice, co-operation and competition are key elements in the NHS reform programme, and constitute the pillars of system management for the CCG, in developing systems which are designed to protect and promote patients’ and taxpayers’ interests. To enable this, a system management of choice, co-operation and competition is implemented which effectively uses:

- **choice** on the part of patients between providers of clinical services, settings and models of care;
- **competition** between providers for, and in, the healthcare market;
- **governance** arrangements in place in contracting organisations;
- **contracts** between NHS contracting organisations and providers;
- **strategic partnerships**; and
- **information** for patients and referrers to enable them to make informed choices, for commissioners so that they can secure the best services for the people they serve, and for providers and clinicians to benchmark themselves against.

#### 12.22 Equality Act

This plan takes into full consideration all aspects of the equality act 2010, paying particular focus to changes around disability classification, indirect discrimination, rights of carers and
All aspects of the implantation of this plan will take into full consideration and be fully compliant with the equality act.

12.23 The Health and Social Care Act
Doncaster Clinical Commissioning Group as part of the wider NHS services understands its role within the act and the future transformation of services and is committed to doing so. This runs through our five year commissioning strategy, crucially; we are a clinically-led organisation. This Local Transformation Plan is around transformational change and systematic improvements, through the provision of clinically-led commissioned services that are innovative, provide value for money and are based directly on the needs of our population. As the plan has outlined on a number of occasions, Children and Young People have shaped and will continue to shape this plan. This we feel mirrors the key elements of the Health and Social Care Act.

Progress to Date:
Whilst at times this has slowed the process down, we have followed and adhered to NHS procurement regulations 2013 for everything procured using the LTP funding. This has been a challenge in terms of timescales and the volume of subsequent work created but we are confident that we are compliant. We will commission two-year contracts whilst stimulating the market to drive innovation and choice moving forward, in particular around the provision of community eating disorder services.

The plan has and continues to take into full consideration the above acts.

Progress rating: Very Good

Plans for 2016/17
• Continue to adhere to all acts and regulations.

12.24 Development of Outcome Measures
Why is this a priority?
So we can measure performance and outcomes effectively. This underpins the Commissioning cycle.

How will we do this:
• Continue to up skill staff via CYP-IAPT programme
• Express interest in becoming a pilot site for CORC.

In addition to the commitment to the CYP-IAPT programme which focuses on the development of routine outcome measures and more valid outcome measurement tools, we have expressed an interest (through the Yorkshire and Humber Strategic Clinical Network) to be a pilot site working with CORC. CORC have made an offer to CCG’s to monitor outcomes across sectors as part of the Local Transformation Plan. The aim of this work will be to look at how we can develop and implement effective outcome measures across services and sectors to enable a fuller picture of a child or young persons outcomes. We have agreement from the partnership to express interest as a pilot site.

Progress to Date:
There is currently 1 CAMHs practitioner on the CYP-IAPT course. The service will be submitting a request for a place on a therapy pathways course and up to two places on the EEBP course. The CCG will support this by covering the shortfall in funding. Unfortunately we...
were unsuccessful in our bid to CORC to become a pilot site.

Locally as part of the service transformation plan; we have commissioned some additional resource to inform the measures in the CAMHS contract for next year. The proposed reports will include:

- An enhanced report related to use of Goal Setting and scoring across the cohort during the patient journey
- Improvements to the existing SDQ reporting (to include sub scales and clinical interpretation)
- Exploration of wider measures that span the cohort and how they can be used to demonstrate outcomes.

This work is ongoing.

There is a requirement and expectation that the CAMHS service provider will adhere to the provision of the new mental health dataset and data was successfully submitted to HSCIC for February 2016. We are waiting for the first published extract.

**Progress Rating: Satisfactory**

### Plans for 2016/17

| • Agreement of local outcome indicators  |
| • Measure performance against the outcomes listed in the refreshed Local Priority Scheme table. |

**12.25 Data Compliance**

**Why is this a priority?**
The service provider is mandated to provide and submit data for the national minimum dataset.

**How will we do this:**

- Ensure the service provider is compliant
- The service provider to report electronically against the service specification which reflects the LTP CAMHs KPIs.

**Progress to Date:**
The service provider is partially compliant with the requirements of the minimum dataset.

Work is ongoing to meet these requirements.

The service provider is not reporting against all the KPIs of the service specification and for some is doing so manually. This means they are not included in any minimum dataset submissions.

**Progress Rating: Un-Satisfactory**

### Plans for 2016/17

| • Service provider to be compliant with the minimum dataset |
| • Service provider to be compliant with the local reporting requirements. |
Are we on-track?
Everything is on track against the above milestones.

