Derby City Council

NHS
Southern Derbyshire Clinical Commissioning Group
North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group

DERBYSHIRE County Council
Improving life for local people

Derbyshire County and Derby City

Future in Mind Local Transformation Plan

31 October 2016

Final Version

Contents

Appendix

1 Introduction

The Derbyshire and Derby Future in Mind Local Transformation Plan (LTP) continues to be led by children, young people and their families. There is one plan and a single governance structure that covers 4 Clinical Commissioning Groups (CCGs) and two Local Authorities.

- North Derbyshire CCG.
- Hardwick CCG.
- Southern Derbyshire CCG.
- Erewash CCG.
- Derby City Council with Derby City Health and Well-Being Board.
- Derbyshire County Council with Derbyshire Health and Well-Being Board.

We are in the process of moving from 2 units of planning north and south as reported in the 2015 FIM Plan to a single plan covering the whole of Derbyshire and Derby City. This will align to the single Derbyshire and Derby wide CCG Sustainability and Transformation Plan (STP). Future in Mind is a key priority work-stream in the Children and Young People's part of the STP.

This document refreshes the LTP submitted by Derbyshire County and Derby City in October 2015 to secure improvements in children and young people's emotional, psychological and mental health**.** Our plan continues to be underpinned by a whole systems approach that links education, health and social care to improve outcomes by intervening earlier, preventing needs from escalating and reducing demand for high-cost support.

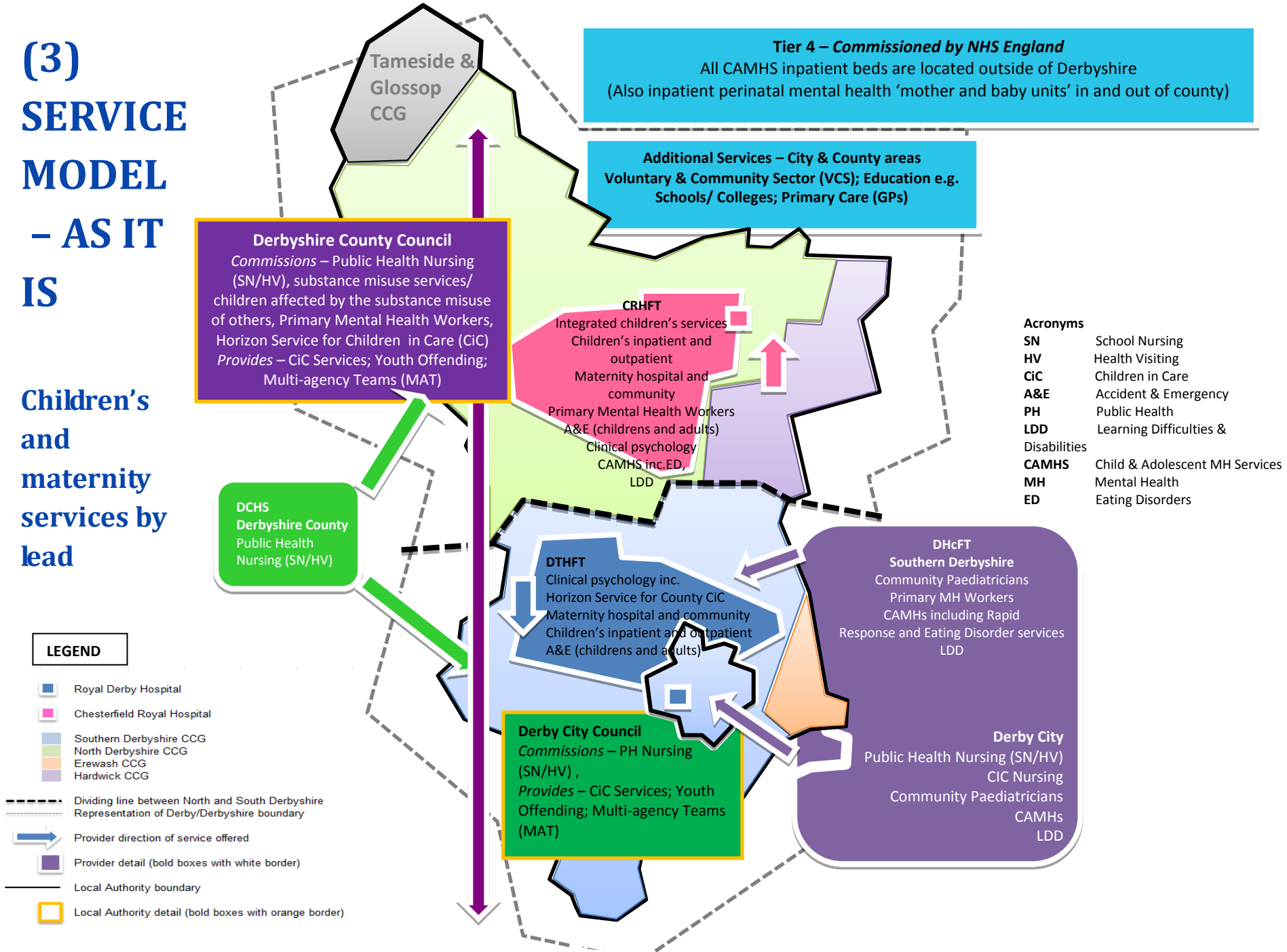
Our plan continues to focus on improving access to effective support in a wider system without tiers and moving towards the 'Thrive' the AFC–Tavistock Model for integrating services. A wide range of stakeholders from local authority, young people, providers in health, and voluntary organisations have contributed to the refresh of our plan. Their views are reflected in the priorities that have been identified for 2016/17. There have been challenges to the pace of change, notably "*fishing from the same pool"* to recruit staff to the new model of working. We set this document out following the Key lines of enquiry from NHSE, acknowledging in each section the work to do and further challenges ahead.

1.1 Summary of achievements

- ✓ New Eating Disorder provision up and running
- ✓ VCS increased capacity
- ✓ New Children in Care service, supporting emotional health and well-being (Derby City)
- ✓ CYP IAPT programme
- ✓ Crisis care /intensive home care and support service specification deployment
- ✓ Consolidation of CAMHS RISE service
- ✓ Outcomes framework development at Phase 3
- ✓ Strong partnership and shared drive
- ✓ Engagement with stakeholders
- ✓ School based pilots and School pack
- ✓ Anti-stigma campaign
- ✓ Procurement of projects in voluntary sector working directly with schools and GPs as a proof of concept)
- ✓ Tool kit for schools
- ✓ Commissioning voluntary sector to work with schools and develop peer support across the county
- ✓ 4 conferences to engage stakeholders, share practise and disseminate progress

(3) SERVICE MODEL – AS IT IS

Children's and maternity services by lead



2 Transparency & Governance

The refreshed Derbyshire Future in Mind Local Transformation Plan (LTP) will be republished on each CCG and local authority website by 31 October 2016. The LTP will be included in the Strategic Transformation Plan (STP) and is one of the key priority work-streams in the Children and Young People and Maternity STP. This also mirrors the priorities for the Health and Well Being Board.

The LTP was signed off and endorsed by the lead Children and Young People's Commissioners for each CCG and each Local Authority and by the Health and Wellbeing Board and the Children's Trusts arrangements in Derbyshire and Derby.

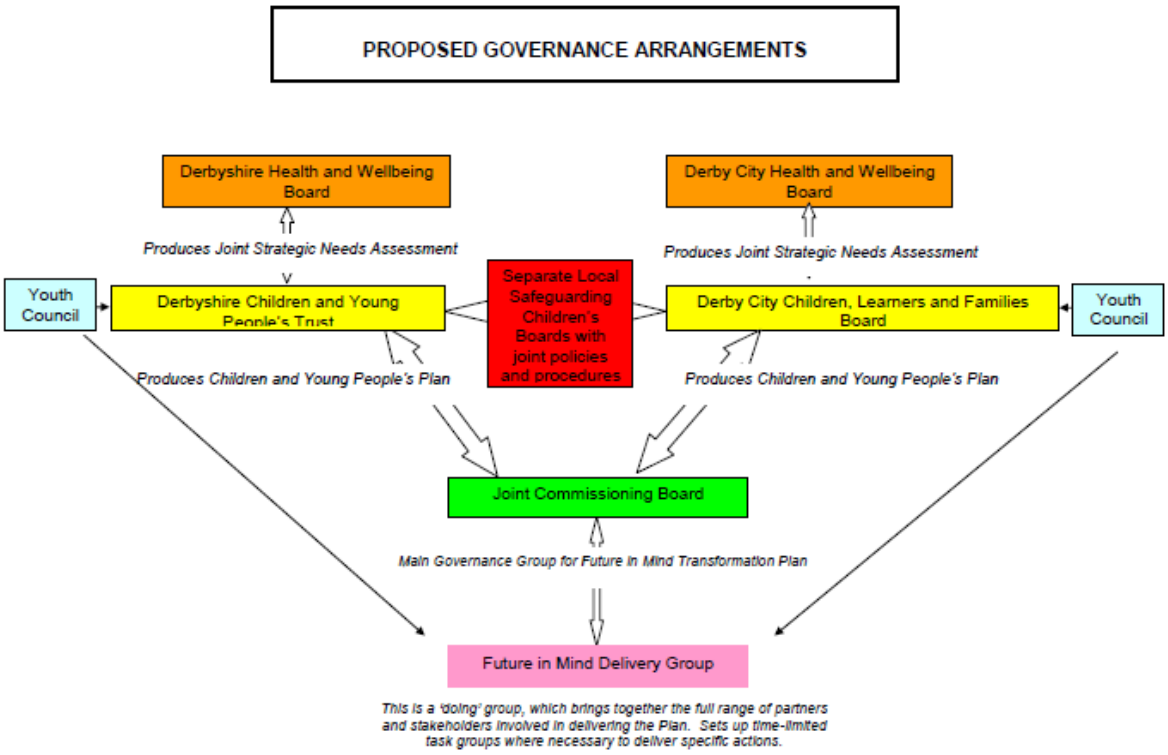
Enhancing Transparency and Governance

To support transparency and enhance governance in terms of responsibility and ownership – our partnership are assigning designated responsibility for milestones on the FIM "journey". These milestones are highlighted on the Refresh Road Map and include a 0-25 Eating Disorder Service by 2020, prevention of intensive home care support service, implementation of an outcomes framework by December 2017, and the delivery of our workforce development strategy by December 2017. Having an identified single senior responsible lead for these crucial milestones across the whole footprint will ensure shared vision and consistent delivery - irrespective of the locality and organisation of the responsible person – as well as streamlined accountability for governance.

We have further strengthened governance arrangements for FIM by ensuring that FIM is a one of the work streams for the Sustainable Transformation Plan. This will help to mainstream FIM and ensure our work for excellent mental health for young people continues as part of the wider transformation plans.

2.1 Governance structure and plans and senior level for oversight for planning and delivery

We have a clear governance structure for the Future in Mind implementation with senior level oversight of planning and delivery. The stakeholders group meet every quarter and has regular representation from young people. Each meeting begins with a patient story brought by Healthwatch and members of the group split into groups to discuss any issues and decide what needs to change in order to ensure better provision in the future. The Children and Young People's Joint Commissioning Group is a well established body working across the whole footprint of Derbyshire and Derby City.



2.2 There are clear mechanisms and KPIs to track progress

Our Future in Mind plan and implementation is tracked at both the strategic level and more locally by each CCG through highlight reports, monitoring the implementation plan reports from providers. The plan has a range of KPIs which need refreshing to take into account changes following the review.

2.3 Effective Provision and Current Challenges and Priorities

The LTP clearly identifies examples of effective provision as well as current challenges and priorities. There have already been, and will continue to be, opportunities to share and learn from best practice and opportunities to discuss challenges and identify solutions and priorities for further development. South Derbyshire CAMHS (Derbyshire Healthcare NHS Foundation Trust) has recently been graded 'outstanding' following a Care Quality Commission Inspection.

There are some generic examples of improved provision including better/increased collaboration, the sharing of knowledge/ideas/funds, wider range of services on offer-diversity, increased leadership from our Community and Voluntary Sector and collaboration securing complementary working and reducing duplication.

