Rotherham Metropolitan Borough Council
Where Everyone Matters

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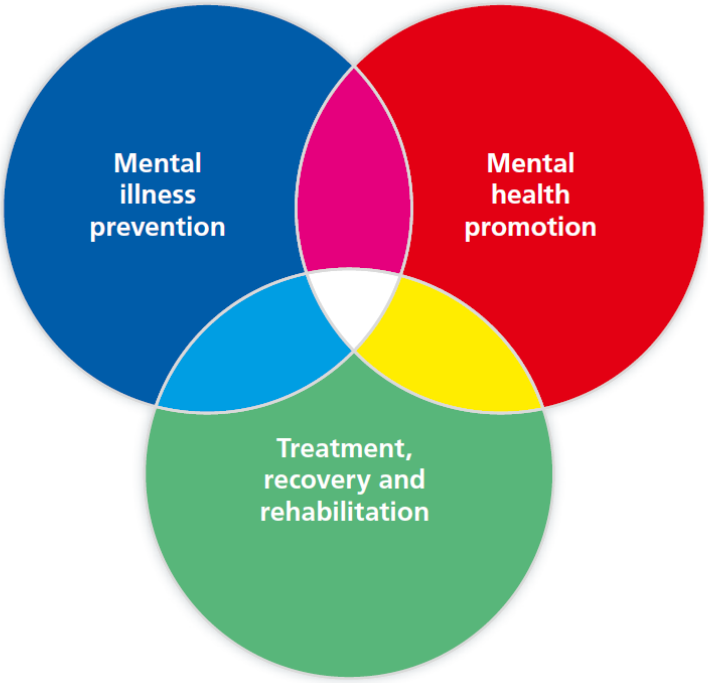
Scrutiny review:
Child and Adolescent Mental Health Services



Joint Review of the Health Select Commission and the Improving Lives Select Commission

September 2014 – March 2015

Scrutiny Review Group:

Cllr Shabana Ahmed
Cllr Judy Dalton
Cllr Jane Hamilton
Cllr Barry Kaye
Cllr Stuart Sansome (Chair)
Cllr Maureen Vines

Report v2 27 March 2015

Contents

Executive summary

The review group comprised the following members: Cllr Shabana Ahmed, Cllr Judy Dalton, Cllr Jane Hamilton, Cllr Barry Kaye, Cllr Stuart Sansome (Chair) and Cllr Maureen Vines.

There were seven aims of the review, which were to:

1. understand the prevalence and impact of mental health problems and illness amongst children and young people in Rotherham
2. understand the costs, value for money and quality of current services
3. clarify how partners work together to support children and young people across all the tiers, especially the role of the Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Duty Team
4. establish how RDaSH engages with service users and their families/carers in order to deliver appropriate and effective services
5. ascertain how identifying and responding to child sexual exploitation is integrated within RDaSH Child and Adolescent Mental Health Services provision
6. determine how effective support for the mental health and emotional wellbeing of Looked After and Adopted Children is provided
7. identify any areas for improvement in current service provision and support

The review was structured around these aims with evidence gathered through written information and discussions with Rotherham Clinical Commissioning Group, Rotherham, Doncaster and South Humber NHS Trust, Rotherham Youth Cabinet and the Looked After and Adopted Children Support and Therapeutic Team; written evidence from RMBC officers and other agencies, supported by desk research.

Summary of findings and recommendations

Although the principal focus of the review was RDaSH CAMHS these services are not provided in isolation but are part of a complex system of service commissioning and provision. The new Emotional Wellbeing and Mental Health Strategy for Children and Young People is a welcome development and should address key issues Members explored in this review, helping to resolve many of the problems young people are experiencing in accessing mental health services. Improved communication between agencies and with families; clarity over access criteria, referrals and care pathways; and renewed attention on health promotion, self-help and early support/treatment will help to avoid the numbers of young people with deteriorating mental health and emotional wellbeing, or in crisis. Data quality remains an issue and there should be greater attention paid to improving and measuring outcomes.

Recent changes to RDaSH CAMHS are positive, such as the reconfigured Duty Team and self-referral. More flexible services available across a range of community settings, and greater links to youth services and schools are a priority to progress further. The volume of referrals is high and although waiting times have been reduced for routine assessments the target is still being exceeded with the service likely to continue to face high demand.

Prevention and early intervention should still be a focus to try and reduce the number of young people needing support at higher levels or continuing into adulthood, given the emergence of many lifelong conditions during adolescence.