12.26 Developing the Workforce
Aim:
That everyone who works with children, young people and families are ambitious for every child or young person to achieve goals that are meaningful and achievable. They will be excellent in practice and able to deliver the best-evidenced care, be committed to partnership working and be respected and valued as professionals.

12.27 Universal services
Why is this a priority?
There is variance in the skills and competencies of staff in universal services and a lack of high level co-ordination of this.

How will we do this:
• Identify workforce educator
• Workforce audit
• Workforce strategy.

By identifying a workforce development lead who will lead on developing a workforce strategy and oversee its implementation. This lead will report back to the Emotional wellbeing and mental health Strategy Group and be the focal point for the rolling interdisciplinary training plan. Funding for this post will be identified in the tracker in 15/16 and we would look at an initial 18 month post with a review point to understand if there is still a need. Ideally we would expect this to be a time limited post to kick start this work.

The starting point will be a skills audit across relevant services, starting off in Schools and Primary Care. The results of the skills audit will directly shape what training is provided (based on need) and will be the ethos of identifying training needs throughout the life of this plan. Rolling training programmes will be provided either by CAMHs practitioners directly or by external organisations supported by CAMHs practitioners to all staff in Universal Children’s Services with themes including; building resilience, recognising and managing stress and anxiety in teenagers, and recognition of escalating or complex mental health problems. This training will be underpinned by raising awareness of the consultation model of delivery and how this works, being clear on roles and responsibilities across services and empowering staff
to work within this model of delivery. This is a key component of Doncaster’s Early Help Strategy. Funding is identified in the tracker to facilitate this and this is where we plan to make the biggest spend in 2015/16. The rationale for this is simple; to develop a workforce that will provide the bedrock for future service developments.

Commissioners will work with the workforce development lead to explore the possibility of an ‘Innovation Partnership’ whereby an external learning organisation can support delivery of evidence-based and nationally accredited learning.

| Progress to Date: |
| The workforce educator service specification has been completed and the provider selected. The post commenced on 14<sup>th</sup> March and the first function was to complete a workforce audit that will directly shape the subsequent workforce strategy. The audit was completed and is an excellent piece of work. It focused on three areas: |
| • School/Academy staff |
| • CAMHs |
| • Universal Services. |

There are a series of key findings and subsequent recommendations for each of the three areas that will form the basis of a workforce strategy. The strategy is to be completed by 30<sup>th</sup> December. An existing task and finish group will be the arena to house this work.

**Progress Rating: Good**

| Plans for 2016/17 |
| Workforce strategy to be completed and agreed by the Mental Health Strategy Group |
| Implementation of the workforce strategy. |

12.28 Targeted and specialist services

**Why is this a priority?**

There is variance in the skills and competencies of staff in targeted and specialist services and a lack of high-level co-ordination of this.

**How will we do this:**

- Training staff.

By using the same ethos as for the training of universal staff; need identified by a skills audit and then a rolling training programme based on need. Examples of need lie in paediatrics.

CAMHs will continue their service development as part of the CYP-IAPT programme. Workers will continue to have access to specialist training in Cognitive Behaviour Therapy (CBT) and systemic Family Therapy (based on learning and evaluation of implementation of CYP-IAPT) and to regular supervision, which will reinforce this learning and continue to improve the skills within the workforce. Organisationally the service will continue to focus on fully embedding the use of routine outcome measures into clinical supervision and clinical decision making/pathway development.

The CAMHs workforce will also attend training and feedback sessions from Peer Mentors who can advise and inform regarding young people’s experiences of the services they have received. All training will be evidence-based and accredited.
Paediatric staff will be involved in the training, especially those involved in community paediatrics to build an appreciation and understanding of the interface between physical and mental health. The CAMHS interface and liaison nurse will be pivotal to this and will support the training of paediatric staff through providing ongoing support and guidance around emotional wellbeing and mental health.

There will be a targeted programme for Children’s Social Care staff including training in attachment and trauma (building on the Social Work Reform Programme agenda).

Progress to Date:
This relates to the 5.1.