In addition, from the engagement that has already taken place, reviewing current provision the following have been identified as working well: -

- SPOA – Single Point of Access. This is a triaging process that is established in Derby City and South Derbyshire, with plans to establish a similar process in North Derbyshire. The process involves representatives from a range of services, including specialist CAMHS services, early intervention community based voluntary sector providers and school nurses. All referrals are discussed with case file notes, and the service is then identified that can best address the particular needs of that individual child. This is used by a wide range of referrers including GPs and schools.
- Peripatetic counselling to address early signs of problem development – this offers opportunity for children and young people to receive the service they need in the community venue of their choice and allows them the control of identifying the number of sessions they need. It averages six sessions but some children identify the need for more and some for less.
- Multi-agency meetings with CAMHS community worker and pastoral teams in secondary schools – this offers opportunity for school staff who have identified mental health concerns to seek advice and support from the CAMHS community worker and others, in addressing the needs of individual young people. Often having received advice, schools staff are confident in supporting the young person without additional input but if needed the discussion may result in early affective packages of care, based in the community, to wrap around the young person and prevent escalation of problem development.

Key challenges and priorities have also been identified and these have contributed to the development of the plans for 2017/18. There are some generic include:

- capacity of services and the challenge of recruiting the right staff to the right service
- reduce the need for children and young people to attend an acute hospital when community provision is more suitable
- safe information sharing between organisations enabling the child or young person to only tell their story once
- improving and integrating IT systems
- the challenge of service provision for children who live near one of the nine borders with neighbouring authorities

Our agreed key priorities for the next year include:

- ✓ 'Place' Community Delivery including GP, Schools and VCS
- ✓ Early help model– in conjunction with schools
- ✓ School-based system (clarity of the service offer)
- ✓ Vulnerable Groups; CIC, CSE, DV, TCP, Disabilities
- ✓ Workforce assessment of need and targeted training
- ✓ Data, evidence of need eg JSNA, ongoing evaluation and impact
- ✓ Improve transition from CAMHS eating disorders service to adults removing BMI as the criteria for access and realising the aspiration to develop a 0-25 years' service.
- ✓ Crisis services/intensive home support to cover whole area footprint
- ✓ Parenting interventions holistic offer across the footprint
- ✓ Improve waiting times and access
- ✓ On-going 'testing proof of concepts'
- ✓ Improve consistency of the offer across the footprint
- ✓ Embedding mindfulness in schools across North Derbyshire, Hardwick and Erewash CCGs as an ethos to support emotional health and well being(cascaded evidence based training model

2.4 Agreed funding allocation for 2016/17. All funding for 2015/2016 was allocated to FIM

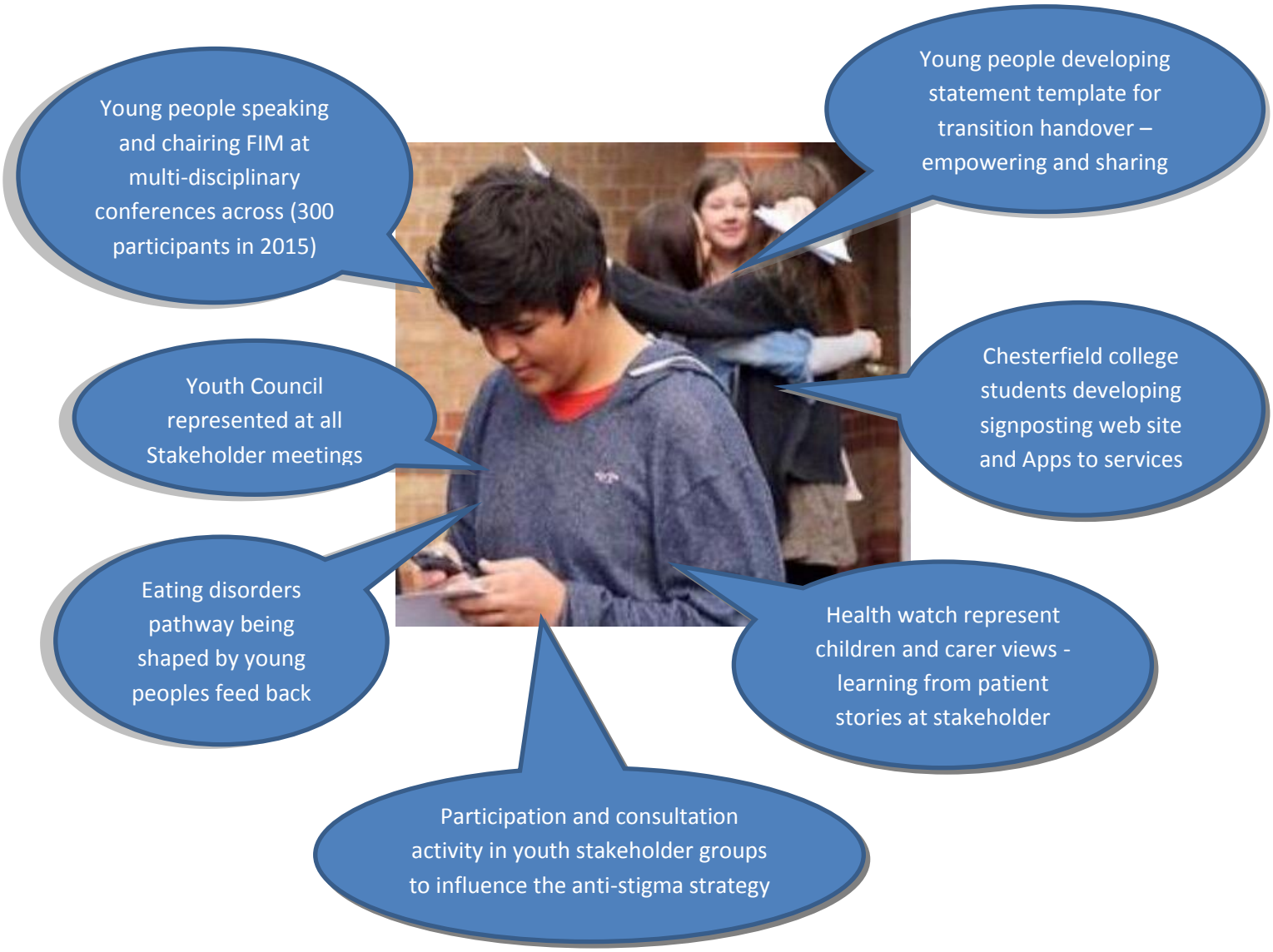
North Derbyshire Unit of Planning (North Derbyshire CCG and Hardwick CCG)

PRIORITY	North Derbyshire CCG	Hardwick CCG
Eating Disorders Service (slight reduction in anticipated costs, but increased response in universal and targeted services reducing development)	£165,865	£62,286
CAMHS Urgent Help / intensive home treatment (We are using £350,000 from CAMHS core budget for Intensive Home treatment, and will have a crisis service in place from January 2017 at an annual cost of £288,000)	£45,523	£16,987
Vulnerable children including Looked After Children and CSE/sexual abuse (big increase in funding for these children to receive services in the community)	£299,488	£113,249
Additional Support for Universal Services including General Practice and Schools in Localities	£243,058	£90,598
Total	**£753,934**	**£283,120**

Planning (Southern Derbyshire CCG and Erewash CCG)

PRIORITY	Southern Derbyshire CCG	Erewash CCG
Eating Disorders Service (includes 276k non recurrent 16/17)	552,000	£64,978
CAMHS Urgent Help / intensive home treatment	120,000	£20,271
Vulnerable children including Looked After Children and CSE/sexual abuse	160,000	£36,861
Additional Support for Universal Services including General Practice and Schools in Localities	187,000	£85,218
Targeted Help - Increasing Early Help/Intervention Capacity for Multi-Agency Teams	148,000	£47,935
Parenting programmes - ADHD	58,000	£11,043
Additional Commissioning Support for Future in Mind	64,982	£0
Workforce development including CYP IAPT backfill £181k for 2017ie 12 months (80k 2016/17)	80,000	
Total	**£1,369982**	**£266,306**

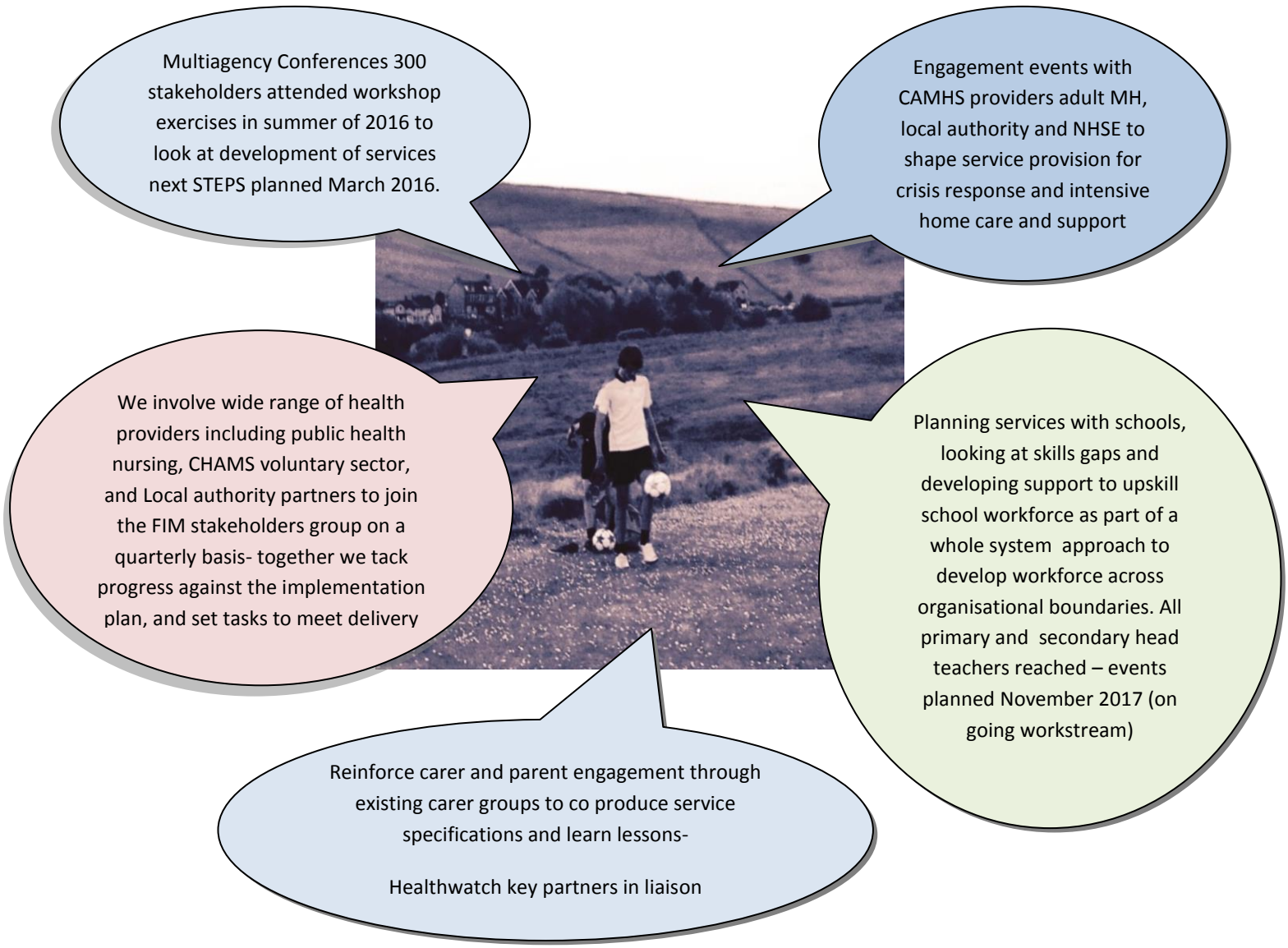
2.5 Examples of how we continue to engage young people in service planning



- Young people have informed the commissioners about their priority needs
- Engagement needs to continue to inform future plans and improvements in service delivery.
- Successful in engaging secondary schools and young people in service planning but recognise the need to focus more on primary schools as a means of engaging younger children in identifying need, co-production of services for them, delivery and evaluation and suggestions for any improvements

2.6 Evidence of continued engagement with other stakeholders

To support governance process needs assessment and service delivery



Examples of minutes from stakeholders groups evidence inclusion

2.7 A flexible approval to commissioning

The core Future in Mind Commissioners have agreed that all Future in Mind contracts will be 'proof of concepts' which allows services to be flexed based on learning from the first few months. These contracts will be in place for 18 months. After 12 months, a full service review and evaluation will be undertaken and decisions made about whether or not the service provision is effective. If it is effective a revised service specification will be finalised

and the service offered through a simple tender process, simple enough to enable voluntary and community sector providers to apply without too much administrative pressure.

