Promoting, protecting and improving our Children and Young People’s emotional wellbeing and mental health

Doncaster’s Local Transformation Plan

2017 - 2020
1. Open Letter to Children and Young People

This is the third year that I am writing to you about the Local Transformation Plan to update on what we have achieved in 2016/17, and to notify you what the areas of focus are for the remaining two and a half years of the plan. It is clear to my colleagues and I, that emotional wellbeing and mental health are very important issues in Doncaster, I have heard this on many occasions, in many different places. It is with this in mind that I am delighted to say that emotional wellbeing and mental health are one of the key priorities within the new Doncaster Children and Young People’s Plan. The priority is to ensure you are healthy with a sense of wellbeing and are resilient. This will be the focus of the last two and a half years of the Local Transformation Plan.

So what did we do in 2016/17.............Well on the whole we continued to make good progress against the plan, in particular making it easier for you to access advice, guidance and support through people you already have a relationship with. The new community eating disorder service continues to evolve and grow with every-one being supported quickly and effectively. There have been strong links built between 20/ academies and colleges and CAMHs to promote a more joined up way of working with great effect. There has been the development of a new schools/ academies and colleges mental health competency framework, which is being piloted in 2017/18. I am thrilled to say that lots of Doncaster schools/ academies and colleges are involved. I think this sends a clear and strong message that there is a real commitment from schools/ academies and colleges to provide the best support they can.

The work we are doing with Young Minds is starting to come to fruition and I am delighted to announce, we now have 15 mental health participation champions who will be at the heart of shaping how we do things in the future. There have also been some challenges and areas where we need to keep focus and making improvements. These include providing better intensive support to those Children and Young People who are in crisis and need intensive support. We need to look at our most vulnerable Children and Young who may be Looked After or involved in the Youth Justice System. We need to get better at supporting Children and Young People with a Learning Disability in the community. I know that we are all committed to making sure you get the best advice, guidance and support you need, when you need it and this Local Transformation Plan outlines what the areas of focus will be for the remaining two and a half years. Some of the areas are as follows:

1. Continue to work with Young Minds to get the voice of Children and Young People.
2. Invest a further £250,000 into children’s mental health over the next two and a half years.
3. Support Children and Young People who require intensive support, to get this at home rather than in hospital.
4. Pilot the schools/ academies and colleges competency framework.
5. Support Children and Young People with a Learning Disability and/ or autism at home and/ or in the community by completing effective Care, education and treatment reviews.
6. Check that the outcomes we want to see actually happen.

We have a real focus on mental health and wellbeing and it is an exciting time in Doncaster, let’s all work together to be the best we can.

Yours sincerely

Damian Allen
Director of People
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.

<table>
<thead>
<tr>
<th>Vision</th>
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<tbody>
<tr>
<td>Vision</td>
<td>Team Doncaster will work to secure sustainable improvements in Children and Young People’s emotional wellbeing and mental health.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Mission</th>
<th></th>
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<tbody>
<tr>
<td>Mission</td>
<td>To provide a responsible and transparent partnership in order to bring about whole system transformation, by developing and implementing the Local Transformation Plan.</td>
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<table>
<thead>
<tr>
<th>Values</th>
<th></th>
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<tbody>
<tr>
<td>Values</td>
<td>- The needs of our population are paramount</td>
</tr>
<tr>
<td>Values</td>
<td>- The partnership will drive forward continuous improvement</td>
</tr>
<tr>
<td>Values</td>
<td>- Relationships based on integrity and trust</td>
</tr>
<tr>
<td>Values</td>
<td>- Children and Young People’s views will be consistently sought, understood and become part of the service delivery model</td>
</tr>
</tbody>
</table>

2.1 Doncaster is in an exciting place............ already on the journey of transformation with clear objectives moving forward. Doncaster Growing Together is the new Borough strategy that sets out the long-term partnership vision for Doncaster. It is based on the knowledge that the next four years represents a series of challenges and opportunities for the business, citizens and local agencies in the Borough. The work will focus on four policy priority areas:

1. Doncaster Learning
2. Doncaster Working
3. Doncaster Living
4. Doncaster Caring

2.2 The LTP sits within this wider strategic framework along with a number of other key strategies including the health and well-being strategy, Doncaster Place Plan, Children and Young People’s Plan, Education and Skills Commission and Domestic Abuse strategy. Doncaster aims to be the most child friendly Borough in the country.

2.3 When considering ecological systems theories and how resilience is developed.............. the transformation of systems and services to create happier children, with parents who have meaningful jobs, who live in nice houses within nice communities is extremely positive in the aspiration to have more resilient families. It feels that as a Borough we are more focused on system transformation than just the transformation of Children and Young People’s mental health services. This is incredibly positive.

2.4 The vision for the next two and a half years will focus more on developing a clear Doncaster offer for Children and Young People who need support around their emotional wellbeing and mental health. We will develop a campaign, working closely with Public Health colleagues and the offer will be across the partnership. The aspiration is that for every Doncaster Child and/ or Young Person there is a standardised effective offer that meets their needs.

The vision for system transformation remains the same for the remaining two and a half years of the plan, however there will be a slight shift in focus to more vulnerable Children.
and Young People, i.e. LAC and LD. This was always the intention once the universal provision had been bolstered to provide easier access to mental health and wellbeing support at the earliest opportunity, in a more systemic manner.

2.5 Transforming Care for Children and Young People (CYP) with a Learning Disability and/or autism will play a far more prominent role in the plan. The effective embedding of Care, Education and Treatment Reviews will echo through the section for the most vulnerable (see section 13.3, page 84).

2.6 We want to improve secure sustainable improvements that means Children and Young People in Doncaster have good emotional wellbeing and mental health.

2.7 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.

2.8 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.

2.9 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.

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

2.11 To develop 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.

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

2.13 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.

2.14 We want a specialist service that offers evidence based interventions as part of a systemic approach, with highly qualified staff.
2.15 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 emotional wellbeing and mental health
*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 the right person provides Young People 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, and 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. Performance Dashboard

3.1 Considering the vision and how we will evidence progress, there has been a significant amount of work completed by partners to develop a performance dashboard that answers the question how will we know if the system has changed?

3.2 The dashboard has three key outcome measures with a number of metrics under each outcome; this gives a real oversight into progress against the system, rather than traditionally looking at CAMHs data. Future in Mind and the LTP are really clear about this being system transformation and we are confident we know have a performance dashboard to measure progress.

3.3 The mental health and wellbeing strategy group has oversight of the dashboard and recently signed off the dashboard. A specific dashboard task finish group with members from across the partnership led on the development of the dashboard.

3.4 Running alongside the development of the local dashboard, the commissioning lead and representatives from DCCG Performance and Intelligence team have been part of the Yorkshire and Humber Clinical Network Data Dashboard Task and Finish Group. The remit of the task and finish group is to develop a regional dashboard. We have made significant progress and the current iteration is played into wider national thinking about the development of a dashboard, alongside other Clinical Networks. The aspiration is to have a regional dashboard akin to the YH maternity dashboard.

3.5 Both the local and regional dashboard are live evolving pieces of work and the aim is to replace the local dashboard with an agreed regional one, in line with other areas.

3.6 The local dashboard is embedded in the appendices (15.1)
4. Introduction

4.1 This document is the third iteration of original Local Transformation Plan (LTP) (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.

4.2 This is a two year plan.

4.3 The first plan was signed off by NHS England as having met the criteria in full with identified strengths. For year two, NHS England commissioned the North of England Commissioning Support Unit to undertake a desktop review of the refreshed LTP’s. This review was undertaken on information published on CCG websites and against the national LYP key lines of enquiry. The one for Doncaster was extremely helpful in sense checking progress at that stage, the headlines were positive, with the majority of key lines being rated as green.

4.4 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), Doncaster’s Place Based Plan, Children and Young People’s Plan (2017-20) at a high level. It will also interface with a number of other local strategies, whilst acknowledging the national context.

4.5 Doncaster is part of the South Yorkshire and Bassetlaw Accountable Care System (ACS), which puts the region at the forefront of nationwide action to provide joined up, better co-ordinated care. Mental health is a priority area for the ACS with the LTP being the formally recognised plans across the footprint to deliver transformation.

4.6 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.
5. Current Commissioning Arrangements

5.1 Doncaster’s Children and Young People’s Plan (2017-20) has four key themes incorporating 12 priorities. One of the themes is Healthy and Happy with the following three priorities:

1. Children and Young People are healthy and have a sense of wellbeing and are resilient.
2. Children have the best start in life.
3. Children and Young People’s development is underpinned through a healthy lifestyle.

5.2 Each of the priorities has clear governance arrangements, including performance measures that sit as part of the wider outcomes framework. This means that mental health and wellbeing and indeed resilience have a high level of focus, which ensures that this agenda stays at the top table.

5.3 The lead commissioner for the LTP is a member of the Children and Families Executive Group and then lead for the Healthy and Happy theme, ensuring a direct link to the LTP.

5.4 As part of the development of the new Children and Young People’s Plan (2017-20), there have been new commissioning arrangements agreed for Children and Maternity. The Joint Commissioning Executive Group has now evolved into a Joint Commissioning (JCRG) and Resource Group that acts as an enabler to the Children and Families Executive Group. The JCRG is newly created (Summer 2017) with the terms of reference still to be agreed. However there is a real will from all partner agencies involved to look at better integrated commissioning. The JCRG retains accountability for commissioning decisions around the LTP, with devolved responsibility to the lead commissioner at the CCG and LA.

5.5 Doncaster Clinical Commissioning Group, The Local Authority and Children’s Trust are members of the JCRG.

5.6 A briefing paper outlining the move to Doncaster integrated commissioning functions for Children and Maternity was agreed at the local Joint Commissioning Committee, which is the senior commissioning forum. This set out clearly the sense of direction to future travel around Children’s commissioning. This links very closely to accountable care systems and the Doncaster Place Plan.

5.7 As outlined above Doncaster is part of the South Yorkshire and Bassetlaw Accountable Care System, which will mean changes to commissioning arrangements over the life of this plan. Mental health and Learning Disabilities is a work stream within the ACS (previously STP) as is Children and Maternity, meaning there is a good level of focus on Children and Young People’s mental health and wellbeing. It is accepted and acknowledged that the LTP’s are the driver for this portfolio. Each work stream has a delivery board that feeds into the executive steering group.

5.8 In Doncaster there are six areas of opportunities to test how we operate as an accountable care system. To relate to Children and Young People:

- Starting Well – a focus on the first 1,001 days
- Vulnerable Adolescents – a focus on those placed out of area.

Clearly both have an impact on emotional wellbeing, mental health and resilience.
5.9 Conversations are starting to happen within the ACS footprint with CCG and specialised commissioning leads, regarding future commissioning models, desired outcomes and what services could be commissioned and provided across the footprint. Crisis and Intensive Home Treatment seem like two sensible starting points. Meetings are to be arranged to facilitate these conversations. The STP lead for mental health and YH clinical network representative will be invited.

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

<table>
<thead>
<tr>
<th>Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)</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>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Doncaster and Bassetlaw Teaching Hospital (DBTH)</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>
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<table>
<thead>
<tr>
<th>Doncaster Children’s Services Trust (DCST)</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, Mockingbird and the Empower and Protect Programme.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaboratives</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, 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.</td>
</tr>
</tbody>
</table>

The South Collaborative has commissioned a CAMHs consultation and advice function for the academies in that area.
5.11 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.

**JASP**

JASP is a part-time, interim educational provision for key stages 3 and 4 pupils referred by CAMHs who are:
- experiencing severe and enduring mental health difficulties
- having difficulty accessing a mainstream education full-time
- actively involved with CAMHs.

The aims of the service are to keep this cohort of Children and Young People engaged in education.

**Young Minds**

Young Minds is the UK’s leading charity committed to improving the emotional wellbeing and mental health of Children and Young People. 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.

**South Yorkshire Eating Disorder Service (SYEDA)**

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/academies and colleges, to professionals and the wider community.

**Open Minds**

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.
6. Local Investment

6.1 There are three primary funding streams for mental health and wellbeing with other smaller funding contributors to the agenda in Doncaster. The primary funders are Doncaster Clinical Commissioning Group (CCG), the Local Authority (LA) and NHS England.

6.2 DCCG baseline funding now includes five year forward view funding (previously badged as transformation funding). DCCG have recognised the five year forward view uplift and this figure is reflected in the total level of investment below, this means there continues to be a year on year financial uplift to this agenda from the primary funders.

6.3 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.

<table>
<thead>
<tr>
<th>Funding type</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG baseline allocations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYP mental health</td>
<td>119.0</td>
<td>140.0</td>
<td>170.0</td>
<td>190.0</td>
<td>214.0</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>30.0</td>
<td>30.0</td>
<td>30.0</td>
<td>30.0</td>
<td>30.0</td>
</tr>
<tr>
<td>National programmes (indicative)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis care models</td>
<td>5.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce development (HEE)</td>
<td>38.0</td>
<td>38.0</td>
<td>22.0</td>
<td>17.0</td>
<td></td>
</tr>
<tr>
<td>Workforce development (Other)</td>
<td>18.0</td>
<td>18.0</td>
<td>12.0</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Specialist in-patient/outreach</td>
<td>21.0</td>
<td>11.0</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerable groups</td>
<td>20.0</td>
<td>24.0</td>
<td>25.0</td>
<td>24.0</td>
<td>21.0</td>
</tr>
<tr>
<td>Other programmes</td>
<td>13.5</td>
<td>4.0</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key

- Local Funding
- National Funding

6.4 Funding for the remaining two and half years of the plan is outlined below. At the time of writing this plan, it is expected that funding will be available for investment.
### 6.5 2017/18

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist CAMHs:</td>
<td>1,910,725</td>
</tr>
<tr>
<td>Single Point of Access CAMHs:</td>
<td>40,000</td>
</tr>
<tr>
<td>Consultation &amp; Advice CAMHs:</td>
<td>200,000</td>
</tr>
<tr>
<td>Intensive Home Treatment Service:</td>
<td>250,000</td>
</tr>
<tr>
<td>Paediatric Liaison:</td>
<td>50,000</td>
</tr>
<tr>
<td>Looked after Children CAMHs:</td>
<td>125,000</td>
</tr>
<tr>
<td>Learning Disability CAMHs:</td>
<td>125,000</td>
</tr>
<tr>
<td>Youth Offending Service CAMHs:</td>
<td>35,000</td>
</tr>
<tr>
<td>CYP-IAPT:</td>
<td>18,275</td>
</tr>
<tr>
<td>Workforce Educator:</td>
<td>50,000</td>
</tr>
<tr>
<td>Workforce Strategy:</td>
<td>75,000</td>
</tr>
<tr>
<td>Amber Lodge:</td>
<td>193,028</td>
</tr>
<tr>
<td>Empower &amp; Protect:</td>
<td>30,000</td>
</tr>
<tr>
<td>Mental Health Crisis and Intensive Community Support:</td>
<td>24,727.50</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>Youth Offending Service Assistant Forensic Psychologist:</td>
<td>35,000</td>
</tr>
<tr>
<td>Establish Named School Leads:</td>
<td>16,000</td>
</tr>
<tr>
<td>Supporting Self Care:</td>
<td>40,000</td>
</tr>
<tr>
<td>Development of Mental Health Portal:</td>
<td>14,000</td>
</tr>
<tr>
<td>Community Eating Disorder Service:</td>
<td>176,000</td>
</tr>
<tr>
<td><strong>Total</strong>:</td>
<td><strong>4,477,394.50</strong></td>
</tr>
</tbody>
</table>

* Doesn’t include acute inpatient specialised commissioning spend

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### 6.6 The table below details the proposed funding split for 2017/18.