**Progress Rating: Good**

<table>
<thead>
<tr>
<th>Plans for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Workforce strategy to be completed and agreed by the Mental Health Strategy Group</td>
</tr>
<tr>
<td>• Implementation of the workforce strategy.</td>
</tr>
</tbody>
</table>

**12.29 Future workforce**

**Why is this a priority?**
To have a workforce that is able to deliver evidenced-based interventions.

**How will we do this:**
• By using the platform of the CYP-IAPT programme.

By using the platform of the CYP-IAPT programme as building blocks to ensure evidence-based practice is at the heart of future CAMHS service delivery. We will be monitoring data across service delivery areas to know levels of demand and types of need and commission services that are configured to meet this need. For example we are aware that there has been an increase locally in the number of young people presenting with depression, a key area of workforce development is to commission training that equips staff to effectively meet this increased need using evidenced-based interventions. Doncaster will be requesting a place for one CAMHS practitioner on a CBT course as part of the ongoing CYP-IAPT programme. North Lincolnshire is part of the partnership and it may be worth noting that they will be requesting one member of staff for CBT and one for enhanced evidence-based practice. I have included the costs for the full partnership on the tracker.

As a partnership we are committed to CYP-IAPT.

Progress to Date:
The workforce audit identified the need for CAMHS to have greater competencies in CBT, mentalisation and family therapy.

By using CYP-IAPT as a platform to embed evidence based interventions into CAMHS. There is one practitioner attending the CYP-IAPT course this year.

**Progress Rating: Good**

<table>
<thead>
<tr>
<th>Plans for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continue to increase competencies within CAMHS via CYP-IAPT</td>
</tr>
<tr>
<td>• Provide training for CAMHS staff around CBT, mentalisation and family therapy.</td>
</tr>
</tbody>
</table>

Are we on track?
Everything is on track against the above milestones.
5. Developing the workforce

Are we on-track?
There has been some delay in getting the workforce educator in post, which in turn has delayed the workforce strategy.

Local Priority Scheme Summary – Where were we at the end of 2015.

<table>
<thead>
<tr>
<th>Local Priority Scheme</th>
<th>Current Stage of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish named emotional wellbeing and mental health leads in schools (internal)</td>
<td>77% positive response from schools/academies</td>
</tr>
<tr>
<td>Continuous consultation and engagement with children, young people and families</td>
<td>Delivery of engagement workshops with CYP and Parents</td>
</tr>
<tr>
<td>Appointment of workforce development lead</td>
<td>Workforce audit completed. Strategy to be completed by 31\textsuperscript{st} October 2016 (in-line with LTP refresh)</td>
</tr>
<tr>
<td>Audit and rolling training programme</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
<tr>
<td>Develop an ‘innovation partnership’ approach with a local university to deliver an accredited training programme with nationally recognised modules</td>
<td>As above</td>
</tr>
<tr>
<td>CAMHS worker to be embedded in the Early Help Hub</td>
<td>Currently 1WTE in post developing links and working through the logistics of embedding into the hub</td>
</tr>
<tr>
<td>Named CAMHS leads in Schools &amp; Primary Care</td>
<td>All staff recruited to post (6WTE) and will go live in September when schools return</td>
</tr>
<tr>
<td>Supporting self-care</td>
<td>An options paper to be presented to strategy group in July 16</td>
</tr>
<tr>
<td>Development of single point of access</td>
<td>Proprietary work is underway to integrate CAMHs referrals into Early Help Hub to form a single point of access. Ongoing evolution of roles and functions. Agreement to move CAMHs duty functions into a SPOA</td>
</tr>
<tr>
<td>Further develop evidence-base</td>
<td>One CAMHs worker booked onto CBT course. CAMHs submitted expression of interest for 2016/17 course(s)</td>
</tr>
<tr>
<td>Implement all areas of the Crisis Care Concordat</td>
<td>24/7 crisis helpline went live in September 2016; CAMHs liaison and interface function model agreed with eight applicants, expect someone in post in July 2016. Liaison and Diversion service is increasing its understanding of CYP services. Ongoing regional work on crisis response based on recent workshops. Police cell not to be used as a place of safety from 1\textsuperscript{st} January 2016 and local system set up. The mapping of all age psychiatry services has been completed. Exploring local crisis solutions in parallel with regional</td>
</tr>
</tbody>
</table>
## 13. Risks to Implementation

There are some continued risks to implementation, these are as follows:

### Workforce

There are still three posts to be recruited to as part of the transformation within CAMHs. In addition because some of the new posts have taken staff from the core CAMHs service, there are agency staff and still two vacancies. There is a current risk to core CAMHs in terms of workforce and also a risk in terms of recruitment to vacancies.