There is identified contract management capacity across the footprint to monitor the progress of Future in Mind services. Providers submit reports each quarter and they are monitored against the service specifications. If services are not delivering the commissioners will arrange a meeting with the provider to understand what the problem is, and see what sort of support the provider needs in order to be able to deliver. If following offers of support they are still unable to deliver, the contract will be amended to make it realistic, and another service identified to provide the service needed. There is a need to smarten up the service specifications with CAMHS and this process has begun.

By 31 October the LTP will be published on local websites for the CCGs, Local Authorities and other key partners. It will be published with summaries of specific plans to improve local services and with key performance targets for each commissioned provider.

2.8 Challenges and work to do

We need to create stronger links with parents and carers to seek their views to support the development of service specification and monitor outcomes. We plan to do this by accessing existing carers groups and forums and as commissioners ensuring that we are more inclusive. Services will be shaped by co production of service specifications reflecting the outcomes that carers and parents and young people need. See enclosed work plan to for planned activity.

3 Understanding Local Need and Data

We are in the process of gaining a better understanding of local need and health inequalities through identified service gaps. In order to better respond to preventable health inequalities (including those suffered by poorer socio economic groups, BME, travelling, asylum seekers, and LGBT communities) our FIM Plan includes plans to drill down into existing information and data (such as the mental Health Profile of Derbyshire and NHS and other Organisations data systems). Our plans include resourcing a dedicated analyst to look at existing data and information, and consider additional information requirements which we can include in commissioning plans as FIM and the wider STP develops. We will also review applicable studies from other areas through our regional and national forums to feed into our JSNA by March 2017.

We will then use this information within our commissioning to ensure specific communities needs are addressed in all our key areas of work including awareness raising (anti-stigma campaign), parenting support, work in schools, crisis and intensive home support, eating disorder and our workforce development strategy and action plan.

3.1 The plan is built around the needs of CYP and their families

The LTP has built around the needs of children, young people and their families. The voice of local children has been at the heart of the work and we have had a good range of input from both local authority Derbyshire Youth Council and Voices in Action (Derby City) throughout the programme.

3.2 Does the plan evidence a strong understanding of local needs and meet those needs identified in the published JSNA?

We recognise the need to make best use of both national and locally based data sources to inform effective allocation of resources, monitoring and evaluation of impact. Our understanding of need is currently drawn from a range of data sources both local and national:

- The JSNA (mental health chapter), which points to the CYP Mental Health and Wellbeing Profiling Tool, as well as discusses risks factors, prevalence etc.
- Local activity reports e.g. CAMHS, and the SEND and Vulnerable Young People's JSNAs
- The State of Mental Health in Derbyshire Report
- The NHS Atlas of Variation
- The National Child & Maternal Health Intelligence Network Knowledge Hub
- Local data, including the Derby Year 7 school survey and Derbyshire Year 8 emotional health and wellbeing school survey.

The individual data sources are triangulated to provide a holistic picture of progress and need across the footprint. A key priority is to further improve data quality, analysis and identify issues relating to equity of access across the County and deep dive into particular areas informed by our priorities. Additional work on this aspect will be carried out in conjunction with analysts within Public Health.

3.3 Health inequalities to be addressed

There are a range of health inequalities the plan seeks to address including:

- Differences in geographic provision
- Workforce training
- Access to services
- Differences in waiting times

Although we acknowledge the above work we have identified that we also need a better understanding of:

- The current demand on services particularly around health inequalities for specific groups.

- the needs parents/carers have in supporting their children with mental health and behaviour difficulties as supporting parents is a key strategic priority for the next 2 years
- Emergency department usage all hospital admissions cause by unintentional and deliberate
- CAMHS (including CAMHS rise and SPOA). All service users including waiting lists

Data collection is in progress. By January 2017 we will have a detailed overview retrospectively and in real time of the exact numbers of children supported by MAT teams and social care with associated mental health problems. We will be able to drill down to ward level looking at the numbers of children in care, and their attainment and attendance levels at schools.

3.4 The plan containing up-to-date information about the local level of need and the implications for local services.

CAMHS Providers

The NHS providers in Derbyshire and Derby City have always been able to provide the data requested as evidence for the Future in Mind Programme, including most recently the requirement to complete the weekly return for UNIFY for eating disorders .

We recognise there is more we need to do to improve data collection processes and systems for data analysis. In view of this we have initially discussed the IT systems used by each of the main CAMHS providers. In the north CAMHS will be embedding the System One IT framework which will be fully implemented from April 2017. This has the advantage of being able to link up and share information with majority of community providers such as GPs, school nurses, community nurses etc.

In the south the CAMHS provider uses PARIS software which is able to provide detailed reports but does not have the ability to share and link with community based System One.

We will require all providers commissioned to flow data as part of the MHSDS. This will also form part of our governance process.

3.5 Information from non NHS services

In order to support the development of the community and early help offers, commissioners need a better understanding of the profile and needs of children and young people's emotional health and wellbeing who present in school, voluntary organisations , single access point Derbyshire Starting point, early health and public health nursing services. Our challenge is that information is kept within services, not collated centrally or in a uniform

format. Where possible we will require all providers commissioned to flow data as part of the MHSDS or to maintain data in this format for comparison. This will also form part of our governance process.

The implications for local services are discussed as part of the planning and governance of the programme. Regular contract meetings are in place with all suppliers at which the FiM is discussed.

3.6 Challenges and what we need to do next

- To collate non NHS data in a simple and uniform form aligned to the MHSDS.
- To identify dedicated data analyst capacity for JSNA and managing Non NHS data
- Collate needs as identified by the needs parents/carers have in supporting their children with mental health and behaviour difficulties
- Produce a CYP MH JSNA. By March 2017. We will produce a JSNA which predicts future demands for service focusing on children's mental health and emotional well-being. We will compare national and local data on the prevalence of mental health problems broken down by condition, age, gender and the likelihood of impact of delivery in each service area. Working with analysts from public health we will ensure there is a detailed breakdown of current service performance including thresholds and waiting times, as part of our tracking and audit process for KPI's.

4 Local Transformation Plan Ambition 2016-2020

Ambition for Excellent Mental Health for Children and Young People

Our Future in Mind Plan contains an innovative "road map" looking at the 5 years of the plan and the key milestones along the way. This shows "where we are going, how and when we want to get there". Each milestone will have a senior responsible officer who will not only champion the work area, but will also take responsibility for delivery, working across organisations and across geographical and administrative boundaries. Using this method we have tied ambition to action.

4.1 Our Vision (how delivery will be different in 2020)

Our original LPT 2020 vision remains our ambition. By 2020 our vision across partners is that:

> 'Children and young people are able to achieve positive emotional health by having access to high quality, local provision, appropriate to their need, as well as a range of support enabling self-help, recovery and wellbeing.'
>
> Derbyshire and Derby City Future in Mind LTP 2015

Every child in our area will have awareness of changes in their own mental and emotional health, will have the skills to be resilient, will know how to access person-centred effective support when they need it and there will be a significant reduction in the children and young people who need specialist services.

We will see a significant shift from intervention to prevention at every stage of identification of problem development. Children and young people will be supported with the awareness and skills to be resilient within their communities and through school. There will be a shift from high cost hospital/specialist provision to low cost preventative support including self-management and community support.

All the services commissioned will be person-centred, and each child or young person who needs a service will be co-producers of their own care plan, including active participants in delivery. Their evaluations will influence further service development and secure continuous improvement in service delivery.

Our ambition is that more children and young people will be able to self-manage any changes in their emotional and mental well-being, and also know where to get help. If a young person needs more specialised support we aim to ensure there is also a flexible range of high quality effective community support that enables 'step down' from specialist support. Schools are key to this. If a child or young person requires specialist clinical intervention these services will be available as close to home as possible.

4.2 Early prevention and early intervention

We have begun work to embed early prevention and early intervention by supporting children and young people to become more resilient. Initiatives such as the 'Art of being Brilliant' are raising awareness through learning and sharing events for leisure activity providers such as church youth groups, dance groups etc. This will encourage problems to be identified and supported early and reduce the risk of escalation.

We are ensuring a named specialist contact for each of the schools, who will provide advice and support to pastoral teams so that they are able to provide effective early intervention.

4.3 Early help provision with Local Authorities;

We are building on existing strong relationships with Local Authorities to complement early help provision. Mental health will be a key agenda at the locality meetings.

4.4 Routine care

We are working towards a THRIVE approach and recognise the importance of friends and family in contributing to the longer term routine care of children with high levels of need. We will embed a person-centred approach in all our commissioned services, and active

participation of the child or young person and anyone in their friendship group or family who they feel would be helpful in aiding their sustainability and recovery.

4.5 Crisis care and intensive interventions

We are developing both a crisis and an intensive intervention provision to reduce hospital admission. These will be outward facing and provide support as close to home as possible. The crisis service will provide a short intense intervention where need may quickly escalate or become life-threatening. The intensive intervention service will provide wrap-around support from clinicians and others including family members or carers.

4.6 Groups with extra vulnerability (e.g. 'looked after children', those who have been abused and / or those within, or at risk of entering the justice system

We recognise the particular vulnerabilities of a number of children including those in care, those who have been abused, those living with domestic violence, those permanently excluded from school or at high risk of permanent exclusion, and those at risk of entering the justice system. We are working with partners in the youth offending teams, the local authority, designated nurses for child protection, social workers and others to ensure that we have a clear focus on these children and ensure they are prioritised for services when they need them.

4.7 Inpatient care

Children and young people will not be admitted to inpatient care unless absolutely necessary and if they are admitted every effort will be made to ensure that services work together to provide a safe and secure place at home or in their local community for return as soon as possible. The child or young person and identified friends and family will be active in care planning and support.

Eating disorder – our work to support children and young people with eating disorder is detailed in Chapter 7.

4.8 Addressing the whole system of care, including specialist care service provision

As well as a special care plan for eating disorders, we are also working on a single early help needs assessment framework to be used across providers, including schools and other organisations, including the 3rd Sector. This will help providers to consider the whole system of care opportunities as early as possible in C&YP care needs.

Other specialist care work includes parenting training to help young people with autism/ADHD.

5 Workforce

Successful delivery of our LTP ambition is dependent on having the right staff with the right skills in the right place. We are currently developing an integrated multi-agency workforce development (due April 2017) that aligns with the wider Children and Young People's workforce Plan. This will enable us to increase the capacity and capability across the workforce. We are building on our strengths, learning from existing training, consultation on training needs and what works for young people.

Our starting point includes:

- 5 years of strong implementation of CYP IAPT full implementation in South Derbyshire (see Chapter 6). Implementing CYP IAPT EEBP training (phase one) in multi-agency community settings in 2015 (e.g. schools, voluntary sector, multiagency teams) have enabled local providers to understand the potential to skill up staff to deliver early intervention. Demand for EEBP places for 2016/17 is already high.
- Roll out of CYP IAPT in North Derbyshire
- Experience and learning from providing a range of brief training sessions delivered by providers in schools and communities and through 2 local conferences (300 attendees) to manage *'emotional distress and what to do about it'*
- Engagement with schools, colleges, multiagency teams
- Evaluation of what works and what we need to do more of
- A workforce matrix used in NW Derbyshire with particular focus on mental health developed Tameside and Glossop CCG
- Examples of training being tested
    - cascading evidence based mindfulness training to teachers and staff in schools and colleges
    - pilot to train
    - building friendship groups within schools, particularly around eating disorders
    - Erewash are building on work being done to raise self-awareness and self-esteem, develop resilience and promote young people as leaders with all Year 7 children 'The Art of Being Brilliant' and the role of young volunteers
    - voluntary sector providers offering one hour awareness raising sessions e.g. body image, the impact of bereavement
    - Development of champions for children and young people with poor mental health and voluntary sector through leisure activity groups

We are developing a new Workforce Development Strategy and Action Plan this will include an estimate of what additional staff we will require. As part of this work we have identified the following numbers for overall need. There are approx. 1 million people in Derbyshire (630,000 in South Derbyshire) and approx. 200,000 0-18 year olds (20%). We estimate there are approx. 20,000 young people with mental health issues at any one time in Derbyshire. Our Future in Mind Local Transformation Plan aims to support 35% of these which is approx.