<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>£3,969,853</td>
<td>£447,814</td>
<td>£24,727.50</td>
<td>£35,000</td>
<td></td>
</tr>
</tbody>
</table>
### 6.7 2018/19

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
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<td>Workforce Strategy</td>
<td>£82,000</td>
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<td>Amber Lodge:</td>
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<td>Empower &amp; Protect:</td>
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<td>£14,000</td>
</tr>
<tr>
<td>Community Eating Disorder Service:</td>
<td>£176,000</td>
</tr>
<tr>
<td><strong>Total</strong>:</td>
<td><strong>£4,629,667</strong></td>
</tr>
</tbody>
</table>

* Doesn't include acute inpatient specialised commissioning spend

### 6.8 The table below details the funding split for 2018/19.

<table>
<thead>
<tr>
<th>Clinical Commissioning Group</th>
<th>Local Authority</th>
<th>NHS England (Five Year Forward View)</th>
<th>Children’s Services Trust</th>
<th>Collaboratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>£4,146,853</td>
<td>£447,814</td>
<td></td>
<td>£35,000</td>
<td></td>
</tr>
</tbody>
</table>
6.9 2019/20

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist CAMHs:</td>
<td>£1,910,725</td>
</tr>
<tr>
<td>Single Point of Access CAMHs:</td>
<td>£40,000</td>
</tr>
<tr>
<td>Consultation &amp; Advice CAMHs:</td>
<td>£360,000</td>
</tr>
<tr>
<td>Intensive Home Treatment Service:</td>
<td>£250,000</td>
</tr>
<tr>
<td>Paediatric Liaison:</td>
<td>£50,000</td>
</tr>
<tr>
<td>Looked after Children CAMHs:</td>
<td>£200,000</td>
</tr>
<tr>
<td>Learning Disability CAMHs:</td>
<td>£200,000</td>
</tr>
<tr>
<td>Youth Offending Service CAMHs:</td>
<td>£35,000</td>
</tr>
<tr>
<td>CYP-IAPT:</td>
<td>£18,275</td>
</tr>
<tr>
<td>Workforce Educator:</td>
<td>£50,000</td>
</tr>
<tr>
<td>Workforce Strategy</td>
<td>£44,000</td>
</tr>
<tr>
<td>Amber Lodge:</td>
<td>£193,028</td>
</tr>
<tr>
<td>Empower &amp; Protect:</td>
<td>£80,000</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>Youth Offending Service Assistant Forensic Psychologist:</td>
<td>£35,000</td>
</tr>
<tr>
<td>Establish Named School Leads:</td>
<td>£16,000</td>
</tr>
<tr>
<td>Community Eating Disorder Service:</td>
<td>£176,000</td>
</tr>
<tr>
<td>*<em>Total</em>:</td>
<td><strong>£4,747,667</strong></td>
</tr>
</tbody>
</table>

* Doesn’t include acute inpatient specialised commissioning spend

6.10 The table below details the proposed funding split for 2019/20.

<table>
<thead>
<tr>
<th>Clinical Commissioning Group</th>
<th>Local Authority</th>
<th>NHS England (Five Year Forward View)</th>
<th>Children’s Services Trust</th>
<th>Collaboratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>£4264,853</td>
<td>£447,814</td>
<td>£35,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.11 Clearly the above splits are based on the date when the plan was submitted (31.10.17) and as such are open to change throughout the life of the plan.

6.12 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. We would expect this to be limited as we have unpicked several children service block contracts and have a good understanding locally on spend.

6.13 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.
6.14 All transformation monies received in 2015/16 were spent on areas identified within the original LTP. A breakdown is as follows:

LTP Q4 16-17
Report Financials.xlsx

6.15 The slight underspend was due to the workforce strategy budget. The mental health and wellbeing strategy group made a conscious decision to delay commissioning the main element of the strategy whilst the schools/academies and colleges competency framework was developed. The strategy was adapted to go to tender for a training provider to support pilot schools/academies and colleges to achieve the competencies outlined in the framework. This will be done in 2017/18. Further details in section 13.5, page 97.

6.16 There is no expected uplift for the remaining two and a half years in line with the Five Year Forward View trajectories.

6.17 Specialised Commissioning Acute Inpatient Spend
Funding from NHS England for specialised acute inpatient spend was as follows:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Doncaster CCG Total</td>
<td>£2,668,815</td>
<td>£1,581,674</td>
<td>£3,484,734</td>
</tr>
<tr>
<td>Alder Hey Children's NHS Foundation Trust</td>
<td>£4,979</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alpha Hospitals</td>
<td>£304,894</td>
<td>£759,709</td>
<td></td>
</tr>
<tr>
<td>Cygnet Health Care Limited</td>
<td></td>
<td></td>
<td>£765,442</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Trust</td>
<td></td>
<td></td>
<td>£114,978</td>
</tr>
<tr>
<td>Northumberland, Tyne And Wear NHS Foundation Trust</td>
<td>£8,614</td>
<td></td>
<td>£1,282,962</td>
</tr>
<tr>
<td>Priory Group Limited</td>
<td>£177,950</td>
<td>£57,227</td>
<td>£55,001</td>
</tr>
<tr>
<td>Sheffield Children's NHS Foundation Trust</td>
<td>£1,770,862</td>
<td>£709,231</td>
<td>£976,074</td>
</tr>
<tr>
<td>The Huntercombe Group</td>
<td>£181,806</td>
<td></td>
<td>£142,437</td>
</tr>
<tr>
<td>Staffing Costs</td>
<td>£14,592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riverdale Grange</td>
<td>£59,320</td>
<td></td>
<td>£7,698</td>
</tr>
<tr>
<td>Tees, Esk And Wear Valleys NHS Foundation Trust</td>
<td>£9,466</td>
<td>£6,655</td>
<td>£88,583</td>
</tr>
<tr>
<td>Leeds And York Partnership NHS Foundation Trust</td>
<td>£9,772</td>
<td>£23,356</td>
<td>£88,639</td>
</tr>
</tbody>
</table>

It is clear that there has been an increase in spend in 2016/17 to the highest figure over the past three years. This reflects the increase in number of admissions and total amount of bed days bought. It may also be linked to improved data validity from NHS England based on the use of a national data source.

6.18 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.
Doncaster was unsuccessful with the first wave of STF monies but is now working within the ACS footprint to submit a bid in wave two.

<table>
<thead>
<tr>
<th>Funding type</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCG baseline allocations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist perinatal mental health</td>
<td></td>
<td></td>
<td>73.5</td>
<td>98.0</td>
<td></td>
</tr>
<tr>
<td><strong>STF monies for allocation (indicative)</strong></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><strong>National programmes (Indicative)</strong></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
7. Engagement with Stakeholders

7.1 The collaboration with Young Minds is now entering an exciting phase. There are 15 participation champions in place and a further 50 participants expressing a desire to be involved. The vision for the programme is that it supports the development of shared values and innovative practice in participation at every level. Through this we will enable and empower young people, parents, carers and front line practitioners to lead the way in transformation.

7.2 The participation champions consist of:
- Five young people
- Five parents/ carers
- Five professionals.

7.3 The remaining 50 are being engaged digitally.

7.4 Previous engagement work led a range of participation activities to be delivered underpinned by a clear set of principles, capturing (extensively) the thoughts and opinions of attendees. These activities included the on-going support to participation champions (to ensure they are equipped to make informed decisions), delivery of a champions events, and evaluation of services across the system and ultimately full engagement across the commissioning cycle. The findings from these events have great depth and are shaping thinking around future provision.
7.5 Doncaster has a new Children and Young People’s Plan (2017-20), which is consistent with the partnership’s pledge to put the voice of the Children and Young People at the centre. With this in mind there was extensive engagement with Children and Young People in setting the plan. Below are the key words Children and Young People use most often.
7.6 Engagement with Children and Young People across the partnership has resulted in them identifying the following priorities. There are grouped against four themes.

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CHILDREN &amp; YOUNG PEOPLE’S PRIORITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Feel safe - knowing that they can safely live and thrive in the borough</td>
</tr>
<tr>
<td></td>
<td>Supported by someone they trust</td>
</tr>
<tr>
<td></td>
<td>Equipped to handle bullying – more resilient and better able to handle difficult situations</td>
</tr>
<tr>
<td>Healthy and happy</td>
<td>Better knowledge of services – what is available to them in their area</td>
</tr>
<tr>
<td></td>
<td>Reduced stigma around mental health – timely support and access to services</td>
</tr>
<tr>
<td></td>
<td>School Nurses to be available more around school and offer increased access</td>
</tr>
<tr>
<td>Achievement</td>
<td>Life skills – making sure that they are well prepared for adulthood</td>
</tr>
<tr>
<td></td>
<td>Pathways to employment – ensuring that they are moving towards good quality, sustainable work</td>
</tr>
<tr>
<td></td>
<td>A broad and balanced curriculum equipping them with the life skills they need to be independent and successful as an adult</td>
</tr>
<tr>
<td>Equality</td>
<td>Treated respectfully – seen as valuable members of society with something unique to bring to discussion</td>
</tr>
<tr>
<td></td>
<td>Listened to – make them feel that their opinion is valued. This should happen in a supportive, nurturing capacity or an informative capacity to enable them to explore a variety of career paths</td>
</tr>
<tr>
<td></td>
<td>Better incentives – encouraging positive choices and patterns of behaviour</td>
</tr>
<tr>
<td></td>
<td>More positive stories – moving from a negative perception of young people to one which focuses on their strengths and achievements</td>
</tr>
</tbody>
</table>

7.7 When testing these priorities back with Children and Young People, they were particularly keen to stress issues around mental health support, being listened to, being supported to stop bullying and having someone to talk to.

7.8 It is clear that mental health and wellbeing, and resilience are high up the priority lists for Children and Young People.

7.9 Under the new Children and Young People governance arrangements, there has been the formation of a partnership and engagement steering group that acts as an enabler to the Children and Families Executive Board (senior decision making board for Children and Young People). There is a new partnership and engagement strategy, which has a clear
vision. This strategy means that partners in Doncaster have made a clear commitment to children’s and young people’s participation. We pledge to:

• Trust young people
• Treat them with honesty and respect
• Make sure that the way we work with Children and Young People is meaningful
• Make sure that the work we do with Children and Young People fits in around them
• Make sure that getting involved is a fun and positive experience.
• Provide regular feedback to young people on their involvement
• Make it possible for all Children and Young People to get involved, regardless of their circumstances
• Make sure that Children and Young People are able to hold agencies that do work with them to account
• Develop digital platforms to consult with and capture the voice of Children and Young People
• Involve young people in the design of services which they access
• Make sure that Children and Young People are aware of the opportunities to get involved
• Ensure that the voice of vulnerable groups is heard.

Participation means creating and promoting positive opportunities for Children and Young People of all ages and abilities to get actively involved in all areas of our work, if and when they choose to do so.

Opportunities to:

• Have their say on issues that affect their lives and to be listened to
• Contribute to and influence policies and services so that they are designed and delivered to reflect their needs
• Have their participation acknowledged, supported and recognised.
7.10 Building on this are the findings from a Children and Young People’s democracy event held 2016. 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:

**Mental Health**

- Not enough is delivered in schools on mental health issues, some schools only offer a one-off lesson.
- Young people stated that Mental Health is ‘Like a secret’ not seen, its invisible.
- When a Mental Health issue is raised teachers/schools can make it worse and unsafe, lack of training and experience.
- Young People feel not enough advertising, publicity and awareness is delivered or available on mental health.
- Young people feel there is a real stigma around mental health and CAMHSs. More needs to be done to address this.
- Young people stated there are still lots of issues around Peer Pressure and that more needs to be done.

- Young people feel there is a real lack of funding for children and young people's mental health service.
- More work needs to be done on pathways into mental health services, they are not clear.
- Current spending on children’s Mental Health doesn’t make sense, more is spent on adults.
- Young people feel there is a real lack of funding for children and young people’s mental health service.
- More work needs to be done on pathways into mental health services, they are not clear.
- Current spending on children’s Mental Health doesn’t make sense, more is spent on adults.

Young people stated that Mental Health is ‘Like a secret’ not seen, its invisible. When a Mental Health issue is raised teachers/schools can make it worse and unsafe, lack of training and experience.

7.11 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.
7.12 A Health Related Behaviours questionnaire was completed by the Schools/ academies and colleges 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.

7.13 All schools/ academies and colleges (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/ academies and colleges and all 18 secondary schools/ academies and colleges agreed to take part. However, during the data collection phase, twelve schools/ academies and colleges (2 secondary and 10 primary) withdrew from the survey or failed to complete before the deadline date for completion. No SEN schools/ academies and colleges agreed to participate.

7.14 Schools/ academies and colleges 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/ academies and colleges also surveyed Year 3 pupils.