### Data

The service provider is not currently compliant in terms of data submission. This poses a real threat to the ability to track and monitor performance through the period of transformation.

| Work | 
|---|---|
| Intensive home treatment service to be provided | Service model being explored and all posts filled |
| Expansion of peer mentoring service | Further training to be provided to develop mentors |
| Enhance the current assessment process to include sensitive enquiries | Audit of 50 cases files to check current skills and if the questions are routinely being asked |
| Enhance the current do not attend policy | Dip sample audit of policy compliance completed and subsequent findings and recommendations to be considered |
| Develop multi-agency teams | Not intended for 2016/17 implementation |
| Improved community paediatric services (inc ASD and ADHD) | Both are NICE compliant, however there have been resource issues that has led to an increase in the autism waiting list. A new community paediatric model has been agreed and financials redistributed to increase capacity within the autism pathway |
| Development of domestic violence multi-agency teams | Multi-agency teams are in place |
| Provision of eating disorder community services | Services began on 1st March 2016 and this will be a phased evolution of service. Consultant psychiatry post is only new post vacant. SYEDA are delivering education sessions. 100% of CYP are meeting access and waiting time standards |
| Redeploy generic staff currently seeing ED cases now seen by community team to improve access to self-harm and crisis and invest underspend from ED funds | Not intended for 2016/17 implementation |
Finances
The funding from NHSE goes into the CCG base line, which is a real risk. The published allocation is 2.38%, however we have 3 allocations (CAMHS being one) that are in baseline. Once these are taken out (if we view as ring fenced) then the allocation reduces to 1.8%. Nationally guided increases in pension costs and living wage means that is actual fact we are in a negative position just to fund inflation. This means there is great pressure on the CAMHs allocation.

Headroom reserve of 1% (approx. £4.5million), which we have previously used to facilitate service improvement, and change now has to be held across the STP footprint. This means that we have to set this aside as mitigation in case any provider (including acute) don’t meet their financial requirements. This further adds pressure.

We are spending approximately half our allocation on an intensive home treatment service yet any savings from reduced tier 4 activity will be realised by NHSE.

Cuts to Public Health and the impact this has on services, i.e. HV and SN.

The impacts of austerity on Doncaster that is still reeling from the previous austerity.

There is a projected increase from this funding source year on year until 2010/21, however it is not yet known if this is true additional funding or from savings made elsewhere in the system that are to be redistributed. If the latter is the case then there is a risk because the majority of the savings will sit with NHS England in terms or reduction in tier 4 admissions. The national landscape for the NHS is also unpredictable and fragile with many provider trusts having a financial deficit. This in turn makes the redistribution of any realised savings very difficult to enact.

CYP-IAPT Funding
There was a late reduction in funding from NHS England for CYP-IAPT which now places a responsibility on local CCG’s to part fund places. Doncaster has committed 97% of it’s funding on recurrent activity leaving very little left. This additional funding has come from the wider workforce funding which in turn reduces that amount.

Mitigation of Risk
A way to mitigate the risk is plan and work in collaboration with other CCG’s to ensure we are not all going for the same staff and providers at the same time. In Doncaster we have already formed relationships with Rotherham, North Lincolnshire, Sheffield and other CCG’s in the area and there is a commitment from CCG’s within the Yorkshire and Humber Strategic Clinical Network to work together. This may take the shape of regional commissioning and/or time planning of recruitment.

Transformation Support
To support the delivery of the plan, it would be helpful to support in the following areas:

- **Workforce** – Support (nationally) to ensure there are enough practitioners available to fill all the posts that are needed. It would be great if emphasis could be placed on training more practitioners with skills and expertise in emotional wellbeing and mental health, as these types of staff underpin our Local Transformation Plans.
- **Finance** – Clarification on national funding, is this true additional income or expected savings? Funding to come into CCG’s to be ring fenced.
• **Collaborative Commissioning** – It would be really helpful to jointly explore the possibility of any savings made through a reduction in tier 4 admissions flowing down to local CCG’s. This would allow us to further implement the principles of Future in Mind.

• **Continuation of CYP-IAPT** – Continued funding to further increase evidence based practice across CAMHs.

• **Development of Validated Outcome Measures** – This would be really helpful so as commissioners we could have greater confidence in measuring outcomes.

• **Commissioning Support** – From fellow commissioners via the Strategic Clinical Network.

• **Evidence Base** – Guidance and policies that are evidenced-based, i.e. NICE are extremely helpful in ensuring we commission evidenced based services.

• **Digital Tools/Apps** – It would be great if there was development in the efficacy and availability of digital tools and apps, ideally some that are recommended or even carry a national benchmark.

• **Timing** – Could we ask that any funding is made available earlier in the year or apportioned over the following year, as receiving funding late in the financial year is extremely difficult.