7000 C&YP. Currently CAMHS see approx. 3500 C&YP a year. Training more staff in preventative evidence based best practice interventions is a major part of our plan to support an additional 3,500 C&YP annually. To enable this, the Workforce Development Strategy will:

1. Map the developing mental health needs of C&YP against available resources
2. Identify the gaps in provision and consider priority actions, including:

- Ways to increase the overall "pool" of support
- Ways to increase appropriate training for staff, parents and volunteers
- Consider recruiting new roles eg Psychological Wellbeing Practitioners, Recruit to Train Schemes
- Training staff in schools and MAT teams in Effective Evidenced Based Practice
- Providing training for those supporting parents with C&YP with autism/ADHD
- Promoting the take up of e learning "iThrive" web courses

Through these and other actions in the developing Workforce Development Strategy and to ensure work toward this target is met we will allocate responsibility to a senior commissioning manager on the FIM Core Group to lead a task and finish group with stakeholders to co-produce the strategy. Workforce is as a standing agenda item.

5.1 The plan

Keeping children and young people at the heart, our workforce plan will respond to the wide spectrum of training need including:

- A system wide review of skills and capacity in the system at all levels from awareness raising to evidence and goal based interventions
- A comprehensive developmental plan for IAPT across Derbyshire with projections and required outcomes by 2020
- Upskilling the wider workforce e.g. voluntary organisations schools and multiagency teams and
- Promote self-help, strengthen community resilience and developing peer support
- Extending evidence based specialist interventions across the system
- Prioritising skills that meet the needs of vulnerable young people including children in care, care leavers, those permanently excluded from school, those who are refugees, children who are living in refuges, and those with a learning disability.
- Measures that show evidence of the impact of training for children and young people
- A range of training methods including self-directed, eLearning, and face to face

- Remodel the work of existing workforces to meet future need e.g. primary mental health workers
- Consider new workforces roles such psychological well-being practitioners (PWP)
- Involve CYP parents in carers in delivering training
- Provide multi agency training
- Development of a strong community of skilled practitioner and multi-agency teams, school staff, voluntary sector providers, social workers and parents/carers that can support and challenge
- Responding to request for more practical skills on how to support and manage children and young people e.g. 'what to do if.. / trouble shooting', looking at case studies – particularly MAT/early help', more help with preschool children.

5.2 Challenges and what we need to do next

Building capacity across the whole children and young people's workforce is crucial to success. Workforce is a significant risk to successfully delivering our LTP. Our priority is to complete our strategic workforce plan and finalise the skills and capacity to deliver the LTP by 2020.

The workforce plan will be led by our Task and Finish Group for Workforce Taskforce that includes IAPT CYP leads, clinicians, voluntary sector, schools and Local Authorities. We will consider additional staff required by 2020 and new roles such as the PWP. . Our vision will include a mandatory training Matrix to be embedded across organisational boundaries.

We will be also need to increase the specialist workforce so for example we have enough supervisors to support practitioners deliver CYP IAPT. The risk remains that like all local areas we are fishing from the same pool of staff.

6 Collaborative Commissioning

We are developing a local integrated pathway for children and young people that will include plans to support crisis, admission prevention and support for safe discharge. This is work in progress expected to be published December 2017 as we await the arrival of the Collaborative Guidance due to be distributed. We will work with NHS England and our specialist service providers in implementation of our plan so that we respond the needs of children with more complex/specialist needs. The Derbyshire and Derby City plan will be developed with Health and Justice commissioners and include clear pathways for transition in and out of secure settings, SARCs and liaison and diversion activities, forensic CAMHs.

Derbyshire and Derby City working together across children and adults services have already been successful in securing an additional £650,000 as a contribution to capital funding development for a place of safety or a safe place. Meetings have been held with key stakeholders including providers and commissioners of children's as well as adult services, to consider how the funding might be used most effectively to provide short term (up to 72 hours) safe places so that practitioners have time to assess and work intensively with the young person to reach a stable position and agree with the young person the plans for their immediate future and longer term goals.

The discussion that focused on provision for children and young people identified the need to have close joint working with the CAMHS crisis intervention services and the intensive home support services. These services will be in place from January 2017 and will offer intensive wrap around multi-agency support to the young person and the parent/carer in their home, following their time in the safe place, to reduce the likelihood of needing admission to Tier 4 beds and ensure safe discharge home. The work will be based on the plan agreed with the young person in the safe place and the goals they have identified as steps to recovery.

Initial discussions also outlined the physical environment that might be most conducive to aid the stability of the young person including single en-suite rooms that enable 'watchful waiting', be on the same site as acute provision so that any physical needs such as intoxication can be addressed quickly, include a multi-agency team with the appropriate social workers, and youth offending team members where necessary, ensure support for parents/carers addressing their needs as well as those of the children and young people.

We will ensure that there is join-up between the Future in Mind programme and the safe place development to ensure they complement and add value to one another, both having a primary aim of reducing the need for admission to Tier 4 beds, and avoid any duplication. The plan will be developed through the engagement of all relevant partners agreeing a clear aim and commitment to deliver, development of pathways, identify resources (including

transfer of resources) timescales, benefits and outcome measures, risk assessments and solutions to potential barriers.

6.1 Sexual Assault Referral Centres (SARC)

Local CCGs recognise that they have a key role to play to work with NHSE and the new regional Paediatric Service will be live from 1 July 2017 in the East Midlands.

We are currently commissioning some specialist support through voluntary agency 'SV2' to support young people who experienced sexual assault. We will work with NHSE to ensure there is appropriate additional local therapeutic support once the initial 10 therapeutic sessions, and the Crisis Worker provided by NHSE, are complete in line with the SARC pathway as child ISVAs are not part of the specialist specification.

6.2 Collaborative Commissioning challenges and work to do

We need to further develop a more integrated pathway for CYP to ensure we have robust wrap around intensive care bundles in the community to prevent admission to hospital. We also need to further develop work with the integrated workforce to ensure that YP admitted have excellent discharge support packages back in the community as part of step down or discharge.

Recognising that some children and young people have complex emotional and behavioural needs, we will build on learning for our Care and Treatment Review process by ensuring the pathways have more cohesion and clear levels of responsibility. We will work more closely with health and justice commissioners in the development of integrated pathways that support young people returning to local services from liaison and diversion provision and custody.

7 CYP Improving Access to Psychological Therapies (CYP IAPT)

The growth of the CYP IAPT has been collaborative between commissioners and providers. The establishment of the Midlands CYP IAPT Collaborative is welcomed locally. The 2 CAMHS providers are at different stages of development with CYP IAPT Derbyshire Healthcare Foundation Trust Wave 6 and Chesterfield Royal Hospital joining the programme this year. Learning is shared across the providers.

7.1 Derby and South Derbyshire

Derbyshire Healthcare NHS Foundation trust (DHCFT) CAMHS is planning its sixth year of the service transformational CYP IAPT programme. The service has been able to engage with both statutory and third sector partners to develop care pathways supported by evidence

based interventions that are NICE compliant. Year 5 was a year of consolidation so no additional staffs were trained. There are good examples of the EEBP working in community settings from Year 5. A priority for the future is to embed and extend CYP IAPT capacity and strengthen supervision to ensure sustainability of impact. The rationale for this is:

- To ensure sustainability of CYP IAPT skills and measure impact.
- Continue to expand range of EEBP practitioners and supervisors across the CYP workforce
- Embed CYP IAPT to pathway developments e.g. single point to access, role of schools, multi-agency teams.

7.2 Plans for CYP IAPT expansion 2016/2017

DHCFT are working with both the newly established East Midlands CYP IAPT collaborative and the NW collaborative so that required training can be delivered. The request for places is outlined below.

S Derbyshire CAMHs Southern Derbyshire CCG Erewash CCG	16/17	IAPT collaborative
CAMHs		
Eating Disorder Systemic Family Practice (EDSFP)	1	North West
Parenting Therapy (PT)	1	North West
Supervisors Training	4`	North West
Partnership		
Cognitive Behavioural Therapy (CBT) Post grad dip	4	Midlands
Systemic Family Practice (SFP) post grad dip	4	Midlands
Enhanced Evidence Based Practice (EEBP)	16	Midlands

Southern Derbyshire CCG and Erewash CCG have agreed that there is £5k backfill for each EEBP post and up to £30k backfill for the full time courses which will be funded quarterly throughout the duration of the course.

Both the SFP and EEBP courses start in November 2016 and the parenting course starts in January 2017

7.3 North Derbyshire

Chesterfield Royal Hospital CAMHS is in the process of transforming what has been a traditional CAMHS service to a service that aligns with the Future in Mind ethos of making sure that children are able to access the right service, in the right place at the right time for them. The staff working in CAMHS are now building on their community outreach service to establish a community based urgent care service and key named CAMHS staff in each community providing early effective interventions. As part of this, the CAMHS service is now working towards becoming CYP IAPT compliant. In addition partner organisations are identifying staff that will attend the EEBP course, and provide additional capacity in communities.

Plans for CYP IAPT expansion 2016/17

CAMHS	16/17	IAPT collaborative
Evidence Based Counselling Practice	1	Midlands
Supervisor training	2	Midlands
Systemic Family Therapy (CBT) Post Grad Dip	1	Midlands
Enhanced Evidenced Based Practice	2	Midlands
Radically Open – Dialectic Behaviour Training	1	Midlands
Partnership		
Enhanced Evidence Based Practice	12	Midlands

North Derbyshire CCG and Hardwick CCG have agreed that there is £5K backfill for each EEBP post up to 30K backfill for full-time courses (up to a maximum of £50K for CAMHS in total) which will funded quarterly throughout the duration of the courses.

7.4 Derbyshire and Derby CYP IAPT 5 year forward plan

Recent projections have been calculated based on the current position that South Derbyshire CAMHs in in year 6 of CYP IAPT and North Derbyshire are joining the programme this year. These projections are approximate at this stage.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	28%	30%	32%	34%	35%
Number of additional CYP treated over 2014/15 baseline	21,000	35,000	49,000	63,000	70,000

In is anticipated that:

- By 2020 – approx. additional 1400 young people to access evidence based interventions.
- Increase number of young people seen in NHS funded MH services – (12600 y/p under 18 based on 10% prevalence – does not include neurodevelopmental – ADHD/ASD) – by 2020 35% is 4410 (this does not include % increase in population).
- Increase of approx. – 34 new therapists (including North Derbyshire).

7.5 Challenges and what we need to do next

1. To keep the expansion of CYP IAPT on track commissioners and providers to produce a development plan that outlines year on year training required and expected IAPT interventions delivered
2. Extend partnership EEBP IAPT in early help and school settings and evaluate impart
3. Embed the CYP IAPT programme in N Derbyshire
4. Align CYP IAPT Programmes across Derbyshire.

8 Eating Disorders (see Appendix 3 for plan)

As part of the 2015 FIM LTP a separate eating disorder plan was published. This work is integral to FIM though led by a separate Derbyshire wide eating disorder working group.

Since October 2015 we have been developing an expert Children and Young People's (C&YP) Eating Disorder Service that aims to reduce the negative impact of eating disorders and work towards the recovery of a child or young person by providing effective interventions as early as possible.

The attached document acts as a detailed plan refresh updating our action plans to provide a model that embraces the concept of whole system care whilst meeting the recommended standards. The baseline audit of our two providers established different stages of development in October 2015. The refreshed plan, is split into two sections to reflect the CAMHs footprint of North and South units of planning.

The refreshed detailed action plan (included below) demonstrates actions still required to meet the: access, waiting times, treatment, referral standards and provision of a fit for purpose skilled workforce with clear time lines to track progress.

8.1 Fit for purpose workforce

As a high priority the Eating disorder teams have been recruited to base on the recommended model in FIM to cover a population 500,000.

8.2 Establishing current baseline performance against the new eating disorders access and waiting time standards

The target of covering a minimum of 100 new eating disorders per year (50 north and 50 south) is likely to be exceeded by April 2017 based on our 1st quarterly audit of service. The new teams are now meeting the (NICE)-concordant treatment standards within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases. In the north of the county there have been challenges establishing base line data with no fit for purpose It system. However since investment we have worked collaboratively with the North teams to establish base line data which

includes recording the length of care completed and incomplete pathways on a weekly basis (A new IT system will be in place by April 2017).

8.3 Early identification

In partnership with our service users, wider stakeholders and with support from NHS England, we are continuing working closely across the footprint to improve early identification with a drive to skill the universal workforce who come into contact with young people. The Voluntary sector has been commissioned to work closely with eating disorders service in CAMHS developing a continuous program to deliver -GP training, - body image workshops and direct 1:1 support in school settings.

8.4 Family interventions

Those that directly address eating disorders are now offered in the South of the county and by 2018 they will be offered in the North with places secured for SFP and Radically Open Dialectic behaviour training.

8.5 Access to service and web site development for signposting

We are enabling direct access to community eating disorder treatment through self-referral and from primary care services (GPs, schools, colleges and voluntary sector services). We plan to have this live across the Derbyshire and Derby City footprint by August 2017. We are working with college students to develop Apps and web sites for signposting as a proof of concept in the North of the county, providing details of self-referral process, with a view to rolling out Derbyshire and City wide. This will complement the anti-stigma campaign led by public health.