7.15 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:

7.16 Composite self-esteem scores for Primary Schools/ academies and colleges

<table>
<thead>
<tr>
<th></th>
<th>Year 4</th>
<th></th>
<th>Year 6</th>
<th></th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Values 0-4 (low)</td>
<td>5%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Values 5-9 (medium)</td>
<td>21%</td>
<td>26%</td>
<td>19%</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Values 10-14 (med-high)</td>
<td>42%</td>
<td>42%</td>
<td>39%</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>Values 15-18 (high)</td>
<td>32%</td>
<td>26%</td>
<td>38%</td>
<td>36%</td>
<td>32%</td>
</tr>
<tr>
<td>Valid Responses</td>
<td>656</td>
<td>678</td>
<td>433</td>
<td>419</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.
7.17 Composite resilience score for Primary Schools/ academies and colleges

<table>
<thead>
<tr>
<th></th>
<th>Year 4</th>
<th>Year 6</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Low (up to 19)</td>
<td>18%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Med-Low (20-22)</td>
<td>19%</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Med-High (23-25)</td>
<td>22%</td>
<td>26%</td>
<td>25%</td>
</tr>
<tr>
<td>High (26+)</td>
<td>41%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Valid Responses</td>
<td>576</td>
<td>607</td>
<td>404</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.

7.18 Composite self-esteem scores for Secondary Schools/ academies and colleges

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

7.19 Composite resilience score for Secondary Schools/ academies and colleges

<table>
<thead>
<tr>
<th></th>
<th>Year 8</th>
<th>Year 10</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Low (up to 19)</td>
<td>18%</td>
<td>42%</td>
<td>34%</td>
</tr>
<tr>
<td>Med-Low (20-22)</td>
<td>21%</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td>Med-High (23-25)</td>
<td>22%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>High (26+)</td>
<td>29%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Valid Responses</td>
<td>554</td>
<td>600</td>
<td>274</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.

7.20 The plan is to re-commission this questionnaire in 2017 and this is the measurement tool to see if things are improving locally.
7.21 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.

7.22 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 has helped shape the implementation process through a better understanding of individual service needs within the wider system transformation, in particular with schools/academies and colleges.

7.23 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.

7.24 This is felt particularly strongly in schools/academies and colleges as evidenced in 77% of schools/academies and colleges 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/academies and colleges and other services, i.e. CAMHs locality workers. The response from schools/academies and colleges has been extremely positive. There is a clear plan to support those schools/academies and colleges yet to nominate with the aim of having 100% nomination by March 2017.

7.25 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/academies and colleges and agreements have been made on respective roles, responsibilities and the interface. This has been sense checked with children, young people and their families.

7.26 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.
8. Understanding Doncaster's Need

8.1 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. The data (where possible) has been updated and continues to set 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
- CAMHS Performance Dashboard
- PHE Children’s Profiles

Unless stated otherwise the data is for the full year 2016/17.

8.2 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).

8.3 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 304,000, of which 71,684 are Children and Young People (0-19 years). Children and Young People under the age of 20 make up 23.58% of the population of Doncaster, which is similar to the national average (23.73%). The number of children aged 0 to 4 years has slightly declined in 2015 (18,726); 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).

8.4 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).

8.5 Figure 2: Number of children & young people in Doncaster divided by gender and age groups
Source mid 2015 estimate.
8.6 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) 2015</td>
<td>18,726 (6.16%)</td>
<td>334,100 (6.2%)</td>
<td>3,414,100 (6.3%)</td>
</tr>
<tr>
<td>Children (age 0-19 years) 2013</td>
<td>71,684 (23.58%)</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, 2015</td>
<td>Boys 77.6</td>
<td>78.6</td>
<td>79.5</td>
</tr>
<tr>
<td></td>
<td>Girls 81.6</td>
<td>82.3</td>
<td>83.1</td>
</tr>
</tbody>
</table>

Source: CHP 2015

8.7 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.

8.8 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</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></td>
</tr>
<tr>
<td>11.5% of young people aged between 11 to 16 years have a mental disorder</td>
<td></td>
</tr>
</tbody>
</table>
8.9. 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 2016/17 unless otherwise stated.

8.10 Referral Data
A total of 1526 referrals were received in 2016/17, 75 more than the previous year.

8.11 Number of Urgent Referrals
There were a total of 95 urgent referrals received. The chart below shows the number of those deemed urgent assessed within 24 hours. All urgent referrals were assessed within 24 hours, which is very positive.

8.12 Number of Non-Urgent Referrals
There were a total of 669 referrals that were deemed to be non-urgent. The chart below shows the number that were assessed within 4 weeks. 89% non-urgent referrals were assessed within 4 weeks which (whilst not at the level we want), compares favourably with national benchmarking.
8.13 Number of assessed Children and Young People starting treatment with a care plan within 8 weeks of referral
There were a total of 516 assessments completed and the chart below shows the number starting within 8 weeks of referral. 91% of non-urgent Children and Young People started treatment a treatment plan within 8 weeks, again this is very positive against national benchmarking scores.

% Starting treatment plan within 8 weeks of referral

91%
9%

8.14 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. Virtually all Children and Young People left CAMHs in a planned manner.

Number of patients leaving in a planned way

98%
2%

8.15 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%. A very small number of patients returned within 30 days, which demonstrates effective discharge planning.

8.16 Consultation and Advice
The data below shows the early impact of the new consultation and advice service and the increasing demand. The split between primary and secondary schools is fairly even at 55% primary and 45% secondary. The split is also fairly even for telephone consultations at 41% and 37%.
8.16.1 The table shows an interesting breakdown of presenting issues with the top four being:
   1. Anxiety.
   2. Stress.
   3. Attachment.
   4. Low Mood.

8.16.2 A total of 959 Children and Young People were discussed within the first five months of service provision, outlining a significant previously unmet need. The majority of these Children and Young People would have been the ones that didn’t previously meet the CAMHs threshold, and as such were not receiving support around their emotional wellbeing and mental health. This is a big step forward.

8.16.3 73% of consultations were face to face. This was incredibly important in the initial stages of the new service to build effective relationships with schools.

8.16.4 There were very few cases escalated up to specialist CAMHs from consultation and advice.

8.16.5 There were very few cases stepped down to consultation and advice from specialist CAMHs.
<table>
<thead>
<tr>
<th></th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-17</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of planned consultations this month (face to face)</td>
<td>144</td>
<td>78</td>
<td>179</td>
<td>171</td>
<td>192</td>
<td>764</td>
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<tr>
<td>Primary Schools</td>
<td>91</td>
<td>45</td>
<td>86</td>
<td>87</td>
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<td>Secondary Schools</td>
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<td>31</td>
<td>92</td>
<td>81</td>
<td>74</td>
<td>329</td>
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<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Number of unplanned consultations (face to face, telephone, email)</td>
<td>64</td>
<td>23</td>
<td>27</td>
<td>45</td>
<td>40</td>
<td>199</td>
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<tr>
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<td>16</td>
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<td>10</td>
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<td>Method of consultations completed</td>
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<td></td>
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<td>11</td>
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<td>20</td>
<td>30</td>
<td>104</td>
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<td>Face to face</td>
<td>159</td>
<td>58</td>
<td>127</td>
<td>123</td>
<td>175</td>
<td>652</td>
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<tr>
<td>Total Number of Consultations Completed</td>
<td>165</td>
<td>62</td>
<td>194</td>
<td>215</td>
<td>214</td>
<td>850</td>
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<tr>
<td>Total Number Children Discussed In Consultations</td>
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<td>59</td>
<td>191</td>
<td>204</td>
<td>205</td>
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<td>Number of children discussed at consultations with presenting issues of:</td>
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<td>94</td>
<td>250</td>
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<td>60</td>
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<tr>
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<td>10</td>
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<td>27</td>
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<td>12</td>
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<td>Number of referrals taken directly from duty</td>
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<td>20</td>
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</tr>
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<td>GP</td>
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<td>Other</td>
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<td>3</td>
<td>5</td>
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<td>9</td>
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<tr>
<td>Number of Cases escalated into Specialist CAMHS via Consultation</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>22</td>
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<td>Broken down:</td>
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<tr>
<td>Primary Schools</td>
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<tr>
<td>Number of Cases stepped down into Consultation from Specialist CAMHS</td>
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<td>0</td>
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<td>7</td>
<td>7</td>
<td>23</td>
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<td>Broken down:</td>
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</tr>
<tr>
<td>Primary Schools</td>
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<td>0</td>
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<td>GPs</td>
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<td>Number of 1:1 cases</td>
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<td>14</td>
<td>14</td>
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<td>78</td>
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<td>3</td>
<td>3</td>
<td>4</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>Number cases signposted for support from other agencies</td>
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<td>19</td>
<td>24</td>
<td>49</td>
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<tr>
<td>Number of Joint Assessments Completed</td>
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<td>4</td>
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<tr>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Number of MDT Meetings attended</td>
<td>22</td>
<td>9</td>
<td>18</td>
<td>21</td>
<td>22</td>
<td>92</td>
</tr>
</tbody>
</table>
8.17 NHS Five Year Forward View Objectives

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS funded community MH service</td>
<td>28%</td>
<td>30%</td>
<td>32%</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Actual</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.18 It is felt that there is a need to get better clarity on to best measure against this objective. Currently all CYP with a diagnosable mental health are see within the commissioned CAMHs service. The ethos of the LTP is to reduce the number of CYP with a diagnosable mental health so whilst we have included this measure it is for reference.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of additional CYP treated over 2014/15 baseline</td>
<td>829</td>
<td>912</td>
<td>994</td>
<td>1076</td>
<td>1118</td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>936</td>
<td>1978</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.19 There was a significant increase in the number of Children and Young People supported in 2016/17, an increase of 53%. Considering there was only a 7% increase in specialist CAMHs we can see that the increased support was through the new consultation and advice service, which is very much, the plan. This is clear evidence that Children and Young People are getting access to support earlier.

8.20 Access and waiting times
Doncaster on the whole has positive access and waiting times that compare favourably with the CAMHs benchmarking report (2013).
### 8.21 Breakdown of waiting times

#### Doncaster CAMHS Wait Averages

**CAMHS 93 RTT**

<table>
<thead>
<tr>
<th>Completed Treatment Waits - Average (days)</th>
<th>General Service (Not on a Reg)</th>
<th>Learning Difficulties</th>
<th>Looked After Children</th>
<th>ADHD Care Pathway</th>
<th>ADHD Post Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>April - Wait Avg (days)</td>
<td>50</td>
<td>88</td>
<td>47</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>April - Number of Patients seen</td>
<td>59</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May  - Avg Wait (days)</td>
<td>47</td>
<td>48</td>
<td>83</td>
<td>148</td>
<td>88</td>
</tr>
<tr>
<td>May  - Number of Patients seen</td>
<td>41</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>June - Wait Avg (days)</td>
<td>35</td>
<td>0</td>
<td>114</td>
<td>70</td>
<td>188</td>
</tr>
<tr>
<td>June - Number of Patients seen</td>
<td>43</td>
<td>0</td>
<td>3</td>
<td>4</td>
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</tr>
<tr>
<td>July  - Wait Avg (days)</td>
<td>39</td>
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<td>62</td>
<td>137</td>
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<td>4</td>
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<tr>
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<td>0</td>
<td>177</td>
<td>0</td>
</tr>
<tr>
<td>Aug   - Number of Patients seen</td>
<td>26</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Sept  - Wait Avg (days)</td>
<td>22</td>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Sept  - Number of Patients seen</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>1</td>
<td>2</td>
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<td>121</td>
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<td>Nov   - Number of Patients seen</td>
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<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>Dec   - Wait Avg (days)</td>
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<td>1</td>
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<td>63.5</td>
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<td>0</td>
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<td>19</td>
<td>191.2</td>
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<td>2</td>
<td>4</td>
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<td>Mar   - Wait Avg (days)</td>
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<td>25</td>
<td>86.5</td>
<td>202</td>
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<tr>
<td>Mar   - Number of Patients seen</td>
<td>25</td>
<td>0</td>
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<td>6</td>
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</table>

**Doncaster CAMHS Wait Averages**

**CAMHS 92**

<table>
<thead>
<tr>
<th>Treatments still waiting (days) - Target 56 days</th>
<th>General Service (Not on a Reg)</th>
<th>Learning Difficulties</th>
<th>Looked After Children</th>
<th>ADHD Care Pathway</th>
<th>ADHD Post Diagnosis</th>
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</thead>
<tbody>
<tr>
<td>April - Wait Avg (days)</td>
<td>38</td>
<td>15</td>
<td>114</td>
<td>85</td>
<td>111</td>
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<tr>
<td>April - Number of Patients seen</td>
<td>195</td>
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<td>15</td>
<td>15</td>
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</tr>
<tr>
<td>May   - Avg Wait</td>
<td>97</td>
<td>3</td>
<td>98</td>
<td>93</td>
<td>124</td>
</tr>
<tr>
<td>May   - Number of Patients Waiting</td>
<td>32</td>
<td>1</td>
<td>13</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>June   - Avg Wait</td>
<td>31</td>
<td>51</td>
<td>83</td>
<td>85</td>
<td>28</td>
</tr>
<tr>
<td>June   - Number of Patients Waiting</td>
<td>132</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>July   - Avg Wait</td>
<td>36</td>
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<td>74</td>
<td>79</td>
<td>24</td>
</tr>
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<td>127</td>
<td>0</td>
<td>8</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Aug   - Wait Avg (days)</td>
<td>33</td>
<td>0</td>
<td>108</td>
<td>60</td>
<td>62</td>
</tr>
<tr>
<td>Aug   - Number of Patients Waiting</td>
<td>53</td>
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<td>11</td>
<td>19</td>
<td>3</td>
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<td>26</td>
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<td>Oct   - Wait Avg (days)</td>
<td>35</td>
<td>3</td>
<td>78</td>
<td>92</td>
<td>0</td>
</tr>
<tr>
<td>Oct   - Number of Patients Waiting</td>
<td>175</td>
<td>1</td>
<td>13</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Nov   - Wait Avg (days)</td>
<td>43</td>
<td>20</td>
<td>56</td>
<td>100</td>
<td>210</td>
</tr>
<tr>
<td>Nov   - Number of Patients Waiting</td>
<td>192</td>
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<td>7</td>
<td>39</td>
<td>1</td>
</tr>
<tr>
<td>Dec   - Wait Avg (days)</td>
<td>48.6</td>
<td>40.5</td>
<td>86.6</td>
<td>110.9</td>
<td>175</td>
</tr>
<tr>
<td>Dec   - No Patients Waiting</td>
<td>179</td>
<td>2</td>
<td>5</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td>Jan   - Wait Avg (days)</td>
<td>43.8</td>
<td>37.5</td>
<td>33.2</td>
<td>120.9</td>
<td>0</td>
</tr>
<tr>
<td>Jan   - No Patients Waiting</td>
<td>203</td>
<td>2</td>
<td>5</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Feb   - Wait Avg (days)</td>
<td>43.5</td>
<td>69</td>
<td>41.5</td>
<td>108</td>
<td>178</td>
</tr>
<tr>
<td>Feb   - No Patients Waiting</td>
<td>188</td>
<td>1</td>
<td>6</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>Mar   - Wait Avg (days)</td>
<td>46.8</td>
<td>87</td>
<td>35.7</td>
<td>110</td>
<td>210.8</td>
</tr>
<tr>
<td>Mar   - No Patients Waiting</td>
<td>172</td>
<td>2</td>
<td>6</td>
<td>42</td>
<td>10</td>
</tr>
</tbody>
</table>
8.22 General Service
The average waiting time for an assessment (non-urgent) is approximately 23 days which is within the 28 day target, and the average length of time for treatment to start is 39 days after assessment, this gives a total of 62 days which equates to just under 9 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.

8.23 Learning Difficulties
The average waiting time for assessment is 19.5 days for this element and then a further 54 days for treatment to start. This equates to 73.5 days and/or 10.5 weeks. This is over the 56 day target. An additional 0.9WTE resource has been added to the pathway to increase capacity to reduce the waits. Areas of focus for this area are in section 13.3.5 page 86.

8.24 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. An additional 1WTE has been added to the pathway to increase capacity to reduce waits. Areas of focus for this area are in section 13.3.6, page 87.

8.25 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.
## Descriptors

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Activity</th>
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<td>Number of YP assessed with a mental health need (ASSET)</td>
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</tr>
<tr>
<td>Number of YP on caseload</td>
<td>132</td>
</tr>
<tr>
<td>Number of YP starting treatment within 8 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Number of consultations with YP</td>
<td>25</td>
</tr>
</tbody>
</table>

### 8.26 Reviewing Services for Children and Young People with Learning Disabilities, Looked After Children and those in contact with the Youth Offending Service.

DCCG commissioned an external consultant to undertake a piece of work to address the following questions about CAMHs services for Looked after Children, Children with a Learning Disability and Children and Young People in contact with the Youth Offending Service:

- what do the current pathways look like?
- what currently happens at each stage of the pathway?
- are the pathways clear for service users and stakeholders?
- are the pathways adequately resourced?
- what are the thoughts of Children and Young People and their families?
- what are the thoughts of stakeholders?
- do the current pathways/ resources meet the needs of the population?

8.27 At the time of writing the LTP refresh the report was still in draft, but an initial version has been shared with stakeholders with very positive feedback. The report is broken down into three key areas with summary findings are initial recommendations. These were presented to the mental health and wellbeing strategy group with positive feedback. The final version is expected before the end of November 2017.

8.28 Funding has been allocated to the findings; decisions will be made by the mental health and wellbeing strategy group on prioritising the recommendations with a view to implementing.

8.29 There is a wider strategic discussion also taking place around which services we could potentially commission across the ACS footprint. Services for vulnerable Children and Young People are certainly being considered.
### 8.30 Inpatient (tier 4) admissions & bed days

<table>
<thead>
<tr>
<th>Service</th>
<th>PCT</th>
<th>CCG</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Grand Total</th>
</tr>
</thead>
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<tr>
<td>Acute CAMHS</td>
<td></td>
<td></td>
<td>9</td>
<td>21</td>
<td></td>
<td></td>
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<tr>
<td>Adolescent</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
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<td><strong>32</strong></td>
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<tr>
<td>Autistic Spectrum Disorder</td>
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<td></td>
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<td>1</td>
<td></td>
<td></td>
<td><strong>1</strong></td>
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<tr>
<td>Child</td>
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<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>17</strong></td>
</tr>
<tr>
<td>Eating Disorders</td>
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<td>1</td>
<td></td>
<td></td>
<td></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>Learning Disability</td>
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<td>6</td>
<td>2</td>
<td></td>
<td>3</td>
<td></td>
<td><strong>18</strong></td>
</tr>
<tr>
<td>Complex Learning Disability</td>
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<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td><strong>1</strong></td>
</tr>
<tr>
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<td>1</td>
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<td></td>
<td></td>
<td><strong>3</strong></td>
</tr>
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<td>PICU</td>
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<td>2</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td><strong>12</strong></td>
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<tr>
<td>Medium Secure</td>
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</tr>
<tr>
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<td></td>
<td>2</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td><strong>Total patients</strong></td>
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<td>31</td>
<td>17</td>
<td>36</td>
<td></td>
<td></td>
<td><strong>122</strong></td>
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</table>

#### Analysis

It is important to note that this relates to the number of admissions and not the number of YP admitted. There has been a clear increase in the number of admissions bringing it to the second highest level in the past four years. The two main areas of increase are acute CAMHs and PICU.

DCCG have asked the CAMHS provider (RDaSH) to complete a deep dive analysis on all inpatient admissions in 2016/17 by the end of the calendar year, to allow for analysis.

*It is worth noting that we suggest the 2015/16 data is inaccurate.*

#### 8.31 Number of Admissions per 100,000

The total number of admissions over 100,000 is 13.80% which the highest in South Yorks. There has been an increase on previous years and for the first time Doncaster has the highest ratio.

#### 8.32 Distance from Home

The average distance from home for an inpatient admission for a Doncaster Child and/or Young Person was on average 132 miles, being the second highest in South Yorks. This is due to the nature of the presentations and the availability of beds.

#### 8.33 Length of Stay

The average length of stay was 71 days, which is a reduction on previous years. When the initial needs assessment was completed for the original LTP, the average length of stay was 101 days.
8.34 Occupied Bed Days

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
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<td>Grand Total</td>
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<td>3142</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10796</td>
</tr>
</tbody>
</table>

Analysis
The increase in admissions is directly proportionate to the increase in occupied bed days. Excluding 2015/16 the occupied bed days isn’t significantly different to previous years.

The deep dive analysis (section 7.21) will analyse the above data.

It is worth noting that we suggest the 2015/16 data is inaccurate.

8.35 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.

8.36 Transforming the mental health services for children who have been abused (NSPCC)
NSPCC completed a review of LTP’s in September 2017, which examined the extent to which Clinical Commissioning Groups are taking into account the particular needs of
Children and Young People who have been abused and neglected, when planning local mental health services. 79% of plans recognise that mental health issues can be attributed to abuse or neglect in childhood. Each of the LTP’s was given a RAG rating and we are pleased to confirm that Doncaster received a green rating, giving Doncaster a green rating for the second successive year. This shows a clear emphasis on this cohort of Children and Young People.

8.37 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, and 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 North East CYP-IAPT partnership now also includes increased services from TEWV (including York), Leeds, Humber, Gateshead, Northumbria, Newcastle and Sheffield.

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

8.38 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:

8.39 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.

8.40 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 the need for another place on the 2015/16 training, given the need and loss of trained workforce; this was successfully completed.
• Doncaster CAMHS have a further place for CBT training for 2017/18 which will be recruited to directly following a vacancy for this pathway

8.41 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
• With the new pathway structures in the Doncaster CAMHS team, there are 2 identified pathway leads to undertake the service lead training in 2017/18.

8.42 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
• A further family therapist is undertaking the supervisors training, whilst based in North Lincolnshire will support the supervision requirements for individual trainees.
• CBT trainees are supported via the Rotherham CAMHS service.

8.43 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, one clinician has left the service and another remains in post and utilising SFP for self-harm.
• A further clinician has been accepted to the 2017/18 programme to complete the SFP for self-harm and conduct disorder, this practitioner works within the Youth Offending Service

8.44 Interpersonal Psychotherapy for Adolescents (IPT-A)
• Introduced to the programme in 2014/15
• One clinician completed training in November 2015, they have subsequently moved to a more senior role, but one that has limited use for IPT-A.
• A further clinician is undertaking Interpersonal Therapy for Adolescents; delivered via the North West CYP-IAPT collaborative in Manchester; the clinician is due to complete by November 2017
• A training place has been successfully recruited to for 2017/18 from within the Intensive Home Treatment pathway.

8.45 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.

8.46 Learning Disability/ ASD pathway
• This was introduced nationally in 2016/17, Doncaster CAMHS has a clinician attending the training in London, alongside supervision allocation to support the trainee; the training is part time over 2 years
8.47 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 as a result of staff being on CYP-IAPT training, remaining around 30 days for assessment and the service is continuing to strive to see all young people to start treatment within 8 weeks of 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. The development of locality ‘advice and consultation’ posts has support the access to services from a wide range of young people, who may not have traditionally attended GP surgeries to access help. There has been a specialist eating disorder service developed to meet specialist needs.

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. The service is moving to a new electronic records system in December 2017, with an expectation that there will be an ability to report team-wide outcome feedback in order to review the service needs, influence future developments and support feedback to wider stakeholders about the effectiveness of services.

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; this has moved to being within the town centre located therapy base for CAMHS. Children and Young People can also contact the service directly to discuss referrals; additionally, the service is exploring the opportunity to join school nurse colleagues in the drop in sessions run within the local secondary schools/academies and colleges.

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 care group meetings and meetings with commissioners and other stakeholders via the emotional health and well-being multi-agency meetings.

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, more recently additional opportunities have been undertaken through other collaboratives in the North West and London.

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. In the 5 years of participation in training opportunities, there have been no issues with availability of appropriate cases, which have impacted on completion of training.

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. The reporting of the data set has been incorporated into the MHSDS, the new electronic records system developed to support reporting.

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. Following reduction in the national CYP-IAPT funding of backfill support, the local Doncaster CCG has continued to support with additional resource to enable clinicians to continue to benefit from the training opportunity.

Agree to participate in service accreditation to IAPT standards - this is on-going, service accreditation will be considered through the ‘Delivering With, Delivering Well’ criteria. The service reviews progress towards the ‘Delivering With, Delivering Well’ standards on a quarterly basis

8.48 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 on-going 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.

8.49 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.
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>TOTAL</td>
<td>57</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>TOTAL</td>
<td>64</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.

8.50 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 that 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

8.51 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>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of emergency cases received</td>
<td>0</td>
</tr>
<tr>
<td>Number of urgent cases received</td>
<td>13</td>
</tr>
<tr>
<td>Number of non-urgent cases received</td>
<td>20</td>
</tr>
<tr>
<td>Number of cases admitted into T4</td>
<td>5</td>
</tr>
<tr>
<td>Seen within access target</td>
<td>100%</td>
</tr>
</tbody>
</table>

South Yorkshire Eating Disorder Association has 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>

8.52 Early Intervention in Psychosis Service
RDaSH provide an EIP service for YP and adults aged 14yrs to 35yrs, with the CAMHs service being the lead service for those aged under 16yrs supported by the EIP service. The EIP service leads for all those aged over 16yrs. This is linked to lead prescribing role. The aims of the service are as follows:

- Reduce the stigma associated with psychosis and improve population level awareness of the symptoms of psychosis, and the prodromal phase, and the need for early assessment.
- To be able to identify, assess and treat people who are in the prodromal phase of psychosis, and so at risk of developing early onset psychosis.
- By identifying people in the prodromal phase reduce the length of time young people remain undiagnosed and untreated.
- Encourage treatment concordance by meaningfully engaging people with the services involved, using evidence based interventions and an empowering approach to recovery.
- Work holistically with people to improve stability in their lives, support emotional and personal development, including self-esteem building and provide meaningful social activity to promote such development.
• Treatment will be provided in the least stigmatizing environment, treatment will take place where the person feels most comfortable, and of their choosing. Ensuring that this place is safe for the person and whoever is providing them with support/treatment at that time.
• There will be emphasis on the person’s development of personality and education, and work around societal norms.
• To provide treatment/interventions for this group of people for up to 12 months as per the evidence base for conversion to psychosis, with swift access to treatment in place for an additional 24 months.
• People will be seen and assessed within 2 weeks of referral into the service.
• Provide a clear and easily accessible pathway that allows people to be referred, or to self-refer into this service.
• Ensure that at all points in the treatment journey there is timely access to evidence based interventions/treatment and when required onward referrals are made.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients referred</td>
<td>17</td>
<td>21</td>
<td>15</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td>Patient experiencing a first episode of psychosis treated with a NICE approved care package within 2 weeks</td>
<td>15</td>
<td>18</td>
<td>11</td>
<td>21</td>
<td>65</td>
</tr>
<tr>
<td>% Compliance</td>
<td>88.2%</td>
<td>86%</td>
<td>73%</td>
<td>91%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

On the whole performance is good with the majority of patients seen within the two weeks NICE guidance target. There is scope for improvement, which will be picked up as an action within the plan (see section 13.2.6, page 83).

8.53 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. The below graph shows the Out of Hours Service for Doncaster CCG only for 2016/17. There were a total of 105 call-outs for this period.

Number of Call-outs per month
8.54 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:

2013 – 2014: 2YP
2014 – 2015: 5YP
2015 – 2016: 3YP
2016 – 2017: 6YP

8.55 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:

2012 – 2013: 0YP
2013 – 2014: 2YP
2014 – 2015: 1YP
2015 – 2016: 0YP
2016 – 2017: 0YP

8.56 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 an annual total of 45 young people in 2016/17. There were a total of 17,145 Mental Health calls to the Single Point of Access Team, of which 95 resulted in a referral to CAMHS. 72 of the 95 calls came within in hours and the remaining 23 were received in Out of Hours.

8.57 Childhood Development
The percentage of children achieving a good level of development at the end of reception in Doncaster (69.7%) is higher than the national level (69.3%). During 2015/16, 2,710 children achieved good levels of development (CHP 2015).

Table 3: Percentage of children achieving good level of development at the end of reception (2015-16)

<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>2013/14</td>
<td>1,981</td>
<td>53.1</td>
<td>60.4</td>
</tr>
<tr>
<td>2015/16</td>
<td>2,710</td>
<td>69.7</td>
<td>69.3</td>
</tr>
</tbody>
</table>

Source: CHP 2015-16

8.58 Special Education Needs
Doncaster has about 6,230 children who require special educational needs (with or without statement) and this equates to 12.86% of school children (DfE. 2017). The highest
percentage of children with SEN in a community from Doncaster was 36.4% while the lowest was 8.6%. A total of 3,587 pupils (12.3%) with SEN were from Primary Schools/academies and colleges, 1,882 pupils (10.5%) were from Secondary Schools/academies and colleges and 567 pupils were from Special Schools/academies and colleges.