8.6 Stakeholder and service user engagement

We will continue to engage young people in the development of our eating disorder service. They have a strong presence in our stakeholder group that meets quarterly, where there is focus on learning lessons from patient stories.

8.7 Transition to adult services

Young people are part of our subgroup looking to improve transition from young peoples to adult services. We are developing a template with young people that they complete as a personal statement that will be part of the transition handover to adult care.

Our young people's eating disorder service now demonstrates some flex in the system to keep young people on beyond 18 years on an individual case by case basis (for example young people with exam stress). The services work closely together to provide a seamless approach to support with the joining of care at 17 years and 6 months.

8.9 The gaps in service, risks and solutions for transition

The present BMI criteria to enter adult services is 16.9. Young people tell us that this runs the risk of young people losing weight to fit the criteria to get support. Adult services also do not accept referrals for ENDOS (someone whose symptoms did not meet all of the criteria for anorexia or bulimia or where their symptoms were a mix of those for anorexia and bulimia). This group of young people are presently left aged 18 to access the voluntary sector and primary non specialized services.

The vision is that by 2020 we will have an eating disorder service secured as part of a 0-25 years pathway. We have an opportunity to incentivize providers to improve the pathway with CQIUN targets.

9 Data evidence included in 'Understanding the need' section

10 Urgent & Emergency (Crisis) Mental Health Care for CYP

10.1 Crisis care and intervention – intensive home care and support -wrapping care around children in our community

The challenge of supporting a child or young person in a crisis includes making sure that there is a swift and comprehensive assessment of the nature of the crisis, ensuring that intensive home treatment is an option for those at risk of inpatient admission or those being discharged from inpatient provision.

10.2 Drivers for change – our guiding principles

We have engaged stakeholders in a series of workshops including young people, primary care, schools, social care, ED, paediatrics and adult services to shape the service specification and KPIs with the following drivers for change:

- Achieving Better Access to Mental Health Services with appropriate mental health support in A&E available.
- 4 hour emergency waiting times, *(clock starts ticking at referral point)* with an option to follow up with a maximum of x 4 intensive home care support sessions over a 2 week period
- Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
- Ensure availability of rapid access provision 24/7 by 2020

Continue to monitor use of a police cells as a place of safety - *this has been made a never event under the Crisis Care Concordat*

10.3 Addressing the whole system of care

Our specification and subsequent pathway development adopts the 'Thrive' the AFC–Tavistock Model for CAMHS .and Re-focus specialist CAMHS services to be more outward-facing and achieve integrated working with Social Care, Education, the voluntary other NHS services in crisis.

	North	South	Challenges and risks
Developing an agreed service specification that is outcome focused and meets waiting time standards to deliver Crisis care and intensive home care and support.	Both providers working very closely together and with commissioners to agree a service specification. <u>This will be completed by 30/10/16</u> and will share the same outcomes irrespective of starting points, to ensure there is an equitable service across the whole unit of planning in all CCG areas.  REVISED DRAFT SPEC INTENSIVE HOM		
Intensive home care support agreed start times	January 2017	tbc	Recruitment to model "*fishing from the same pond* " may have a negative impact on reducing waiting times, also staff displacement staff
Model finance agreed	Yes - £288 K	£108,229 (yr1)	
Model building on existing resource	A 5 day week 9-5 small community outreach team exists <u>By 2017/18</u> New improved service will be extended to provide 365 days /year10am-10pm. Offering Rapid assessment and Care in the community, working closely with ED departments	CAMHs **RISE** Rapid Intervention, Support and Empowerment Working to ensure that children and young people who are in urgent need of care due to self-harming or suicidal thoughts get RAPID the support they require. Present service 365 days a year, from 8am to 11pm.*operational since January 2016*	The Southern team required to build on RISE to be more outward facing building capacity to provide assessment and short effective interventions in the community.
Pathway development, monitoring and audit	Work very closely with NHSE to monitor reduction of in patients. Work closely with paediatrician's to monitor		Requirement to *up skill* workforce in universal settings to support young people back in

of service provision	bed day reduction Need to increase capacity between 2017-2020 to achieve ambition of 24/7 crisis support Stakeholder engagement to be ongoing to achieve ambition of extending the pathway to 25 years by 2020.	communities following intervention and support.

11 Early Intervention in Psychosis (EIP)

The EIP service provided by DHcFT is ageless taking young people from 13 with no upper limit or younger by negotiation with respective consultants when clinically appropriate (this will be very rare). The EIP service works in cooperation with CAMHS to deliver the full range of NICE approved treatment pathways. The EIP service has always worked with young people since its inception to policy implementation guidance spec in 2004. There is one service split into three teams covering the geographical areas of Derby City, South Derbyshire and North Derbyshire.

The service is developing protocols to support this approach and is fully compliant with the national requirements.

11.1 Challenges and what we need to do next

1. Ensure the current service meets need and that this pathway is integrated with others

12 Impact and Outcomes

In addition to monitoring KPIs and service activity, we are working to toward measuring impact and outcomes that are identified and matter to children and young people. We currently include and monitor outcomes measures through:

- Outcome measures built into new service specifications for the proof of concepts
- Service specifications
- Outcomes framework
- Expansion of goal based outcome IAPT
- Parenting courses

12.1 Development of an Outcomes Framework

Over the last 2 years a key priority underpinning the existing CCG CYP transformation programme has been the development of an outcomes framework that takes us from activity to outcome based commissioning. Our commitment through is to implement the Framework from 2107. There have been 3 phases:

Phase 1- the engagement stage of developing the framework, established the goals that matter most to children and young people and identified how an outcomes focused service should deliver services to help children meet their goals. Stakeholders attending a range of development workshops agreed the benefits of, and a shared vision for, commissioning for outcomes. (Supported by COBIC).

Phase 2 – the framework development stage ended on 31 March 2016. The deliverables include a refined Outcomes Framework that includes a set of strategic indicators and guidance for service and pathway level outcome and process measures. There is a toolkit of appropriate measurement tools and worked examples to demonstrate the framework in action along with example performance data dashboards. Supported by **Child Outcomes Research Consortium** (CORC).

Phase 3 - the implementation of the framework using a collaborative testing and learning approach to commissioning for outcomes to improve the health outcomes of children and young people and deliver better value. Starts January 2017. We expect this phase to:

- Deliver better for less
- Empower children and young people and their parents and carers
- Create an innovatory culture

12.2 Challenges and what we need to do next

Developing a consistent process

- Changing provider culture
- Deliver phase 3 of the outcomes framework

13 Other Comments

13.1 Risks to delivery controls and mitigations

Delivery of the LTP is monitored by the FIM Core Commissioning Group through highlight reports. The control mechanism is that risk and issues are reviewed and where possible addressed through this process and escalated as required.

Risks	Mitigation
Workforce development Workforce development needs greater than FIM can support CYP IAPT partnership EEBP school pastoral care demand for training outstripping supply Insufficient specialist capacity Possible increase in waiting lists as service	 Consider range of skills required and training methods. Promote self-directed learning Evaluate how implementation works to make best use in school settings. Stepwise increase. Consider alternatives Review skills needed

providers trained up "Graduates" do not fully use their new skills productively Inappropriate/ inequitable recruitment	Work with HEEs/innovation opportunity, Recruitment process targeted at those that can deliver greatest benefit including targeting areas of greatest need (eg BME community service providers)
Data and outcomes Having the right systems in place to demonstrating impact of LTP Separate data collection systems and measures of outcomes vary Understanding of inequalities	Co- develop single data collection system and measures across Derbyshire footprint tying in with development of outcomes framework. Complete planned health equity audit Explore potential of non NHS data sets
Transition points in care pathways Inconsistent thresholds between children's and adult services resulting in barriers to service provision Capacity in adult services to manage transition in eating disorders	Transition Conference planned spring 2017 Utilise CQUIN funds to incentivise providers Stakeholder/client feedback Engage the service user in the preparation of handover planning and notes Review use of Body Mass Index as a threshold condition for service provision
Procurement process proof of concept destabilising the system	Evaluate impact and agree in the next 12 months what provision needs remodelling or recommissioning to provide stability Seek procurement advice
Risk step down from acute into community provision lack of capacity/ placement breakdown **Increase in waiting times in CAMHS if resources are utilised "downstream" on prevention**	Co-develop multiagency response Model demand and capacity and balance investment

13.2 Issues log

Risks	Mitigation
Road Map including trajectories which include clear year on year targets for improving access and capacity to evidence based intervention Need to develop this with clear KPI's	Ensure excellent engagement with all stakeholders, clear timeline and implementation plan, clear focus on goals IAPT projection planning already in place
Service user engagement gap children and parents carers	Work with stakeholders to address this with a particular focus on carer involvement, build on extensive work with young people

13.3 Examples of Innovation

- **Emotional Health and well-being Toolkit for schools in Derbyshire and Derby** (October 2016) a result of the Southern Derbyshire and Erewash CCGs successfully participated in the Accelerated CAMHs co commissioning pilots (Dept of Health funded) based on request from schools for practical help.
- **Anti-stigma DVD Eating disorder** First Steps made by young people, parents , volunteers and staff local voluntary sector provider for eating disorder https://www.youtube.com/user/firststepsd
- **Online counselling through Live Chat** Relate Derby and Southern Derbyshire https://www.relate.org.uk/
- **CAMHs RISE** (Rapid Intervention, Support and Empowerment) South Derbyshire 7/7 8am – 11pm crisis response at children's emergency department with follow up Dialectical behaviour therapy (DBT)to build resilience and prevent representation http://www.derbyshirehealthcareft.nhs.uk/services/childrens-services/camhs/camhs-rise/
- **Development of a CYP Outcomes Framework**
- We are working with Young People to consider the use of social media and apps to respond to need

13.4 Alignment with the Derbyshire and Derby City Sustainability and Transformation Plan

Children's and Maternity Outline Business Case OBC as of 7 October 2016:

By 2021 we will provide a **seamless** health, education and social care pathway for pregnant women, children and young people in Derbyshire and Derby City. This will enable all children and young people to be **healthy and resilient** and, if support is needed, enables them to **plan their care** with **people who work together**, allowing them to achieve the **outcomes that are important to them.**

In Scope:

All acute and community children's and maternity services which are commissioned by Local Authorities (Derbyshire County and Derby City) and the four Derbyshire CCGs (North Derbyshire, Hardwick, Erewash and Southern Derbyshire and in close liaison with Tameside & Glossop) to include:

- Out of hours and unscheduled care for children and young people
- **All psychological and mental health provision for under 18's including CAMHS Liaison and crisis pathways i.e. urgent care***

- End of life and palliative care for children and young people

Services provided by VCS sector

- Early help offer
- Community services for children and young people (universal, targeted and specialist)
- Long Term conditions for children

***Future in Mind commissioning Group will become a CTP STP work stream**

All high cost placements including tier 4 collaborative commissioning.

- Collaborative work with Tameside and Glossop to address the needs of children and families in Glossopdale.
- Age range from conception to age 18 (age 19 if attending a special school) and up to age 25 for some local authority services
- Joint or integrated working and opportunities around shared resources with local authority commissioned/provided services (education, social care, public health)

Out of scope:

- 19-25 age group (under SEND legislation) with respect to the use of adult health services for this cohort urgent and emergency care in an acute setting (à included within Urgent Care OBC) Assisted conception services
- Interdependencies: All other OBCs where children and young people are not specifically excluded from scope

13.5 NHSE Joint proposal - Children and Young people's mental health: waiting times for treatment

Southern Derbyshire, North Derbyshire, Hardwick and Erewash CCGs 31 October 2016

The four CCGs in Derbyshire have submitted a joint proposal for this additional resource to reduce waiting times in Children and Young People's Mental Health. This includes two projects which prioritise two groups of vulnerable young people in particular need of timely assessment and initiation of treatment:

- a discrete priority service for children coming into care, taking them out of the usual waiting list for mental health services Derbyshire County
- children with complex behaviour and mental health needs Derby

Allocated resource October 2016 - March 2017 by CCG.

Erewash CCG	43k
Hardwick CCG	48k
North Derbyshire CCG	126k
Southern Derbyshire CCG	230k

Appendix 1 Jan 2016 Plan on a Page

Classification: OFFICIAL

Derbyshire county and Derby City's plan for children and young people's mental health and wellbeing 2015-2020

By 2020 our vision is that:

'Children and young people are able to achieve positive emotional health by having access to high quality, local provision, appropriate to their need, as well as a range of support enabling self-help, recovery and wellbeing.'