Pupils with SEN who had a statement were divided into:

- Level of Learning Difficulty 48%
- Social, emotional and Mental health 18%
- Speech, Language and Communications Needs 17%
- A level of Impairment 8%
- Physical Disability 2%
- Autistic Spectrum Disorder 2%
- Other Difficulty/Disability 4%

8.59 Schools/academies and colleges

Schools/academies and colleges 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/academies and colleges showed there is variance across schools/academies and colleges (sample size of 50% of all schools/academies and colleges). For full details see Appendix 5. However, the main points were:

- Over half of schools/academies and colleges 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/academies and colleges, but in the majority of cases where they do provide support, they have had no formal training
- In some schools/academies and colleges there is a nominated lead for emotional health and wellbeing
- Schools/academies and colleges and CAMHs are not closely configured and don’t have robust systems to enable effective joint working. This means there was very little consultation, advice and guidance provided into schools/academies and colleges from CAMHs.

8.60 An emerging theme from recent engagement with schools/academies and colleges 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.
8.6.1 Early Help Offer

Effective partnerships have enabled the Early Help agenda to progress significantly from the 2015 position. As a result, the Early Help Strategy has been revised and updated to reflect the publication of the Doncaster Children and Young People's Plan (C&YPP) 2017- 2020.

This new Early Help Strategy provides the opportunity to refocus our understanding of Early Help and, importantly, how Commissioners and provider services ‘think’ and ‘work’ more effectively together over the long term. Early Help should not only be seen as a response to additional or multiple/ complex needs requiring a multi-disciplinary team around the family (TAF) alone. Early Help is also an overarching philosophy that promotes prevention and earlier intervention that should influence all Strategies in Doncaster to achieve better outcomes for Children and Young People with a focus on the whole family’s needs. In all cases, it should seek to narrow the gap in outcomes for some Children and Young People who are disadvantaged, either by their circumstance or the environment in which they live. Early Help requires a whole family integrated approach and goes beyond a response and focus on solely children and their outcomes. It requires a collective universal response across a broad range of services, both in the community and adult services to address parents’ own vulnerability, or challenge behaviour, which affects their children’s, lives now and in the future.

Early Help infrastructure and processes are now well established. There is increasing evidence that thresholds for intervention are embedded and there are an increasing number of professionals taking on the lead professional role and early help assessments. This is working towards Children and Young People receiving the right support as issues arise thereby securing better outcomes and avoiding more costly interventions in the future. Further work is needed to ensure the quality and effectiveness of the early help assessments and plans; harmonising the Early Help pathway with SEND and behaviour support processes to avoid duplication and to increase the use of the Families Information Service by families to ‘self-serve’ and by practitioners to improve integrated working.

8.62 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.

8.63 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.

8.64 Childhood development and school achievements

During 2015/16 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 54.7% of young people achieved higher GCSE grades compared to a national average of 57.8%.

8.65 Not in education, employment or training (NEET)

The percentage of young people not in education, employment or training has declined. The figures for 2013 shows 5.5% of total young people were NEET and in 2016/17 it shows 4.3%.
8.66 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.

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

<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>

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

8.69 Hospital admissions for unintentional and deliberate injuries

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional Injuries (0-14yrs)</td>
<td>461</td>
<td>386</td>
<td>415</td>
</tr>
<tr>
<td>Deliberate Injuries (0-14yrs)</td>
<td>1</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Unintentional Injuries (15-24yrs)</td>
<td>272</td>
<td>314</td>
<td>292</td>
</tr>
<tr>
<td>Deliberate Injuries (0-14yrs)</td>
<td>10</td>
<td>21</td>
<td>13</td>
</tr>
</tbody>
</table>

8.70 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 2016/17, 148 Children and Young People were admitted to acute wards due to self-harm. This is an increase from 137 in 2015/16. The caveat to this data is that it includes alcohol poisoning so it must be interpreted with this consideration.
8.71 Suicide

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number admitted to acute wards via A&amp;E or CAMHs for attempted suicide</td>
<td>12</td>
<td>27</td>
<td>14</td>
</tr>
</tbody>
</table>

8.72 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.

8.73 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).

8.74 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 that 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:

![Graph showing ages at time of admission to an acute ward for attempted suicide.](image1)

![Gender distribution graph.](image2)

![Themed issues graph.](image3)

![Levels of Need graph.](image4)
There were several examples of good practice and what worked well, a selection of these are listed below:

- 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 DHBFT 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.

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.

8.77 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>
8.78 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.

8.79 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.

8.80 Domestic Violence
Doncaster Children’s Services Trust (DCST) with Partners Continues 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.
We have maintained our Domestic Abuse Navigation Service which provides therapeutic support to children and families impacted by domestic abuse, and are supporting our universal and early help services to identify indicators of coercive control so families are supported they need help from the police or social care at a relatively high level of risk. DCST is also supporting the Safer Stronger Doncaster Partnership to embed our philosophy of practice to ensure Children and Young People receive support as well as adult victims or perpetrators, so immediate efforts to reduce short term risk reduce risk in the long term, leading to less repeat victimisation with different partners in new relationships, and young people going on to become victims or perpetrators in their adult life. We’ve also increased interventions focused on Children and Young People, to enable the recovery of victims and their children together, in order to achieve sustained reduced risk of victimisation.

8.81 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.
9. Self-Assessment Toolkit

9.1 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:

9.2 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/ academies and colleges and this will be the building block to a wider programme. This includes CAMHs, Education Psychology and schools/ academies and colleges 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.

9.3 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.
9.4 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/academies and colleges, GP practices
- Schools/academies and colleges 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.

9.5 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 16yrs 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.

9.6 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.
10. Workforce

10.1 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. This is updated annually and shows the changes made over the first three of the plan. 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 positions June 2015</th>
<th>Number of Practitioner/ Staff positions October 2016</th>
<th>Number of Practitioner/ Staff positions October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Based Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Named Mental Health Leads</td>
<td></td>
<td></td>
<td>101</td>
</tr>
<tr>
<td>JASP</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Thrive</td>
<td>40</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td><strong>Children’s Trust Based Service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic Psychologist</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Forensic Psychologist (in training)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Multi Systemic Family Practitioners</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Third Sector</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open Minds</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>NHS Based Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist CAMHs</td>
<td>29.8</td>
<td>15.6</td>
<td>17.19</td>
</tr>
<tr>
<td>Consultation &amp; Advice</td>
<td>0</td>
<td>5.5</td>
<td>10</td>
</tr>
<tr>
<td>Intensive Home Treatment Service</td>
<td>0</td>
<td>5</td>
<td>5.1</td>
</tr>
<tr>
<td>Paediatric Liaison</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community Eating Disorder Service</td>
<td>1.6</td>
<td>11.9</td>
<td>11.9</td>
</tr>
<tr>
<td>Looked after Children CAMHs</td>
<td>2</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Learning Disability CAMHs</td>
<td>2</td>
<td>4.1</td>
<td>4</td>
</tr>
<tr>
<td>Youth Offending CAMHs</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ADHD</td>
<td>4</td>
<td>3.8</td>
<td>5.44</td>
</tr>
<tr>
<td>Autism</td>
<td>3</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>Single Point of Access CAMHs</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>95.40</td>
<td>127.90</td>
<td>278.83</td>
</tr>
</tbody>
</table>

10.2 There continues to be a significant increase in the workforce (+55%) who have a direct impact on working with Children and Young People. The big change comes in the recognition of the named mental health leads within education.
10.3 The increased workforce is clear evidence of the continued investment in Doncaster and the focus on early help and prevention. The direction of the LTP is very much about supporting Children and Young People at the earliest opportunity possible and as such the growth in workforce will be focussed in this area, rather than in more therapists and supervisors. This doesn’t therefore necessarily align to the Five Year Forward View, but it is right for Doncaster.

10.4 There has been a significant increase in the number of Thrive practitioners in Doncaster and DCCG commissioned x2 school staff to attend a train the trainer intensive course. This brings the option to Doncaster schools/ academies and colleges to receive this training at a significantly lower cost.

10.5 The intention was always to direct the initial additional funding to early help and prevention services, in particular the consultation and advice service, in line with the ethos of the LTP. This service has almost doubled in the past year with one of the posts to be funded by a collaboration of schools/ academies and colleges. The aim for the remaining two and a half years is to realise the reductions in the number of Children and Young People requiring specialist CAMHs, allowing for a redistribution of resources. The aspiration is to move to a minimum of 12WTE Consultation and Advice workers.

10.6 There has been an increase in specialist CAMHs, however this is primarily in the vulnerable Children pathways, LAC and LD) using the waiting list funding from NHSE. This funding has been sustained by the partnership to ensure additional capacity. The plan is to further increase resources within these pathways using the five year forward view monies.

10.7 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.

10.8 Five Year Forward View Workforce Requirements
Delivering improved access to mental health services is quite rightly a key driver in the document with suggested increases in therapists and supervisors. The table below shows the suggested trajectory.

<table>
<thead>
<tr>
<th>Workforce Type</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists</td>
<td>200</td>
<td>428</td>
<td>428</td>
<td>228</td>
<td>52</td>
</tr>
<tr>
<td>Supervisors</td>
<td>50</td>
<td>107</td>
<td>107</td>
<td>57</td>
<td>13</td>
</tr>
</tbody>
</table>

10.9 This has been translated into what it means to Doncaster and the figures are below.

<table>
<thead>
<tr>
<th>Workforce Type</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists</td>
<td>23</td>
<td>25.5</td>
<td>28</td>
<td>29.35</td>
<td>29.65</td>
</tr>
<tr>
<td>Actual</td>
<td>20</td>
<td>25</td>
<td>28*</td>
<td>30*</td>
<td>30*</td>
</tr>
<tr>
<td>Supervisors</td>
<td>11.3</td>
<td>11.9</td>
<td>12.6</td>
<td>12.9</td>
<td>12.97</td>
</tr>
<tr>
<td>Actual</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The future numbers of increased therapists in service will be dependent on, on-going HEE and NHS England support with future delivery and access to specialist CAMHS training via HEIs.
10.10 Whilst the actual therapy numbers are below the national trajectory, there is a clear plan to increase to meet the figures for the next two and a half years of the plan.

10.11 The actual number of supervisors in Doncaster meets the national target and will continue to do so over the next two and a half years of the plan.

10.12 Stepping Forward to 2020/21 - The Mental Health Workforce Plan for England

Stepping Forward focuses on the health workforce to 2021 whilst acknowledging social care, housing, community and the third sector all provide invaluable services. The document sets out the high level road maps for regions, STP’s and local areas. The Five Year Forward View sets out the ambition of transformation; Stepping Forward outlines the opportunities and challenges to getting a workforce in place to enact the transformation. There is an acknowledgement that there is a need for innovation and doing things differently.

10.13 Mental Health Nurse training courses are oversubscribed however the rate of growth in nursing posts has not kept pace with other professions, meaning that currently 11% of all posts (Children and Young People and adults) are vacant. More worryingly there is a negative net effect meaning fewer mental health nurses are employed each year. The reliance on non-UK staff will also be impacted by Brexit. It is clear that as services expand more nurses will be needed; the removal of the nurse bursary may potentially have a negative effect.

10.14 There are currently 11,400 medical posts in mental health services of which 5,400 are consultants, 12% are vacant. There has been lower growth in psychiatrists employed relative to the wider workforce. To consider how best to increase the supply of medical staff, it is helpful to understand the pipeline, which eventually produces a doctor eligible to be a Consultant Psychiatrist. The key points are as follows:

- Not enough newly qualified doctors choosing/ able to train in psychiatry
- Low direct transition rates from core to higher specialist training
- Recruitment into higher psychiatry is therefore reliant on non-UK doctors in training
- A quarter of recently qualified consultant psychiatrists do not go onto be employed by the NHS
- The psychiatric workforce also relies heavily on non-consultant, non-training grade doctors

10.15 For Children and Young People the picture in terms of classical workforce is challenging. Nationally there are 11,400 posts with 1,100 vacancies (9% of total workforce).

10.16 There are an expected 3,300 extra posts needed in Children and Young People mental health by 2021.

10.17 It is clear that simply increasing the number of funded posts by 2021 in growth areas will not deliver the improvements needed. It is also clear that traditional training routes within the timescales required cannot meet the sheer scale of this growth.

10.18 The Five Year Forward View sets out a vision for more integrated services offered in community settings. The move to Accountable Care Systems and the Doncaster Place Plan set out an equal vision. Innovation is needed to think about how we resource services to ensure quality of care in line with expected growth. We are clear that there is no one right way to deliver outcomes, rather we need to commission and configure services in such a way to meet our objectives, in this case to achieve the vision and objectives of the LTP.
10.19 Therefore the proposal is to commission a review of the current workforce in terms of
the model to give clarity on what posts are needed now and for the future. Discussions are
on-going about whether this should be done across the South Yorkshire and Bassetlaw
Accountable Care Systems footprint. This will enhance the previous workforce audit that
looked more at training needs for existing workers rather than looking at future profiles.

10.20 **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.

10.21 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/ academies and colleges.
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/ academies and
colleges grew, a deeper dive took place that was further supported by four locality schools/
academies and colleges events.

10.22 The schools/ academies and colleges 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/ academies and colleges

<table>
<thead>
<tr>
<th>Findings</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schools/ academies and colleges welcome the opportunity to work more closely with CAMHs professionals in the new model</strong></td>
<td></td>
</tr>
<tr>
<td>Most expertise in schools/ academies and colleges is vested in a small number of pastoral support staff</td>
<td></td>
</tr>
<tr>
<td>A small number of schools/ academies and colleges 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>
<td></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>
<td></td>
</tr>
<tr>
<td>There are no standards for the systems and processes that should be in place to underpin the activity schools/ academies and colleges engage in to identify and intervene to meet need</td>
<td></td>
</tr>
<tr>
<td>Generally, interventions in schools/ academies and colleges are applied inconsistently and lack structure and evidence base</td>
<td></td>
</tr>
<tr>
<td>The point at which schools/ academies and colleges individually exhaust their competence and confidence and turn to external support varies significantly. Specialist schools/ academies and colleges 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>
<td></td>
</tr>
<tr>
<td>Schools/ academies and colleges 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>
<td></td>
</tr>
<tr>
<td>There is limited sharing of practice or knowledge between schools/ academies and colleges. Emotional Health and Wellbeing Leads in schools/ academies and colleges have no systems or processes in place for engaging formally with each other across schools/ academies and colleges</td>
<td></td>
</tr>
<tr>
<td>Whilst some schools/ academies and colleges have very positive relationships with the CAMHs service these were often built on one-to-one relationships or where schools/ academies and colleges had specific skills or competencies that enabled them to engage with CAMHs in a ‘CAMHs Language’</td>
<td></td>
</tr>
</tbody>
</table>
10.23 The wider workforce was consulted with the key findings as follows:

<table>
<thead>
<tr>
<th><strong>Findings Summary – Wider Workforce</strong></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 process 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/ academies and colleges 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/ academies and colleges are able to specify in an annual plan the key areas they require School Nursing services to focus on. Many schools/ academies and colleges identify emotional health and wellbeing as one of those areas, not all schools/ academies and colleges 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/ academies and colleges 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>
10.24 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>
10.25 There are a series of recommendations that come directly from the above key findings.