Our commitment to children young people and families

Our plans will be underpinned by a whole systems change approach. We understand that each part of the system has an integral part to play and that links between education, health and social care across all ages are imperative if our vision is to be realised.

We will involve all stakeholders in the development of an anti-stigma campaign which will be delivered within schools and colleges.

We will provide clear information about the range of services available, so that children, young people and families know who does what and how to access help.

Our priorities

Promoting resilience, prevention and early intervention

- Develop the 'teaching' of resilience within the school curriculum
- Ensure development of peer support and those with lived experience around mental health being more included in delivery of services.
- Develop an improved service for children and young people with eating disorders that will reduce the negative impact of their condition and work towards their recovery by providing effective interventions as early as possible.
- Improving resilience of parents and carers

Improving access to effective support

- Improve Integration of CAMHS within schools, Primary Care, Multi Agency Teams (MATs), youth offending and social work teams.
- Develop a 'menu' for young people to personalise their individual needs.
- CAMHS providers will develop a self-referral system for children and young people.

Care for the most vulnerable

- Ensure availability of rapid access provision 24/7 with intensive home treatment is an option for those at risk of inpatient admission.
- Ensure that there is effective support for children and young people who have experienced or are at significant risk of sexual abuse/child sexual exploitation or looked after or youth offenders
- Ensure that evidence-based interventions are available for young people with Learning Disabilities and/or neurodevelopmental disorders including support for parents/carers and young people with learning disabilities and neurodevelopmental disorders

Accountability and transparency

- Develop and implement key performance indicators which will enable a better understanding of all areas including waiting times for CAMHS.
- Ensure that Youth Council and CAMHS service user groups have an active role in scrutiny and development of plans.

Developing the workforce

- Improve and make more training available to professionals working with children, young people and families where there are emotional or mental health difficulties.

Classification: OFFICIAL

NHS
Southern Derbyshire Clinical Commissioning Group
North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
DERBYSHIRE County Council
Improving life for local people
Derby City Council

Goal date Journey to goal	**Appendix 2** Draft Derbyshire and Derby City foot print road map / implementation plan 2016-2020 Where we are going and when we are going to get there												
	Milestones	**RAG Rating**	**2016**	**2017 Jan-June**	**2017 July-Dec**	**2018 Jan-June**	**2018 July-Dec**	**2019 Jan-June**	**2019 July-Dec**	**2019 Jan-june**	**2019 July-Dec**	**2020 Jan-june**	**2020 July-Dec**
1. Eating Disorder Service	• Recruitment for model.												
	• Voluntary Sector-procure services review proof of concept.												
	• Stakeholder young people and providers oversight group 6 monthly.	On going											
	• Stakeholder carers and parents events 6 monthly.	On going											
	• Service specification signed off.												
	• Improve transition to adult services by removing BMI as a barrier.												

	• Improve transition pathway by developing a 0-25 years' service by 2020.												
	• Service user involvement to design statement for handover at transition.												
2. Urgent Help /crisis intervention	Service specification for crisis intervention signed off.												
	• Provision of Urgent Help / crisis intervention response time of 4 hours in the community north.												
	• Provision of intensive home care and support building on the outreach service and blending with new crisis response in the north.												
	• Provision of				Tbc								

	intensive home care and support building on the outreach service and blending with crisis response from RISE.												
3. Improving provision of a place of safety	• Realising ambition to improve access to secure safe place of safety (new capital monies separate to FIM). • Will create better access north and south of the county							tbc					
4. Vulnerable children including LAC Those affected by & CSE/sexual abuse	• More specialist therapeutic support for children and young people who have been sexually abused/raped waiting for court case NUOP – proof of concept –												

	• Review and procure service												
		TBC	TBC										
	• Improved support for CIC SUOP Integrated emotional health and wellbeing service for LAC. Piloted from April (1 year)		TBC										
	• Priority for spending – ○ Training sessions universal and targeted ○ Crisis work ○ Engagement – work with children and young people ○ Joint work to design and pathway	Ongoing											
4 Additional support for universal services, locality/place	• Stakeholder event – to improve transitions from children's to												

including general practice and schools in localities	adult services												
	• Implement new delivery model for CAMHS redesign service specification and implement new service specification based on previous stakeholder engagement vents – 2015/16												
	• Test mindfulness training and cascade model reaching 90 staff in schools to be trained. • Across 60 schools • Reaching over 2000 children (proof of concept – 18 months)												

5	Increasing Early Help interventions, including increased capacity for MATs	• South unit of planning only Produce a JSNA covering Derby City and Derbyshire to inform the Refresh October 2017											tbc
6	Improved data collection and impact analysis	Triangulate all data sources at locality level from: starting point- mat teams – social care CAHMS education , build picture of health inequalities and inform JSNA Implementation of outcomes framework by Dec 2017											
7	Parenting programmes	• Scope out existing provision and meet gaps in provision											
8	Anti-Stigma Campaign	• County wide strategy implementation											

9 CYP involvement in decisions and shaping services	antistima engagement 03-16.d Further develop our engagement with children and young people and their parents/carers												
10 Workforce development plan	To include continuous IAPT up skilling of work force Baseline data to understand skills and knowledge of staff groups (Roll out of training matrix Mandatory training matrix	Ongoing											

Appendix 3

Eating disorder FIM plan refresh for NHSE -7th October 2016

Since October 2015 Derbyshire County and Derby City have been developing an expert Children and Young People's (C&YP) Eating Disorder Service that aims to reduce the negative impact of eating disorders and work towards the recovery of a child or young person by providing effective interventions as early as possible.

This document acts as plan refresh updating our action plans to provide a model that embraces the concept of whole system care meeting the recommended standards. The baseline audit of our two providers established different stages of development in October 2015; therefore the plan refreshed is split into two sections , North and South units of planning which partners the following CCG s:

- North Derbyshire (North)
- Hardwick (North)
- Southern Derbyshire (South)
- Erewash CCGs (South)

The refreshed action plan demonstrates actions still required to meet the: access, waiting times, treatment and referral standards.

In partnership with our service users, wider stakeholders and with support from NHS England, we have been working very closely across the Derbyshire County and Derby City footprint to improve early identification with an drive to skill the workforce and increase capacity to reduce waiting times..

North Derbyshire CCG Hardwick CCG area CRH CAMHS and First Steps action plans refreshed

1. Needs assessment /baseline data and action plans

1. **Treatment**

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. Service to improve early identification	• A more proactive programme of advertisement including website etc., with personnel linked to gps, schools and multi agency teams. Addition of CAMHS liaison worker and voluntary sector support workers to work in partnership • Voluntary organisation continues to link closely with eating disorders service in CAMHS voluntary sector has full continuous program to deliver --gp training, - body image workshops direct 1:1 support in universal settings	Current development plans for primary care and CAMHS • Primary threshold pathway document in draft – to complete January 2017 • First steps worker visited team 2016/ meeting with First Steps re pathway 6.9.16  voluntary sector targets for improving • • IT plan ongoing- once system identified links can be added. (systm 1 in place January 2017)
B. Offer evidence-based family interventions that directly address the eating disorder	• Increased capacity of dedicated systemic family therapy to be able to offer more consistently. • multi-systemic family therapy training and systemic cyp iapt needed. • home treatment family intervention needed – 7 day • capacity to offer family group meetings	• MSFT training needed- awaiting whole team training 2017 • We are now members of the east midlands IAPT collaborative

	• All referrals considered for Family Therapy input as appropriate, either formally, or within home.	
C. family members including siblings should normally be included in treatment	• Regular availability of group/family support, advice and training sessions. • Family assessment arranged for all referred children and YP. • Parents group to be recommenced in coming year 2017	• April 2017
D. interventions may include sharing of information, advice on behavioural management and facilitating communication	• Need increased capacity to deliver home support and liaison with schools, MATs, GPs. Training and awareness rising from voluntary sector. • First Steps delivering training into schools. • Freed Beeches liaising with schools re individuals.	• Information sharing with schools and school meetings attended on individual basis sept 2016 . • Consent and confidentiality policy clear and used sept 2016.
E. Offer age-appropriate care to address rise of early-onset eating disorders in those under 13	• Increase in availability of individual therapy for children less than 13yrs such as Creative Therapy – consider voluntary sector provision. • Creative therapy available within CAMHS . • Early identification at primary level advised via primary referral pathway to consider voluntary sector at early stage.	• APRIL 2017
F. accessible to females and males and culturally	• Need to consider gender, race, ethnicity and difference, currently no dedicated male clinician available	• Now … ongoing

appropriate	• Existing Female, white British team, can access male clinicians as needed from generic team.	
G. Clinicians will need to continue to offer NICE-concordant treatment within the framework outlined in this guide	• increased capacity of dedicated SFT and CBT	• Systemic family therapy available to all referred families. CBT available from experienced CBT Therapist 2016
H. Treatment should include specialised community family interventions for anorexia nervosa and specifically adapted forms of CBT for bulimia nervosa, in particular CBT-E	• Increased capacity of dedicated SFT and CBT • Multi-Systemic FT Training and Systemic/ CBT CYP IAPT • Home treatment family intervention needed – 7 day • Capacity to offer family group meetings • CBT-E training	• MSFT training needed, application to join Quality assurance group made, in order to access whole team training, 2017.
I. Use up-to-date evidence-based interventions to treat the most common types of coexisting mental health problems (for example,	• Increased capacity of dedicated SFT and CBT to enable increased provision for co morbid presentations. • All children & YP assessed and reviewed by psychiatrist, as needed, from 2016. • Access to CBT, individual and group, IPT, pharmacology and family interventions • Pathway for internal referral allows	• IAPT TRAINING PROGRAM 2017/2018 • With East Midland collaborative

depression and anxiety disorders) alongside the eating disorder	consultation and joint working with core CAMHS staff.	

2 Creation of a service to meet waiting time standards

2.1 Requirements for a viable and dedicated Eating Disorder Service

Recommendations	Where we need to be and action	Date we will achieve recommendations
(NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.	• Increased capacity at the point of referral in order to respond to concerns proactively – e.g. follow up on referral information. Dedicated admin support and additional resource for 'duty response' on receipt of referrals.	• 2016 All routine referrals seen within 4 weeks, urgent within a week. All referrals screened within 24 hrs and liaison made with referrer as needed. • Admin staff appointed, not dedicated.
A. ***Move away from small teams... 1 team preferred*** B. A 'hub and spoke' model or local network model may	• Ensuring continuity of current best practice at local level. • Steering group. Common service specification.	• Dedicated team formed to cover NE Derbyshire, meeting Monday am to process referrals and consult re care. MDT Assessments, alongside paediatrics. • Monthly team supervision • Pathway for primary services in draft 2017 complete • Team members joining NHS England meetings and local

be appropriate, with a clearly defined structure and strong leadership.		joint planning meetings, transition meetings. • Ongoing liaison with team lead for S Derbyshire CAMHS.
C. Receive a minimum of 50 new eating disorder referrals a year, which are likely to include anorexia nervosa, bulimia nervosa, binge eating disorder and related diagnoses	• Current eating disorder pathway does not have capacity to meet the requirements to include 'related disorders'. Increased capacity is required for comprehensive service	• Current referral numbers indicate the minimum referrals will be met.
D. Cover a minimum general population of 500,000 (all ages)	• To form one team of a county wide service following one pathway. • regular meetings with SDCHCFT CEDS • Joint training for one member of staff in RO DBT with DHCFTand Adult ED service sept 2016.	• Joint pathway is being explored and developed by April 2017
E. Include medical and non-medical staff with significant eating disorder experience	• need to develop CBT E and increase capacity for SFT • Training environment for Specialist registrars, student nurses, trainee psychologists. • Team consists of experienced clinicians with knowledge and experience of working with YP and families with eating disorders.	• April 2017 In place existing

F. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• A proactive programme of advertisement including website referral option. • Electronic systems to facilitate liaison and rapid communication with primary services and service users. • Develop relationship with voluntary sector • Awaiting website developments and electronic system for CAMHS • Duty professional on call 9-5pm to take calls. • Ongoing development of relationships with voluntary sector	• April 2017
G. Most children and young people should be treated in the community with inpatient admission considered where there is high or moderate physical risk	• For paediatric admissions to be fully commissioned for those where compensatory behaviours are limited and medical stability will be strengthened by a slightly longer admission to in order to support a robust discharge home for further home treatment and avoid tier 4 referral	
H. Admission should be to appropriate facilities with access to educational provision and related activities.	• Access to urgent medical input as co-located with paediatrics. Matron and dietician now identified within CAMHS CED team and so seamless service. • Admission available through CRH paediatric ward for short term focused admission in keeping with Jnr Marsipan guidelines. A MDT approach to these admissions with weekly meetings, ED care plan and dietetic input, daily CAMHS review.	In place Audit by commissioners 2017

	• Slightly longer admission to facilitate robust discharge is occurring currently- needs clear commissioning. • Education base on Paediatric ward. Teaching staff and play specialist staff attend ward rolling programme of CAMHS teaching re ED's and join MDT meetings for children, liaising with child's school to ensure continuity of education provision • Staffing of play specialists adjusted as needed for admissions. Tier 4 admissions – education is facilitated within provision	
I. When in-patient admission is required, this should be **within reasonable travelling** distance	• Psychiatric inpatient care not currently available within reasonable travelling distance. • Local tier 4 beds in generic CAMHS units at distance. Specialist beds for ED's less accessible	• Intensive home care support will see reduction in tier 4 beds – 2017- 2020
J. User involvement in commissioning	• Service user involvement vital – build on the engagement events for Future in Mind - local group set up and will meet with commissioners and providers a minimum of 6 month intervals – however during the first year of transforming services will meet quarterly • Service user group links within generic CAMHS links to Derbyshire Youth Group. • Plans for specific service user group development for CEDS CAMHS. 2017, all will be feedback to commissioning	• 2016- on going

3 **Referral Process**

Recommendations	Where we need to be and action	Date we will achieve recommendations
A. The CEDS-CYP should have clear online referral forms. Each service should have clear, accessible contact details on a website, which are easy to find via main search engines, with clear instructions in appropriate languages on how to call the service, send an email or complete an online self-referral form.	New IT system in place JANUARY 2017 Web site links /apps will cross organisational links including schools, youth groups Mat teams to developed web link at CAMHS Working with Chesterfield College to develop further with students.	• On line referral system to be in place by June 2017
B. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• A more proactive programme • Advertisement including website referral option.	• See above
C. **Avoid lengthy referral in-house processes**	Meets standards	Standards tracked via UNIFY

CAMHS team is required to make contact with the CEDS-CYP as soon as the possibility of an eating disorder is raised. This should be done by telephone or electronically following discussion with the child or young person and their parents or carers		
D. **The causes for missing an appointment** should be investigated carefully, and the referrer and the GP/trusted adult informed. This is recorded in the child or young person's clinical notes. An appointment should be booked to take place within 2 working days of the missed appointment.	• Review appointment service and make appointments available within 2 working days • regarding missed appointment protocol will be included in pathway of care. December 2016 • Current practice must include this and staff document the same	• April 2017

4 Classifying risk and urgency

Recommendations	Where we need to be and action	Date we will achieve recommendations
A. Telephone or in-person contact to be made with the child or young person and the parent or carer *on the same day* to clarify risk.. This rapid response is essential when it is not known if the child or young person is under the care of a healthcare professional and the level of risk remains unclear	• New Eating disorders team provides increased capacity to respond to referrals on the same day regardless of referral information • 2016 current practice means that contact is made on same day regarding urgent referrals • this needs to be considered for all referrals as urgency and risk may not be indicated in referral information.	2016 -on going
B. For some milder presentations supportive eating disorder treatment may be provided in a primary care setting with treatment by trained eating disorder staff. If treatment is delivered in a non-eating disorder, supportive setting, the CEDS-CYP must oversee treatment and provide consultation and supervision.	• Need to develop a training programme for schools, MATs and capacity for ongoing support and supervision- liaison and collaboration with 3rd sector provider • First Steps delivering school training 2016- full program for delivery • Consultation available to partner agency staff regarding their interventions. • CAMHS currently developing role	• August 2017 –2020 ongoing

5 **Information sharing with parents / carers**

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. Guidelines referenced in The Working together to safeguard children website and Paragraph 12 and 13 of the Mental Capacity Act 2005 Code of Practice are followed re: sharing information with parents and carers with respect of 16 and 17 year olds.	• Will involve children and young people to develop service specific guidelines. • Building on established links continue service user direct involvement in writing specification and focus on transition from Childrens to adult service. • Focus of these meetings to gain feedback as part of baseline of service at start of service & develop participation agenda for service development, in keeping with guidelines and CYPIAPT. • Parent /carer focus group planned for October 2016, YP focus group January 2017.	• Ongoing – ethos to always involve service users /key stakeholders review 6 monthly

6 Workforce competencies and experience

Recommendations	Where we were /baseline October 2015	Where we need to be and action plan	Date we will achieve recommendations
The team's collective membership needs the following expertise:			
A. Psychiatric assessment for	• Meeting the standards	• Meeting the standards	• Meeting the standards

	children and young people			
B.	Medical assessment and monitoring	• Meeting the standards	• Meeting the standards	• Meeting the standards
C.	Rapid response to referrals- outlined in the care pathway	• Not meeting standards of contacting young person on day of referral.	• Need to develop same day response • Crisis response in a service available 24/7 • Current capacity of service- 5 days, utilising out of hours support from generic CAMHS	• To build into pathway January 2017
D.	Staff trained to supervisory level for evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• Not available currently – shortage of available supervisors.	• Develop capacity for CBT E and SFT supervision	• Team lead completing AFT accredited systemic supervision training complete 2017 • CBT E Training required within team.
E.	Staff trained in the delivery of evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• CBT and SFT available	• We need to develop resources and for dedicated provision for the eating disorders pathway	Staff trained in delivery of evidence based interventions for systemic family therapy and CBT and can access supervision for these. Need for team to undertake training in MFT Training and CBT E. • Assistant psychologist developing resource system electronically.

F. Community care: the team should have the experience to be able to provide home treatment and family support	• limited availability available via Outreach team	• Need to develop dedicated home treatment service. Additional outreach work.	• 2016 -1.5 wte experienced staff band 6, employed to support home treatment, however geographical area increased for the team to include High Peak, Buxton, incurring additional travel time.
G. There should be lead consultant/champion for acute eating disorder care, as advised in the Junior MARSIPAN.	• **There is at present no dedicated consultant champion for acute eating disorder care,**	The specialist eating disorders service would provide appropriate psychological and medical and social support interventions aimed at recover and the reduction of risk in accordance to the NICE guidelines and the junior MARSIPAN.. this will be achieved by the recruitment of the paediatrician and the integrated of care being developed with the CRHFT It is anticipated that the psychological interventions delivered will be a minimum of 6 months duration, as identified by NICE 2004 .The presence of a specialist service is expected to facilitate earlier discharge of	2016 acute medical care for young people is accessed with ease, there is a clear pathway of MDT care, should a child, YP present either as a medical emergency or become unstable medically whilst under care of CAMHS. The paediatric Matron and Dietician has joined planning meetings for the service over the last 6 months, and join all MDT on the ward for YP admitted to paediatrics. There are two named consultant paediatricians who link with the team. All young peoples discharge

		patients from specialist inpatient units. This service would be a tertiary service accessed via the CAMHS team.	plans are undertaken with care and collaboration undertaking risk assessment throughout. Should a young person be in a specialist inpatient unit the community care co ordinator within the team will attend all CPA meetings and ensure supportive discharge planning throughout to facilitate as early a discharge as possible.
H. Acute service and paediatric support: support should be provided to these services 7 days a week	• Generic CAHMS psychiatric support currently available via on call system however they are not eating disorder specifically trained.	• Explore options for training specialist psychiatric support.	• Additional training to CAMHS team to be planned 2017
I. Administrative and management support; by experienced staff with training in relevant areas including data entry.	• limited availability as part of generic Tier 3 CAMHS	• Dedicated admin and managerial support. • Electronic records system	• Dedicated managerial support delivered through out • Admin support appointed- not dedicated

Training of eating disorder team

Recommendations	Where we are /baseline	Where we need to be and action	Date we will meet recommendations
A. Develop multi-disciplinary eating disorder teams	Currently managed by generic CAMHS clinicians	Need to develop dedicated specialist team.	CED CAMHS specialist team now formed including child psychiatrist, psychologist, dietician, systemic family therapist, children's mental health workers, assistant psychologist and paediatric matron/ paediatrician.
B. Understand the complex nature of eating disorders. Develop early intensive skills training and support and supervision	As a service we understand the complex nature of ED	dedicated specialist team to deliver evidenced based training	specialist team to deliver evidenced based training during 2017 TO CAMHS need for clarity as to boundaries of clinical supervision and consultation to others, outside of the NHS system
C. Develop a strong team culture	Strong team culture currently which benefits from the paediatric input and established structures for care planning and supervision		• Team meets weekly, with additional monthly supervision group. • Review documentation in clinical files completed • All staff undertake clinical and managerial supervision

			monthly, with ongoing appraisal process annually • Care plan letters sent 3 monthly • Plans for passports to be introduced to aid transition
D. Adopt core CYP IAPT principles	Action plan developed	Needs IT infrastructure (planned 2016)	IT infrastructure (planned 2016) NE Derbyshire application to join collaborative currently 2017 Service aiming to become CYPIAPT compliant 2017
E. Evaluate the impact of training on transformation of services	NA	Outcome measurements as per CYP IAPT	
F. Local Education and Training Board to be aware of the number of	Whilst training has had a positive impact in supporting young people we acknowledge the	To be developed as part of wider strategic plan to ensure that resources meet	We are keen to be part of regional training plan and have identified key gaps in training including

professionals provider has identified who need training and link with regional plan to meet local need	need for a strategic approach to ensure investment is driven by need in communities for specialist provision	local need- top be driven by the FIM delivery group	Maudesley training and CBT E.

SDDD and Erewash CCG area DCHCFT CAMHS and First Steps

1 Treatment

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. How is service is improving early identification	• Improved links with primary care, schools and voluntary sector to improve identification of potential cases of eating disorder and promote prompt referrals. Easily accessible information needs to be available regarding referring directly to specialist team. First steps linking with schools to raise awareness and knowledge of referral process. • Eating disorder team now taking direct referrals. • CAMHS Ed team in process of developing written service information in conjunction with user participation Group and Planning service awareness event for primary care	• On going voluntary sector targets for improving
B. Offer evidence-based family interventions that	• Offering family based interventions to all cases of eating disorder where this type of intervention is clinically indicated and accepted by the family.	• Achieved Jan 2016 • Recruitment Feb 2017 .

directly address the eating disorder	• CYP IAPT Systemic training completed January 2016. • Due to deliver multi family therapy group October 2016 • Recruitment in progress for .0..6 band 8A family therapist	
C. family members including siblings should normally be included in treatment	• The increase in availability of family based interventions alongside systemic thinking about care planning should ensure that family involvement is paramount. • Increased family therapy groups in development	• Achieved Jan 2016 March 2017
D. interventions may include sharing of information, advice on behavioural management and facilitating communication	• Robust early assessment should ensure that psycho-education and behavioural advice is given in a timely and effective manner. An extended and skilled team will aid effective communication with families, GPs, schools, voluntary and other agencies • ED team are providing consultation and support across all Camhs teams to individual cases where eating difficulties aare present	• SEPT 2016 • Jan 2016
E. Offer age-appropriate care to address rise of early-onset eating disorders in those under 13	• Improved recognition and identification of eating disorders should help to identify those with an eating disorder at an earlier stage. Evidence based therapies including SFP will be offered to this age group.	• January 2016-ongoing development
F. accessible to females and males and culturally	• Training and education would aim to encourage identification of males with eating disorders as they are likely to be under recognised and stigma may be greater.	• April 2017

	appropriate	• To consider wider access if needed to male clinical staff in Camhs /First steps .	
G.	Clinicians will need to continue to offer NICE-concordant treatment within the framework outlined in this guide	• Focus on providing evidence based treatments within the defined time periods such as family based interventions, CBT-E and treatment of any co-existing mental health problems • Cbt therapist now in post -,trained in CBT-E. • Multi family therapy group to be implemented in October .4 members of team have received MFT training in London . • 2 Team members in process of RO-DBT training and plan to implement classes in conjunction with adult and north Camhs ED services • We have made 3 referrals for intensive support to First steps ,2 of these are currently receiving intervention from Clare – support worker in co-work with Camhs E.Dteam and the 3rd young person has been offered a support plan from first steps on discharge from inpatient care .	SEPT 2016 October 2016 May 2017
H.	Treatment should include specialised community family interventions for anorexia nervosa and specifically adapted forms of CBT for bulimia nervosa, in particular CBT-E	• Cbt therapist now in post with training in CBT-E. • Systemic family practice available to all families in eating disorder team . • Multi family therapy group planned • RO-DBT training ongoing in north ,south and adult ed teams .To work together to offer this as an intervention	• Sept 2016 • 2017 –access whole team MSFT training in conjunction with north derbys team and first steps . • January 2017 for ro-dbt .
I.	Use up-to-date evidence-based interventions to treat the most	• We are further developing a treatment pathway model so that there is streamlines access to evidence based therapies and treatments for co-existing mental health conditions • ED pathway developed	• Ongoing –planned Jan 2017

common types of coexisting mental health problems (for example, depression and anxiety disorders) alongside the eating disorder	• Internal referral pathway to provide consultation ,dietitan support and co-working with core Camhs teams .	Sept 2016