<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 Develop 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 intervening 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. The portal will be able to be used by staff across any service providing support to children and young people.</td>
<td>1 2 3 4 5 6</td>
<td>Schools, Health Visitors, School Nurses, Early Help Hub, Children’s Centres, Nurseries. Voluntary and Charitable sector including youth clubs and youth organisations</td>
<td>CAMHS support and advice</td>
</tr>
<tr>
<td>2 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 own 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 ‘Engage Doncaster’ portal.</td>
<td>1 2 3 4 5 6</td>
<td>School’s EH&amp;W staff, Health Visitors, School Nurses, Early Help Hub, Children’s Centres Nurseries. DCST staff</td>
<td>Schools</td>
</tr>
<tr>
<td>3 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 or ongoing mental ill health and acting to reduce the stigma associated with mental health issues.</td>
<td>1 2 3 4 5 6</td>
<td>All staff across the Borough who work with children and/or young people.</td>
<td>CAMHS with Educational Psychology</td>
</tr>
<tr>
<td>4 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.</td>
<td>1 2 3 4 5 6</td>
<td>School’s EH&amp;W staff, front line staff in IFST, Early Help Hub, children’s centres, Nurseries, Project 3</td>
<td>CAMHS</td>
</tr>
<tr>
<td>5 Increase in the availability of counselling skill in schools: Development of a Doncaster Schools Counselling offer in line with the DfE recommendations</td>
<td>1 2 3 4 5 6</td>
<td>Schools, EH&amp;W leads with support from CAMHS</td>
<td>Schools</td>
</tr>
<tr>
<td>6 Development and delivery of a series of shared learning opportunities for specific needs: Cognitive Behavioural Therapy, 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.</td>
<td>1 2 3 4 5 6</td>
<td>All children’s services</td>
<td>CAMHS</td>
</tr>
<tr>
<td>7 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</td>
<td>1 2 3 4 5 6</td>
<td>Focused on staff who already work with C&amp;YP and families with multiple and/or complex needs</td>
<td>CAMHS, DCST</td>
</tr>
<tr>
<td>8 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</td>
<td>1 2 3 4 5 6</td>
<td>CAMHS clinical staff</td>
<td>CAMHS</td>
</tr>
<tr>
<td>9 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.</td>
<td>1 2 3 4 5 6</td>
<td>CAMHS clinical staff HV/SN staff</td>
<td>RDaSH</td>
</tr>
<tr>
<td>10 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.</td>
<td>1 2 3 4 5 6</td>
<td>CAMHS clinical staff</td>
<td>CAMHS with RDaSH L&amp;D</td>
</tr>
<tr>
<td>11 CAMHS – Specific higher level interventions: Additional level skill stratagising in Mentalisation Based Therapy, Family Therapy and Mindfulness</td>
<td>1 2 3 4 5 6</td>
<td>CAMHS clinical staff</td>
<td>CAMHS with RDaSH L&amp;D</td>
</tr>
<tr>
<td>12 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.</td>
<td>1 2 3 4 5 6</td>
<td>CAMHS staff</td>
<td>CAMHS</td>
</tr>
<tr>
<td>13 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.</td>
<td>1 2 3 4 5 6</td>
<td>School’s EH&amp;W staff</td>
<td>Doncaster MBC and Doncaster Children’s Services Trust</td>
</tr>
</tbody>
</table>
11. Key Objectives

11.1 The original LTP outlined the key objectives and broadly these remain the same.

**Support Universal Services**
By creating provision to specifically support universal services. This will include named CAMHs workers for schools/academies and colleges, 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.
### 12. Children & Young People’s Plan (2017-20)

12.1 It is useful to understand the four theme and 12 priority areas of the new Children and Young People Plan and how emotional wellbeing, mental health and resilience fits within this. The LTP sits within the Healthy and Happy theme.

<table>
<thead>
<tr>
<th>THEMES</th>
<th>KEY PRIORITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Children have access to the right services at the <strong>earliest opportunity</strong></td>
</tr>
<tr>
<td></td>
<td>Domestic abuse practice is <strong>transformed</strong> across Doncaster</td>
</tr>
<tr>
<td></td>
<td>No child suffers significant harm as a result of <strong>neglect</strong></td>
</tr>
<tr>
<td></td>
<td>Keeping teenagers and young people <strong>safe</strong></td>
</tr>
<tr>
<td>Healthy and happy</td>
<td>Children and young people are healthy, have a <strong>sense of wellbeing</strong> and are <strong>resilient</strong></td>
</tr>
<tr>
<td></td>
<td>Children have the best <strong>start in life</strong></td>
</tr>
<tr>
<td></td>
<td>Children and young people’s <strong>development</strong> is underpinned through a healthy lifestyle</td>
</tr>
<tr>
<td>Achievement</td>
<td>Ensure all children are <strong>school ready</strong></td>
</tr>
<tr>
<td></td>
<td>All children <strong>attend a good or better setting</strong> and <strong>aspirations</strong> are raised to ensure they reach their <strong>full potential</strong></td>
</tr>
<tr>
<td></td>
<td>Young people are equipped to access <strong>education, employment or training in a way that supports future social mobility</strong></td>
</tr>
<tr>
<td>Equality</td>
<td>Diminish the difference between <strong>disadvantaged</strong> and <strong>non-disadvantaged</strong> children and young people</td>
</tr>
<tr>
<td></td>
<td>Fewer children live in <strong>poverty</strong></td>
</tr>
</tbody>
</table>
13. Transformation Plan & Updates: areas for change, how this will be delivered in 2017/18 -20 and progress made so far.

The following are the priority areas for implementation over the next two and a half years. This section offers the detail on how and why these priorities will be implemented, and gives an update on any progress made since the launch of the LTP.

13.1 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.

13.1.1 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?
- Continue to work with schools/ academies and colleges and academies to achieve the target that 100% have a named emotional wellbeing and mental health lead.
- Provide a comprehensive workforce training offer to named leads.
- Support schools/ academies and colleges to achieve a whole school approach to emotional wellbeing and mental health.
- Create a true single point of access.
Progress to Date:
A significant amount of engagement work with education has taken place over the past two and a half years, with an extremely positive response from education to this agenda. Developing a relationship with education and linking them to CAMHs has been one of the main benefits to date, and crucial to the new ways of working, shifting the focus to early help and prevention.

A letter was sent out to all schools/ academies and colleges/academies in the Borough from the Assistant Director for Education in 2015/16, asking for nominations for named emotional wellbeing and mental health leads. The current number of schools/ academies and colleges 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/ academies and colleges in total
Response rate 81%

The target by March 2017 was to have 75% of schools/ academies and colleges so this is extremely positive. There is a clear strategic and operational will in education to support the mental health and wellbeing agenda. There is a need to build upon this through the delivery of an effective training programme for named leads.

The plan to engage with the other schools/ academies and colleges that have yet to nominate is that once the new consultation and advice model is implemented, schools/ academies and colleges/academies will sell it to their colleagues as they realise the benefits. There is a fairly even split between the schools/ academies and colleges and academies that haven’t responded and work is on-going to engage with these.

The original 14 pilot schools/ academies and colleges have increased to 21 and they continue to actively support the agenda, in particular around piloting the schools/ academies and colleges competency framework. The mental health and wellbeing strategy group has a representative from the schools/ academies and colleges forum (collective of head teachers) and the task and finish group has representatives from the pilot schools/ academies and colleges.

Previously a CAMHs worker has been placed within the Early Help Hub with varying degrees of success. After some initial successes in terms of building relationships, the role of the CAMHs worker became unclear. The partnership has moved to a single front door (that incorporates Social Care and Early Help), and there are current discussions around moving the CAMHs duty resources and functions into this single front door. The aspiration is still very much to create a true single point of access including mental health and wellbeing. There is confidence across the partnership this will happen.
Areas of Focus

- Continue to work closely with education.
- Work towards 100% of schools/academies and colleges having a nominated mental health lead to enable a point of focus in every school and academy.
- Integration of CAMHs duty functions and resources into single point of access (front door) to enable better joint working arrangements.

13.1.2 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?
- Test options with Children and Young People and the Young Minds participation champions.
- Make recommendations to mental health and wellbeing strategy group.

Progress to Date:
The options paper was discussed by the champions who felt that it was too narrow.

Subsequently trial login access has been given to the champions and other Children and Young People to ‘test’ some websites. A recommendation will be made to the mental health and wellbeing strategy group in November 2017.

Impact
- Effective on-line options for Children and Young People, which are secure and offer reliable advice and guidance.

Progress Rating: Satisfactory

Areas of Focus

- The aim is still to commission digital support to Children and Young People.
- Recommendation from Children and Young People made to mental health and wellbeing strategy group.
- Procure recommended option (finance permitting).
13.1.3 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 learning from successful wave one STF funded areas.
- By submitting one single bid for wave two STF monies across the ACS footprint. This means we are looking to commission a regional service that meets both regional and local need.

Progress to Date:
Due to pilot ending there is now no specialist community service to support parents experiencing perinatal mental health problems. This is an area of concern and key priority.

Regional steering group to develop ACS bid for STF funding based on a hub and spoke community model.

Impact
- None at this stage.

Progress Rating: In need of improvement

Areas of Focus
- Develop and submit bid.
- If successful, implement the new programme(s).

1. Promoting Resilience

Are we on-track?
Broadly yes, there has been progress against some indicators, in particular named mental health leads in schools/academies and colleges and academies and digital apps, however there is a real gap in terms of a community based perinatal mental health service.
**13.2 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.

**13.2.1 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/academies and colleges 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 increasing the number of community consultation and advice CAMHs workers.
- CAMHs locality workers continue to provide 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.
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

- CAMHS Consultation and Advice Only
  - School Champion/Family/CAMHS agree the plan

- Consultation and Advice plus CAMHS staff link with network (school, family, school nurse etc.)
  - Additional CAMHS Consultation to network

- Ongoing Consultation and Advice to network
  - Potential to work systemically for a number of weeks/months (revising plan)

- In addition to ongoing network Consultation and Advice, an agreed treatment/therapy is agreed and delivered by CAMHS
Progress to Date:
The consultation and advice service continues to be embedded into the local system and feedback from schools/academies and colleges has been on the whole very positive.

“I feel that the meetings in school are very beneficial to the pupils that require support.”

“I would like to (on behalf of school x, y & z) express our sincere gratitude for all the support, professional guidance and interventions.”

There are 10WTE positions within the consultation and advice service (including management and clinical leadership), which breaks down to 8WTE frontline workers. They are split equally across the four localities. This is a 50% increase on 2016/17 and the aspiration and plan is to further increase the resource to 12WTE.

A collaborative (collection of schools/academies and colleges within a designated area) have agreed to commission a further 1WTE to provide support to academies within the South area of Doncaster. This is extremely positive and further demonstrates the commitment from education and the desire to work collaboratively.

The plan was to establish this new service and a more systemic way of working (primarily with education in the first instance), with the aim to provide support to Children and Young People earlier, and as such reduce the number of Children and Young People who need to be seen within a specialist CAMHs service. In quarter one this year there has been a 7% reduction, which is extremely positive. We will continue to monitor this with the aim to sustain a reduction, allowing for the redistribution of resources.

The activity of the workers (see section 8.16, page 31) in terms of face to face consultations has significantly exceeded the contract targets and has really helped to establish a new way of working.

58% of Children and Young People seen in quarter one were seen by this service, which is extremely positive, and above the March target of 50%. This evidences transformation and also the fact that a vast number of Children and Young People are being supported earlier and in a more systemic manner.

However there is a shortage of capacity and resource in the consultation and advice service, leading to some frustration and some Children and Young People still being referred into the specialist service. A recent discussion at the Children and Families Executive Board concluded with the board recommending a business case is submitted to secure additional pump prime funding for the extra workers (taking to the 12WTE target).

It is interesting to note only 2% of the total number of consultations has resulted in an escalation into specialist CAMHs. Conversely only 3% of referrals into specialist CAMHs have been de-escalated to the consultation and advice service. This demonstrates that whilst there has been good integration into education, there is room for improvement in the synergy between specialist CAMHs and consultation and advice.
Impact

• Children and Young People being identified earlier and provided support at an early stage.
• Children and Young People being supported by professionals they already have a relationship with, rather than a hand-off referral (as requested by Children and Young People.
• Schools/ academies and colleges feel much more supported.
• Building of joint working relationships between schools/ academies and colleges and CAMHs.
• Slight reduction in referrals into specialist CAMHs.
• Increasing buy-in from schools/ academies and colleges.

Progress Rating: Very Good

Areas of Focus

• Continue to embed the new consultation and advice functions.
• Develop and submit business case for extra 3WTE.
• Fastrack to 12WTE, meaning 3WTE is each locality.
• Consultation workers to continue to build string links in schools/ academies and colleges, but also stretching the remit to include the wider partnership.
• Continue to work across the system to embed systemic working and the shift away from written referrals.
• Audit the consultations that have escalated and de-escalated.
• Better synergy between specialist CAMHs and consultation and advice.
• Move to no thresholds.

13.2.2 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?
• Provision of a 24/7 crisis hub.
• CAMHs interface and liaison nurse placed in acute hospital setting
• Facilitate training for Local Diversion Service around the Children and Young People agenda and local services.
• Explore options of regional section 136-suite and crisis accommodation.
• Ultimately the effective implementation of the crisis care concordat.
Progress to Date:
The 24/7 crisis support helpline after a trial period has now been commissioned and is in contract. There is limited activity coming into CAMHs from the service. The coding doesn’t allow for a quick analysis of how many calls are made for Children and Young People that don’t ultimately end up in a referral into CAMHs. However the service is providing a good level of support.

After a protracted start the CAMHs interface and liaison function is now becoming embedded into the acute provider.

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 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 on-going.

The Section 136 project involves the development of a Section 136 Health Based Place of Safety for young people detained under Section 136 by the police (in order to prevent the young person from being held on an adult ward or in a police cell). The first phase of this project is complete, with the Section 136 facility open for young people from Sheffield. The next stage of the project is to expand the facility so that young people across South Yorkshire and Bassetlaw are able to access it. We will be working with other CCG’s and Sheffield Children’s NHS Foundation Trust to plan this development in 2017/18.

In 2017/18 we will also be further developing our Section 136 facility into a regional provision, we anticipate that this will be mobilised during 2018; however this is subject to agreement with our provider and other CCG’s. Before mobilisation can take place, we need to agree how the provision can be accessed across South Yorkshire and Bassetlaw. We also need to ensure that a young person from anywhere in South Yorkshire and Bassetlaw could be quickly supported back to their home if they were detained under Section 136.

The data demonstrates that no Children and Young People have been detained in a police cell for the past two and a half years, which is very positive.

A service specification is in the later stages of development regarding the commissioning of an enhanced foster carer(s) provision to support Children and Young People in a period of crisis. This is building on the Empower and Protect model that was successful in South Yorkshire. Clear working protocols are also being developed to underpin practice.

Doncaster and Rotherham were successful in securing some non-recurrent mental health crisis and intensive community support funding from NHSE to support the development of an enhanced all-age crisis service. The services will be locality focused and complement the existing in hour’s service, providing a more robust out of hour’s service for these in crisis.
**Impact**

- Improved 24/7 crisis support for Children and Young People.
- Clarity of what needs to be done to ensure effective crisis support.
- Better understanding of Children and Young People services by the liaison and diversion service, meaning Children and Young People are better supported.
- Children and Young People better supported in the local General Hospital by the liaison nurse and wider acute paediatric workforce.
- Movement to a specific Children and Young People section 136 suite.
- Movement to a different offer (foster carer(s) for Children and Young People in crisis.

**Progress Rating: Satisfactory**

**Areas of Focus**

- Local discussion to decide if there is a need to complete a dip sample audit of the telephone calls made into the crisis hub to gain a better understanding of need for Children and Young People.
- Continue to embed the liaison functions within the acute paediatric and A&E hospital setting.
- Agree start date for a regional Children and Young People section 136 suite and pathways in and out.
- Complete the Empower & Protect service specification, working protocols, recruit foster carer(s) and implement the new service.
- Work with the provider to implement the all age crisis service.

**13.2.3 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?**

- Effective implementation of the intensive home treatment service to act as an alternative to tier 4 provision.
Progress to Date:
The service made a phased implementation from September 2016 and all posts were recruited to. Unfortunately there have been some issues with retaining staff and there are now vacancies back in the team. The Lead Nurse, band 6 nurse post and Social Worker have been the only consistent staffing, meaning the service continued to carry three vacancies. To mitigate this there has been an increased focus by DCCG on this area and in response the provider has recruited to two of the three vacant posts, both will start imminently. This means that there will be a total resource of SWTE and a clear expectation from the commissioner that from quarter three we will see significant improvements in the service.

There have been issues with the referral criteria set by the service which (in some cases) acted as a barrier to supporting the right Children and Young People. A new referral criterion has been agreed and there is a need for those services to begin to make better links with partner agencies.

This is the priority area of focus from the strategy group as there is an expectation that there will be improvements made to this service as a matter of urgency. The lead commissioner has asked for monthly reports on progress.

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

Impact

- Very limited at this stage, although there has been some improvements to the step down process from acute settings.

Progress Rating: In need of improvement

Areas of Focus

- 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.
- Discussions with specialised commissioning and ACS commissioning colleagues to explore commissioning an ACS wide intensive home treatment service.
- Discuss with specialised commissioning colleagues the development of hub-based budgets.

13.2.4 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.
- Compliance with transition CYPMH CQUIN.
- Work with YH SCN to develop guidance documents for transition.
- Add resource to peer mentoring service.
Progress to Date:
CAMHs have 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 action plan will be monitored through the mental health and wellbeing task and finish group.

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

Impact
- Children and Young People feel supported by the peer support workers through periods of transition.

Progress Rating: Satisfactory

Areas of Focus
- Review transition benchmark findings
- Peer mentoring service to be reviewed with a view to expanding.

13.2.5 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?
- Robustly evaluate the pilot model.
- As part of a task and finish group explore the possibility of increasing the provision across the region to 0-25yrs.
- Continue to raise awareness.
- Continue to achieve access and waiting time standards.
- Implement new NICE guidance to service.

**COMMUNITY EATING DISORDER STAFFING STRUCTURE**
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. The service specification has been agreed and there is a clear implementation plan to underpin delivery. Quarterly regional commissioner/ provider meetings take place and Doncaster has a steering group.

There continues to be a full team across the hub and spoke model and Doncaster, meaning full provision and support that is be actively promoted.

Performance is very positive with all access and waiting time standards for Doncaster being achieved (as they have done since the implementation of the new service). It is interesting that demand remains low, albeit with a slight increase. Increasingly, locally we are thinking about what a community service should look like to ensure we are meeting the needs of the total population. The intention (notwithstanding the evaluation findings) is to move to a 0-25yr old pathway and as such, the community eating disorder steering group has extended its membership to include adult representatives. This group has been constituted and is meeting regularly, building on the findings from a workshop. In Doncaster we are clear now on demand across all ages and also what resource is available. A request has been made to commissioning colleagues in Rotherham and North Lincs for clarity if they have an intention to move towards a 0-25yr old pathway. Ideally this will be the case so we can move across the region. There is a strong feeling in Doncaster that there is sufficient capacity within the existing 0-19yr resources to extend to 0-25yr.

The external review of the model and service was expected in August 2017 and there has been a delay to this. There is an expectation that this report will be submitted to DCCG by the end of October 2017.

Impact

- Children and Young People have better support around eating disorders.
- Reduction in the number of Children and Young People requiring acute mental health provision.
- Children and Young People have access support within agreed timeframes.
- There is an increase in awareness and education in Doncaster.
- Children and Young People have access to support within a community setting.

Progress Rating: Good

Areas of Focus

- Evaluate the external review through the steering group.
- Explore the option of extending the provision to 0-25yrs service across the region through the task and finish group.
- Work with acute provider to develop links between community and acute.
- Explore why numbers are low q (if they are)
- The service provider to implement changes to the current service in response to changes in NICE guidance.
13.2.6 Early Intervention in Psychosis

Why is this a priority?
There is a need to improve the timeliness of support to all patients who experience a first episode of psychosis.

How will we do this?
- Review the current provision.
- Analyse the data to understand the age breakdown of patients.
- Improve access times to 100% seen within two weeks.

Progress to Date:
Implementation of NICE guidance for the majority of patients. There is real clarity on the lead practitioner role and interface with CAMHs for those aged under 16yrs.

Impact
- The right professional sees Children and Young People at the right time, with the appropriate secondary support in place.

Progress Rating: Good

Areas of Focus
- Review the current provision to understand any barriers to achieving 100% of all patients being seen within two weeks.
- Data analysis to be completed.

2. Improving Access to Effective Support

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.

In quarter one in 2017/18 approx. 58% of referrals were seen by the consultation and advice service. This is extremely positive and clearly evidences elements of transformation in line with the LTP objectives.

We are confident that we are on-track to achieve the remaining milestones.
13.3 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.

13.3.1 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?
- Anchor the changes into corporate culture so this practice becomes the norm.
- Explore the possibility of commissioning a specialised psychology/ psychiatry support for Children and Young People where there is suspected sexual abuse.

Progress to Date:
An audit of current practice was completed and there were some recommendations, to be implemented by the provider. This was reviewed in June 2017 and all but one recommendation have been completed. The final recommendation is to complete a further six month dip sample audit to check compliance. There has been good progress made in this area.

Impact
- CAMHs staff have a greater awareness of the impact of trauma, abuse and/or neglect on mental health.
- Children and Young People are identified more effectively and as such are likely to get the right support.

Progress Rating: Very Good

Areas of Focus
- Complete dip sample audit to assess progress.
- Thereafter regularly monitor to ensure the changes in practice have been embedded.

13.3.2 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?
- Embed a new DNA policy where no Children and Young People is discharged for not attending.
- Change in practice underpinned by audit process.
Progress to Date:
The DNA audit recommendations were reviewed as per the action plan (6mths after inception) and the report has outlined that whilst many actions have been completed, there are still some actions outstanding. These include; review of delivery locations to allow maximum flexibility for clients, the finalising of the new policy and the use of admin for a call back service. New deadlines have been sought for the outstanding actions and this work will continue to be overseen by a task and finish group. A second routine audit of practice will be completed when outstanding actions have been completed.

Impact

• Reduction in total DNA rates to 8.5% (target of 10%).
• Less Children and Young People are being discharged for not attending.

Progress rating: Satisfactory

Areas of Focus

• Implement the audit recommendations.
• Re-audit to check there has been a change in practice.
• In the new contract round 2019, the lead commissioner will be explicit (contractually) about the new DNA policy.

13.3.3 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?
• Testing how this could work through the Vulnerable Adolescents area of opportunity.
• Commission based on outcomes using an accountable care provider to deliver an integrated service

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

Areas of Focus

• Finalise the scope of the vulnerable adolescents area of opportunity.
• Work with wider ACP operational group to establish new governance arrangements (Inc. finance) to underpin new contracts and service specifications etc.
• Explore funding stream to increase PMO capacity to lead on this work.

13.3.4 Transforming Care Partnership

Why is this a priority?
Doncaster is part of the South Yorkshire and North Lincolnshire Transforming Care Partnership (TCP), and there is significant work to be completed across the region for Children and Young People to be compliant in all areas. It is worth noting that direction and focus for Children and Young People is new and as such we need to respond. NHS England provide a RAG rating each quarter; the first RAG rating in the Summer stated that bat the current time
the level of support needed was red. Each TCP has an action plan detailing areas for focus and individual RAG ratings.

How will we do this?
- Work closely with NHSE representative to make the required improvements at pace.
- Doncaster Lead commissioner is the named lead for Children and Young People for the TCP.
- Develop and establish effective governance arrangements, locally and regionally.
- Share best practice.
- Ultimately by achieving all areas of the action plan, which more importantly would mean less Children and Young People being admitted to an acute provision.

Progress to Date:
Despite the red RAG rating, lots of progress has been made and we would expect an amber rating next quarter. Progress has been made in the following areas:
- Local and regional governance arrangements for Children and Young People.
- Better line of sight on what needs to be done and by when.
- CETR’s are being completed but not in all cases
- Named lead for Children and Young People.

Impact
- Better understanding of roles and responsibilities within the TCP footprint and at board level.

Progress Rating: In need of improvement

Areas of Focus
- Continue to focus on Children and Young People as a TCP board.
- Turn the amber and reds in the action plan green.
- Achieve the target of 90% of Children and Young People having a CETR within the guidance time lines.
- Clear local understanding and commitment to the implementation of CETR recommendation needs to be put in place within a monitored quality assurance framework.

13.3.5 Learning Disability
Why is this a priority?
Children and Young People wait longer to be seen than in core CAMHs.

How will we do this?
- Learn from the recent review of service.
- Implement the recommendations from the recent review of service.

Progress to Date:
An external review of service has been completed with a series of recommendations.

Impact
- Better understanding of current service provision against need.
- Clarity on next steps.

Progress Rating: In need of improvement
13.3.6 Looked after Children

Why is this a priority?
Looked after Children wait longer to be seen than in core CAMHs.

How will we do this?
• Learn from the recent review of service.
• Implement the recommendations from the recent review of service.

Progress to Date:
An external review of service has been completed with a series of recommendations.

Impact
• Better understanding of current service provision against need.
• Clarity on next steps.

Progress Rating: In need of improvement

Areas of Focus
• Implement the recommendations.

3. Caring for the most vulnerable

Are we on-track?
For some areas yes, and for others no. The completion of an enhanced training package has been delayed, however there was a conscious decision made to wait for the development of the schools/ academies and colleges competency framework and commission training to compliment this. There has been good progress with the assessment process for the most vulnerable with changes made to practice.
**13.4 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.

**13.4.1 Lead Commissioner Arrangements**

**Why is this a priority?**
To ensure we have a strategic lead and a figurehead to co-ordinate. To improve the link between key strategic documents and to improve accountability for delivery. There is a need to link the LTP better with other strategies to begin to think wider around resilience.

**How will we do this?**
- Designated lead commissioner.
- Embedding of this portfolio within the new governance arrangements in Doncaster.
- Closer links to the Children and Young People’s Plan and development of an outcomes framework (which includes mental health)
- Lead commissioner member of local joint commissioning resource group.
- Lead commissioner to be an active member of the Yorkshire and Humber Mental Health and Wellbeing Commissioners Forum and steering group.
- Explore options of developing integrated commissioning functions.
- The LTP to sit within the wider Children and Young People Plan governance arrangements.
13.4.2 The diagram below illustrates the governance structure for the Children and Young People Plan. LTP sits within the Healthy and Happy Theme with the lead commissioner accountable for this theme. The boxes in red are enablers. Details as follows:

13.4.3 The Health and Wellbeing Board have devolved accountability to the Children and Families Executive Board to sign off the LTP. The mental health and wellbeing group has responsibility for overseeing the implementation of the LTP and has both a strategic and operational role. A task and finish group sits below the strategy group and has deals with operational aspects.
Progress to Date:
The development of new governance arrangements that work more effectively across a wider strategic footprint, and link strategies and work streams together much better, whilst improving accountability.

There is an improved clarity on how emotional wellbeing and mental health sits within the wider Children and Young People’s agenda and indeed Borough’s agenda (Growing Together), which provides a better foundation for success.

Impact
• Improved strategic thinking around emotional wellbeing and mental health.

Areas of Focus
• Embed the LTP within the Healthy and Happy theme.
• Ensure wider strategic thinking around the development of resilience.

13.4.4 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 and are value for money.

How will we do this?
• Collaborative working based on trust and transparency.
• Oversight of respective agendas.
• National procurement for acute inpatient beds.
• Local Intensive Home Treatment Service reducing the need for acute inpatient beds.
• Look to develop hub based budgets.

There is an effective joint working relationship between the lead commissioners and specialised commissioning colleagues that is underpinned by trust. Regular meetings ensure there are effective lines of communication and an oversight of respective agenda’s. This was highlighted through the recent redeployment of commissioning responsibilities for outreach services provided by Amber Lodge from specialised commissioning to CCG’s.