2 Waiting time standards

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
(NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.	• Additional staff recruited , • Accepting direct referrals ,screened on day of receipt and ability to respond within 24 hours where very urgent need /risks identified in liason with consultant psychiatrist and paediatrician .. • Team assessment system in place to offer urgent assessment within 1 week and routine within 4 weeks if possible –ability to meet these waiting times to be monitored and any difficulties /barriers identified .	• Recruitment ongoing –feb 17 Sept 2016 Sept 2016
A. ***Move away from***	• Single provider model would work well in the future.	• Sept 2016

small teams - 1 team preferred B. A 'hub and spoke' model or local network model may be appropriate, with a clearly defined structure and strong leadership.	However a potential model of two providers under 1 steering group with clear policies regarding governance, accountability and an agreement of shared resources when appropriate to attain the required targets, KPI's and NICE concordant treatment. • Developing monthly team supervision • Team building –developing a team approach to care –team day 5/10/16 • Next meeting with First steps team 28/9/16 • Regular liason with North derbys team to share practice and develop common working . •	November 2016 Started and ongoing development.
C. Receive a minimum of 50 new eating disorder referrals a year, which are likely to include anorexia nervosa, bulimia nervosa, binge eating disorder and related diagnoses	• We would envisage the proposed team to work with 65 referrals per year. In addition to providing support and consultation to eating disorder cases within the generic CAMHS, ensuring concordance of the ED care bundle. • 2 posts to recruit to achieve full staffing with existing budget	• March 2017
D. Cover a minimum general population of 500,000 (all ages)	• To extend to cover the Derbyshire the population of around 1,000,000 to include North Derbyshire with population of 380,000	Ongoing

	• Continue to develop joint working relationships and opportunities for joint work with North Derbys Team	
E. Include medical and non-medical staff with significant eating disorder experience	• We wish to increase the capacity of the specialist eating disorder team by increasing the clinical time of the multidisciplinary team. • 2qualified systemic practitionrs ,2 part time specialist nurses ,1part time CBT therapist ,1part time agency dietitian 1 full time team manager /senior nurse .Family therapy supervision available .2days paediatric liason nurse ,Isession weekly paediatrician .Part time child /adolescent psychiatrist now in post	• March 2017
F. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Extend access by allowing self-referral and direct referrals from primary care, schools and voluntary sector for all patients with a suspected eating disorder. This role historically was partially achieved through the PMHWs. It is our wish that access to this pathway can additionally be supported by the development of social media and web based information.	• Sept 2017
G. Most children and young people should be treated in the community with inpatient admission considered where there is high or	• A specialised eating disorder team would aim to both reduce admission rate and length of stay due to earlier access to evidence based treatment and increased ability to liaise with inpatient units to facilitate earlier discharge • Currently developing intensive support work plans with First steps to reduce likelihood of admission • Short term admission to paediatric ward where this will	• Jan 2017

moderate physical risk	enable enough stability to return home with support and avoid Tier 4 admission . -2week max assessment period ?	
H. Admission should be to appropriate facilities with access to educational provision and related activities.	• The specialist CED Team will have the opportunity to develop the specialist links and pathways to support educational attainment whenever possible.	• tbc
I. When inpatient admission is required, this should be **within reasonable travelling** distance	• It is unclear if this will be modified with increased resources in a specialised eating disorder team. • The team actively tries to secure the most appropriate bed closest to home with some success although this cannot be guaranteed .	• intensive home care support will see reduction in tier 4 beds – and reduction in bed days 2017-2020
J. User involvement in commissioning	• Service user engagement to continue regularly • Service user participation group has been developed ,meets monthly .Although membership is low at present ,an information leaflet is been developed for youg people ,parents and professionals	• October 2016

3 Referral Process

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. The CEDS-CYP should have clear online referral forms.	• Our aim is that this is supported the development of online self-referrals and access to detailed information across the NHS	

	and our partners web pages.	
B. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Extend access by allowing self-referral and direct referrals from primary care, schools and voluntary sector for all patients with a suspected eating disorder.. • Access to this pathway can additionally be supported by the development of social media and web based information. • Awareness raising and advertising of service and referral pathways needs to be developed and implemented .	• 2017
C. Each service should have clear, accessible contact details on a website, which are easy to find via main search engines, with clear instructions in appropriate languages on how to call the service, send an email or complete an online self-referral form.	• Introduce one direct contact point for referrals for suspected eating disorders • Our aim is for the development of online self-referrals and access to detailed information across the NHS and our partners' web pages.	• 2017
D. <u>Avoid lengthy referral in house processes</u> CAMHS team is required to make contact with the CEDS-CYP as soon as the possibility of an		

eating disorder is raised. This should be done by telephone or electronically following discussion with the child or young person and their parents or carers.		
E. The causes for missing an appointment should be investigated carefully, and the referrer and the GP/trusted adult informed. This is recorded in the child or young person's clinical notes. An appointment should be booked to take place within 2 working days of the missed appointment.	• The CED-CYP will have the ability to directly investigate missed appointments and inform GP/trusted adult. Appointments will be rescheduled within 2 working days.	• Develop protocol in team for responding to missed appts and build in capacity within team to enable this t happen . • 2017

4 Classifying risk and urgency

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. Telephone or in-person contact to be made with the child or young person and the parent or carer *on the same day* to clarify risk. This rapid response is essential when it is not known if the child or young person is under the care of a healthcare professional and the level of risk remains unclear	• Greater staffing levels within the specialist eating disorder team would allow professional to contact to be made on the same day to clarify risk. • We have a duty worker in the team every day ,this could be included in their role	• Plan needs to be developed to implement this November 2016
B. For some milder presentations supportive eating disorder treatment may be provided in a primary care setting with treatment by trained eating disorder staff. If treatment is delivered in a non-eating disorder, supportive setting, the CEDS-CYP must oversee treatment and provide consultation and supervision.	• Consultation and supervision to GPs and school nurses to be provided by members of the CEDS-CYP. It is also our aim that we will be developing our online resource to facilitate this and improve access. • Need to develop training programme for primary care ,MATS in conjunction with North derbys team and First steps .	• First steps currently offering training to schools . • Camhs provide some training via PMHW'S • Camhs ed team provide consultation and support to partner agencies .and internally to Camhs staff .

5 Information sharing with parents / carers

Recommendations	Where we were /baseline October 2015	Where we need to be and action plan	Date we will achieve recommendations
A. Guidelines referenced in the Working together to Safeguard Children website and Paragraph 12 and 13 of the Mental Capacity Act 2005 Code of Practice are followed re: sharing information with parents and carers with respect of 16 and 17 year olds.	• Current guidelines met	• N/A	• NA

6 Workforce competencies and experience

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. Psychiatric assessment for children and young people	• The Consultant Psychiatrist along with other staff with appropriate mental health training will complete this as part of initial assessment and on-going treatment and review within the CED-CY team.	
B. Medical assessment and monitoring	• Our psychiatrist is part of the multi assessment team so medical assessment is available at first contact	• Standards met Sept 2016

C. Rapid response to referrals- outlined in the care pathway	• Referrals are screened by member of the CEDS-CYP on day of receipt and action taken according to risk.	• Standard met Sept 2016
D. Staff trained to supervisory level for evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• Increased supervisory staff including in family therapy/practice to support both the clinical delivery of family based interventions and to consider the systemic networking requirements of working in an intensive treatment modality, supporting all families accessing family based interventions. There is an identified need to increase CBT capacity, in particular there needs to be supervision for CBT-E.	• 2017
E. Staff trained in the delivery of evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• More training is needed for CBT-E specifically and SFP to allow for staff changes and absence to ensure a robust service.	• CYP IAPT places available for application to start training January 2017
F. Community care: the team should have the experience to be able to provide home treatment and family support	• An increased capacity to support home treatment where this is identified as a benefit – we aim that this role could be developed in partnership with our third sector providers.	
G. Acute service and paediatric support: support should be provided to these	• Involvement of a named Consultant Paediatrician within the CED-CYP. This would allow co-ordinated paediatric assessments for complex community cases and effective management for	• We have a named paediatric consultant who attends ED team meetings every 2 weeks and is involved in the care of all young people admitted to Paediatric care with eating

services 7 days a week	any short term inpatient paediatric admissions. We would aim to gradually work towards providing assessments from the CED-CYP within 24 hours of referral.	difficulties .
J. There should be lead consultant/champion for acute eating disorder care, as advised in the Junior MARSIPAN	The specialist eating disorders service would provide appropriate psychological and medical and social support interventions aimed at recover and the reduction of risk in accordance to the NICE guidelines and the junior MARSIPAN.. this will be achieved by the recruitment of the paediatrician and the integrated of care being developed with the CRHFT It is anticipated that the psychological interventions delivered will be a minimum of 6 months duration, as identified by NICE 2004 .The presence of a specialist service is expected to facilitate earlier discharge of patients from specialist inpatient units. This service would be a tertiary service accessed via the CAMHS team.	
H. Administrative and management support; by experienced staff with training in relevant areas including data entry.	• Increased administrative staffing of CED-CYP to ensure effective referral process. There also needs to be effective on-going communication with primary care, school health and other agencies	• We are moving towards implementation of a dedicated admin resource to the eating disorder .

7 Competencies/training

Recommendations	Where we need to be and action plan	Date we will achieve recommendations
A. Develop multidisciplinary eating disorder teams	• The full CED team will be established in January 2016 but with limited capacity. The proposed additional staffing will make this a NICE compliant CED team	• Achieved
B. Understand the complex nature of eating disorders	• Training to all staff. Access to the specialist CED team for consultation and support. The implementation of the ED Care Bundle.	•
C. Develop a strong team culture	• Ongoing	•
D. Develop early intensive skills training and support and supervision	• Training to all staff. Access to the specialist CED team for consultation and support. The implementation of the ED Care Bundle.	•
E. Adopt core CYP IAPT principles	• We will continue to transform CAMHS in line with the CYP IAPT principals and are working towards fully integrated care pathways, supporting workforce development strategies across all CYP services.	•
F. Evaluate the impact of training on transformation of services	• Ongoing	
Local Education and Training Board to be aware of the number of professionals provider has identified who need training and link with regional plan to meet need	• To be developed as part of wider strategic plan to ensure that resources meet local need- top be driven by the FIM delivery group	

8 **Eating disorder team progress based on FIM recommendations (South)**			
Number of referrals per annum	**50**	**Actual in post now**	**Comments**
Head of service (psychiatry/psychology)	0.6	0.6	
Speciality Doctors (psychiatry) (Registrars)	0.8	0	
Paediatric medical treatment (Consultant)	0.1	0.1	
Senior Clinical Staff (Bands 8a and 8b)	1.3	0	Recruiting 0.6 8Afamily therapist
Eating disorder therapists (Band 7)	3.4	3.6	
Home treatment specialists (Band 6)	1.3	1.2	
Dieticians (Band 6)	0.8	0.6	Agency
Support Staff/Assistant Psychologists (Band 4)	0.9	0	
Voluntary sector			

Eating disorder team progress based on FIM recommendations (North)			
Number of referrals per annum	**50**	**Actual in post now**	**Comments**
Head of service (psychiatry/psychology)	0.6	0.4wte	Consultant psychiatrist
Speciality Doctors (psychiatry) (Registrars)	0.8		Current registrar offers input to the team
Paediatric medical treatment (Consultant)	0.1	0.1wte	Consultant support ongoing /Matron for paediatrics
Senior Clinical Staff (Bands 8a and 8b)	1.3		
Eating disorder therapists (Band 7) Clinical psychologist (Band 7)		Family therapist/team lead 1.0 wte Oct 2016 0.4wte	
Home treatment specialists (Band 6)	1.3	CEDS Workers	1.5 wte
Dieticians (Band 6)	0.8	0.4 (band 7)	Due in post October 2016
Support Staff/Assistant psychologists (Band 4)	0.9	0.5 wte	