National Specialised Commissioning Oversight Group (SCOG) decided in March 2016, that a single national procurement would not be in the best interest of patients and the approach taken would need to strengthen the requirement for regional planning and delivery. It would need to align with, and support the move to population based commissioning and the outputs of this work would need to be embedded in local systems. To reflect this, NHS England revised its approach to one of local ownership and delivery under the umbrella of national co-ordination and oversight and is now referred to as the Mental Health Service Review (MHSR) programme.

A key factor and driver in the service review has been a lack of capacity in some areas that has led to out of area placements. The proposed changes in bed numbers aim to address this and ensure that for the majority of services, the right numbers of beds are available to meet local demand in each area. It is predicated on the principle that there is regard to patient flows so each local area should “consume its own smoke”. As these services are specialist in
nature, there is national oversight of this process but with a strong emphasis on local engagement and ownership.

The implementation of local plans will see the re-distribution of beds across the country so patients will be able to access services closer to home rather than having to travel to access appropriate services, except for a few particularly specialist services that it is uneconomic to provide in each area. NHS England is collaborating with local commissioners on the CAMHS Tier 4 bed changes in Yorkshire and the Humber to ensure the interdependencies between localities are managed effectively.

**Progress to Date:**
Development and maintaining effective joint working relationships.

Through the transformation programme we are working on a regional basis with other specialised commissioning, CCG’s and local authorities.

The Amber Lodge project involves the transfer of the Amber Lodge service at Becton in Sheffield from NHS England to a group of local CCG’s from South Yorkshire and Derbyshire. Amber Lodge is a regional service, which provides high intensity mental health support for 5-11 year olds with complex needs. The aim of the project is to transfer the control of the service from NHS England to local CCG’s, to enable the service to be further developed around the needs of the local area and enable more young people to be supported in the community instead of hospital.

This has been a very positive piece of work and will result in an improved offer for Doncaster Children and Young People.

**Impact**
- Improved offer of support from Amber Lodge to Doncaster Children and Young People

**Progress Rating: Very Good**

**Areas of Focus**
- Continue to work closely with specialised commissioning.
- Explore collaboratively the development of hub-based budgets.
- Review the current Amber Lodge provision and (working with commissioners) develop a modified service specification giving an improved offer.

**13.4.5 Accountable Care System Arrangements for Mental Health**

**Why is this a priority?**
Mental Health and Learning Disabilities is a priority work stream form the new Accountable Care System, with clear governance arrangements. Membership includes CEOs and AOs from providers including mental health and primary care, commissioning and local authority organisations, Voluntary Action Groups, Healthwatch, NHS England and the ALBs.

**How will we do this?**
- By working under a well-defined vision
- With three key areas of focus; liaison mental health, IAPT and perinatal mental health.
- Using the LTP as the driver for Children and Young People mental health.
Progress to Date:
This group is in its infancy but there is a clear vision developed and three identified work stream areas.

Impact
• Too early to say

Progress Rating: good

Areas of Focus
• Continue to provide oversight to the three key areas of intervention.

13.4.6 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, parents, carers and professionals a voice
• Work in collaboration with Young Minds for the next two years to embed the Youth Participation Model.
• Start to actively engage the participation champions in the entire commissioning cycle and to test implementation
• Link Young Advisors to Young Minds participation champions.

Progress to Date:
As extensive consultation with Children and Young People, parents, carers and professionals has been completed to inform the participation principles for the programme, which have now been agreed giving a solid foundation.

During the consultation phase of this programme, young people, parents, carers and professionals were recruited as Participation Champions. The final group will be comprised of fifteen members:
• Five young people living in Doncaster
• Five parents and carers who support young people accessing services in Doncaster.
• Five professionals from across the system.

Sixty-one people in total signed up to fulfil these roles. While a core group of 15 has been established from these sixty-one, all will be engaged digitally, and have already taken part in online voting as part of setting the priorities for

On-going recruitment will be completed throughout the delivery of the programme, to ensure that these numbers are maintained.

There are agreed set activities for 2017/18 that will equip participant champions to effectively evaluate services and become central to future commissioning and implementation decisions.
13.4.7 Local Offer

Why is this a priority?
To make sure everyone knows about the plan, its 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 LTP was uploaded to all the above websites.

Impact
• Awareness of the plan and easy access to it.

Progress Rating: Good

Areas of Focus
• N/A

13.4.8 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.

### 13.4.9 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 gender. All aspects of the implantation of this plan will take into full consideration and be fully compliant with the equality act.

### 13.4.10 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.

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**Progress rating: Very Good**

Areas of Focus
- Continue to adhere to all acts and regulations.

13.4.11 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 work with the CAMHs provider to develop meaningful outcome measures.
- Support the CAMHs provider to start to report on meaningful outcomes.

Progress to Date:
There has been no marked progress to date and there is still a gap in terms of meaningful measurable outcomes for Children and Young People.

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**Progress Rating: In need of improvement**

Areas of Focus
- DCCG hold service provider to account to develop an agreed outcome within the first six months of this plan.
- Include any agreed outcomes in the LTP performance dashboard.
- Continue to communicate with commissioning colleagues to share best practice.

13.4.12 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.
• Improve data compliance through the provider installing a new single clinical system that will provide a richness of data between the acute and community services.

Progress to Date:
The service provider is partially compliant with the requirements of the minimum dataset. Work is on-going 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. There is an expectation that with the implementation of the new clinical system we expect to see full compliance.

As part of RDASH transformation plan they are moving to a Single Clinical System for both physical and mental health services which is due to start during Nov 17. A clinical system change will always have an impact on staff time, reporting of services activity, quality outcomes and accuracy of data.

This will involve:
• Staff training on a new clinical system
• Data migration
• Quality data checks and reconciliation of migrated data
• Running 2 systems side by side during this process.
• Creating new data extracts into the data warehouse to fulfil the reporting requirements.

The above steps will have a resource impact on the services and refining period until reporting is truly robust as staff will make mistakes when entering data. Some data may not transfer, in this case the service will have to report up to a point in time from the old system and then there will be a gap until the data starts coming off the new system.

So never a straight forward process but the end product will be a much more robust clinical system for patient records which will result in easier data extraction and reporting process.

Impact
• None to date

Progress Rating: In need of improvement

Areas of Focus
• Service provider to be compliant with the minimum dataset
• Service provider to be compliant with the local reporting requirements.
• Effective installation and embedding of the new clinical system.
Are we on-track?
Everything is on track against the above milestones, which primarily relate to engagement. There are on-going challenges regarding data compliance and the establishment of outcomes.

13.5 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.

13.5.1 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?
- Implementation 13 recommendations from the workforce audit.
- Pilot the schools competency framework.
- Commission training programmes that links directly to the school competency framework.
- Improve competency levels within the pilot schools linked to a developing evidence base.
- Roll out the schools competency framework and training to all Doncaster schools in 2019.
- Work with the Charlie Waller Memorial Trust (Stella Project).

13.5.2 In It Together – A Social Emotional Mental Health Competency Framework for Staff Working in Education.

Future in Mind urges whole systems to work together and identifies the opportunity that education settings provide for achieving this ambition, including the recommendation that those who work with Children and Young People are trained in child development and mental health, understand what can be done to provide help and support for those in need and develop a whole school approaches to promoting mental health and wellbeing. This framework is designed to support this recommendation become a reality.
We want Children and Young People to get the best out of their years in education and achieve their academic potential, growing into emotionally strong and resilient adults. Implementation of Future in Mind is at the forefront of what the Children and Young People’s Clinical Network seek to support. With this in mind, talking to young people who are involved in the Northern Powerhouse and a workforce audit undertaken by NHS Doncaster CCG pointed us in the direction of a gap in what is available for staff working in education settings who want to better support their pupils. Young people told us that they would like to know, and have the confidence, that their schools and colleges are properly trained in emotional wellbeing and mental health. Recent Prime Minster announcements to provide Youth Mental Health First Aid training in secondary schools further reinforced the need to look at role appropriate skills and competencies that individuals working in educational settings need to have.

As the idea of the competency framework started to take shape, we heard more and more of the willingness of schools to develop their workforce, not just because it contributes to their Ofsted rating, but because supporting emotional wellbeing and mental health can improve attainment and a skilled, confident workforce can be a less stressed workforce. Working with Children and Young People with social emotional mental health problems is inevitable, so why not ensure they receive evidence based support from a skilled workforce. The Children and Young People’s Clinical Network was in a prime position to bring together the needed expertise from a wide range of disciplines to co-create a comprehensive framework that can deliver real benefits to staff and pupils, not only outlining the skills needed, but evidence based training options to then gain these skills.

Mental health should be everybody’s business; therefore In It Together; A Social Emotional Mental Health Competency Framework for Staff Working in Education is aimed at all staff, from gardeners to governors, business managers to teachers by outlining role appropriate levels of skill, knowledge and training. It aims to encourage all staff within the setting to work together to support their pupils and each other, knowing their limitations and how to escalate concerns. External parties who may regularly come into the education setting, such as counsellors or safe schools police officers, were not initially included within the scope as they should already have appropriate training and development pathways. However, depending on local arrangements the setting may wish to consider including them as they feel appropriate.

Furthermore, this framework aims to complement but not duplicate existing practice, for example, around safeguarding or special education needs and national guidance such as Public Health England’s Whole School and College Approach and the Department for Education’s Mental Health and Behaviour in Schools departmental advice.

The framework has separate competencies for those working in early years, primary schools, secondary schools and colleges, with clear enhancements included where necessary for special schools. This framework is intended for secondary schools.

The framework is a workforce development tool yet it is not intended to overburden staff or turn teachers into therapists. Nor is it a mental health strategy development tool or PSHE curriculum tool. As the framework was developed a number of useful documents and resources for schools came to light.

(Extract from introduction from the document)
Progress to Date:
There has been progress made against some of the 13 recommendations, with further work to be done on others. Key points to note are as follows:

- Self-advice portal – the site to hold the portal has been developed and we are looking at a January 2018 launch.
- Professionals network – as above.
- Development of emotional wellbeing and mental health course/training others – this has been delayed due to testing the schools competency framework (see below).
- Increase the availability of counselling skill in schools – reviewed current provision and need to develop a plan around this.
- Adapting to and dealing with change – very little progress here which has impacted on the speed of transformation.
- Doncaster should consider the development of a core competency framework for schools staff – This was the basis for the development of the schools competency framework.

In It Together – A Social Emotional Mental Health Competency Framework for Staff Working in Education is being piloted in 53 schools across the Yorkshire and Humber region. 21 of these schools are from Doncaster, which is really positive and shows the commitment from education colleagues. The pilot began in September and will run for the academic year with the results being evaluated.

Doncaster will commission a training provider to deliver an extensive training package based on the competency framework, with the aim of supporting the pilot schools to achieve the competencies needed. The intention is to then roll this out after the end of the pilot.

Leeds Beckett University are involved with the project.

Doncaster would like to extend it thanks to the Yorkshire and Humber Clinical Network for bringing this idea to fruition.

Agreement has been reached with the Charlie Waller Memorial Trust for them to support workforce training and development in Doncaster, with a specific focus on Children and Young People with mental health vulnerabilities. Staff working with Children and Young People with risky behaviours will form the cohort of those trained.

Impact
- Greater understanding of what competencies is needed within an education setting.

Progress Rating: Good
13.5.3 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?**
- Implementation 13 recommendations from the workforce audit.
- Implementation of the workforce plan to target and specialist services.

**Progress to Date:**
See section 10.20, page 64 for an update against the 13 recommendations.

The workforce plan for targeted and specialist staff will roll out in 2018.

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**Progress Rating: Satisfactory**

**Areas of Focus**
- Implement all 13 recommendations from the workforce audit.
- 21 Doncaster schools
- Commission training programme that links directly to the school competency framework.
- Improve competency levels within the pilot schools linked to a developing evidence base.
- Roll out the schools competency framework and training to all Doncaster schools in 2019.
- Charlie Waller Memorial Trust training.

13.5.4 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 ring fencing funding for CYP-IAPT for the next two and a half years.
- Better understand the current workforce and future workforce requirements.
- Develop a future workforce strategy that has innovation at the centre.
- New models of care at the heart of the workforce strategy.
Progress to Date:
One CAMHs practitioner completed the CBT course as part of the CYP-IAPT training

Impact
- Increased CBT competencies within the service.

Progress Rating: Good

Areas of Focus
- Continue to increase competencies within CAMHs via CYP-IAPT.
- Continue to support the CYP-IAPT training by securing funding for the next two and a half years of the plan.
- Therefore the proposal is to commission a review of the current workforce in terms of the model to give clarity on what posts are needed now and for the future. Discussions are on-going about whether this should be done across the South Yorkshire and Bassetlaw Accountable Care Systems footprint.

Are we on track?
Everything is on track against the above milestones. The key area is future workforce planning.

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.
14. Risks to Implementation

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

14.1 Workforce
There are still vacancies within the CAMHs service which is at times compounded by internal movement of staff to different/new positions within the service, i.e. specialist to consultation and advice. The service provider is working hard to recruit to the remaining vacancies but at the moment is relying on some agency staff, whilst carrying vacancies.

14.2 Mitigation of Risk
Initial discussions are taking place between commissioners across the ACS footprint about how we can support the recruitment across the patch so we aren’t (where-ever possible) in competition. This is linked to a wider strategic conversation about future delivery models.

14.3 Intensive Home Treatment Service
The service has been unable to recruit and retain staff, meaning they have never had a full team, which has undoubtedly impacted on the service’s ability to perform. This is evidenced by the high acute inpatient numbers.

Mitigation of Risk
Initial discussions are taking place with commissioners across the ACS footprint regarding different ways to commission intensive and services for those in crisis.

Data
The service provider is not currently fully compliant in terms of data submission.

Mitigation of Risk
The CAMHs service provider is installing a new single clinical system that will enable them to become fully compliant.

Finances
Whilst at the time of writing the plan there is an expectation that the future Five Year Forward View funding will be available for investment. The fact the funding isn’t secured/ring-fenced, the on-going financial pressures faced by the NHS and the Public Sector make it susceptible.

Mitigation of Risk
The partnership is clear on expected investment increases as per the Five Year Forward View and have allocated at this stage. Children and Young People’s emotional wellbeing and mental health has a real profile in Doncaster as evidenced in the new Children and Young People’s Plan.
15. Appendices

15.1 LTP Dashboard

Appendix 15.1 - LTP Children's Dashboard