Exploring a single point of access to CAMHS, with young people triaged to the most appropriate service, seems a positive step towards developing services with the needs of the YP at its heart and surmounting some of the difficulties noted in the course of this review.

Recommendations

1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on the service users and patients:
    a. to help maintain a detailed local profile of C&YP's mental health over time
    b. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

5. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

6. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)*

    Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

7. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

8. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

9. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

10. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

1. Why Members wanted to undertake this review

At its meeting in April 2014, the Health Select Commission (HSC) decided to focus its work around the theme of mental health and wellbeing during the 2014-15 municipal year. Further to this it was agreed in July 2014 that a review of Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Child and Adolescent Mental Health Services (CAMHS) be included in the work programme, following local concerns and a report from Healthwatch.

The overall purpose of the review was to identify any issues or barriers which impact on children and young people in Rotherham accessing timely and appropriate RDaSH CAMHS services at Tiers 2 and 3, and in particular in having an assessment within three weeks.

There were seven aims of the review, which were to:

1. understand the prevalence and impact of mental health problems and illness amongst children and young people in Rotherham
2. understand the costs, value for money and quality of current services
3. clarify how partners work together to support children and young people across all the tiers, especially the role of the RDaSH Duty Team
4. establish how RDaSH engages with service users and their families/carers in order to deliver appropriate and effective services
5. ascertain how identifying and responding to child sexual exploitation is integrated within RDaSH Child and Adolescent Mental Health Services provision
6. determine how effective support for the mental health and emotional wellbeing of Looked After and Adopted Children is provided
7. identify any areas for improvement in current service provision and support

2. Method

A full scrutiny review was carried out by a sub-group of the Health Select Commission and Improving Lives Select Commission, consisting of Cllrs Ahmed, Dalton, J Hamilton, Kaye, Sansome (Chair) and M Vines. Cllrs Hoddinott and Steele were also involved in the early stages of scoping the review and determining lines of inquiry.

An initial report to the Health Select Commission provided an introduction and set the national and local context. Several evidence sessions then followed during which current services, referral processes, resources, performance measures, service user engagement and partnership working were explored in depth. Evidence for the review was gathered through the following means:

- Presentations and discussion with Rotherham Clinical Commissioning Group (RCCG) and Rotherham, Doncaster and South Humber NHS Trust (RDaSH)
- Written information submitted by Rotherham Healthwatch and RMBC officers in Public Health, Commissioning and the Looked After and Adopted Children's Support and Therapeutic Team
- Anonymised case studies to understand how services work together in complex cases
- Round table discussion with members of Youth Cabinet
- Follow up information from RCCG and RDaSH
- Desk top research
- Public engagement at Fair's Fayre event at Magna

Members would like to thank everyone who gave evidence for the review and in particular colleagues from RDaSH and RCCG who provided comprehensive information about mental health services for children and young people in Rotherham. The review group also appreciate the willingness of Rotherham Youth Cabinet to share the findings of their work on mental health.

3. Background

Parity of esteem is the principle that mental health should be given equal priority with physical health. This means equal access to support, treatment and services for both mental and physical ill health and resources for mental health that are commensurate with need. At present no national waiting time targets for mental health are in place, unlike physical health, although these are being introduced, commencing with Improving Access to Psychological Therapies.

Rotherham's new Emotional Wellbeing and Mental Health Strategy for Children and Young People (EWS) includes the following definition of CAMHS, highlighting the importance of an integrated approach across a range of partner agencies.

> "Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone."
>
> (Source – http://www.everychildmatters.gov.uk/health/CAMHS)

In Rotherham mental health services for children and young people are delivered by a range of providers (see model in Appendix A), so it is important to emphasise that this review primarily focused on the CAMHS services provided by RDaSH. Members also considered the interface between RDaSH and other partner agencies and RDaSH involvement in multi-agency working.

At present services are structured around the pyramid model on the next page. This also indicates the percentage of children and young people (C&YP) estimated to have emotional wellbeing and mental health needs at each level, based on national prevalence rates. Recently this model has been challenged for being based around the services provided, rather than services being developed based upon the needs of C&YP and their families. RDaSH Duty Team plays a central role as a pathway and link between universal services and targeted (Tier 2) and specialist (Tier 3) services and is covered in more detail in section 5.3.

Non-specialised services Tier 1 - services provided by professionals in universal services who are in a position to identify mental health problems early on, provide general advice to young people and families, and to take up opportunities for mental health promotion and prevention.

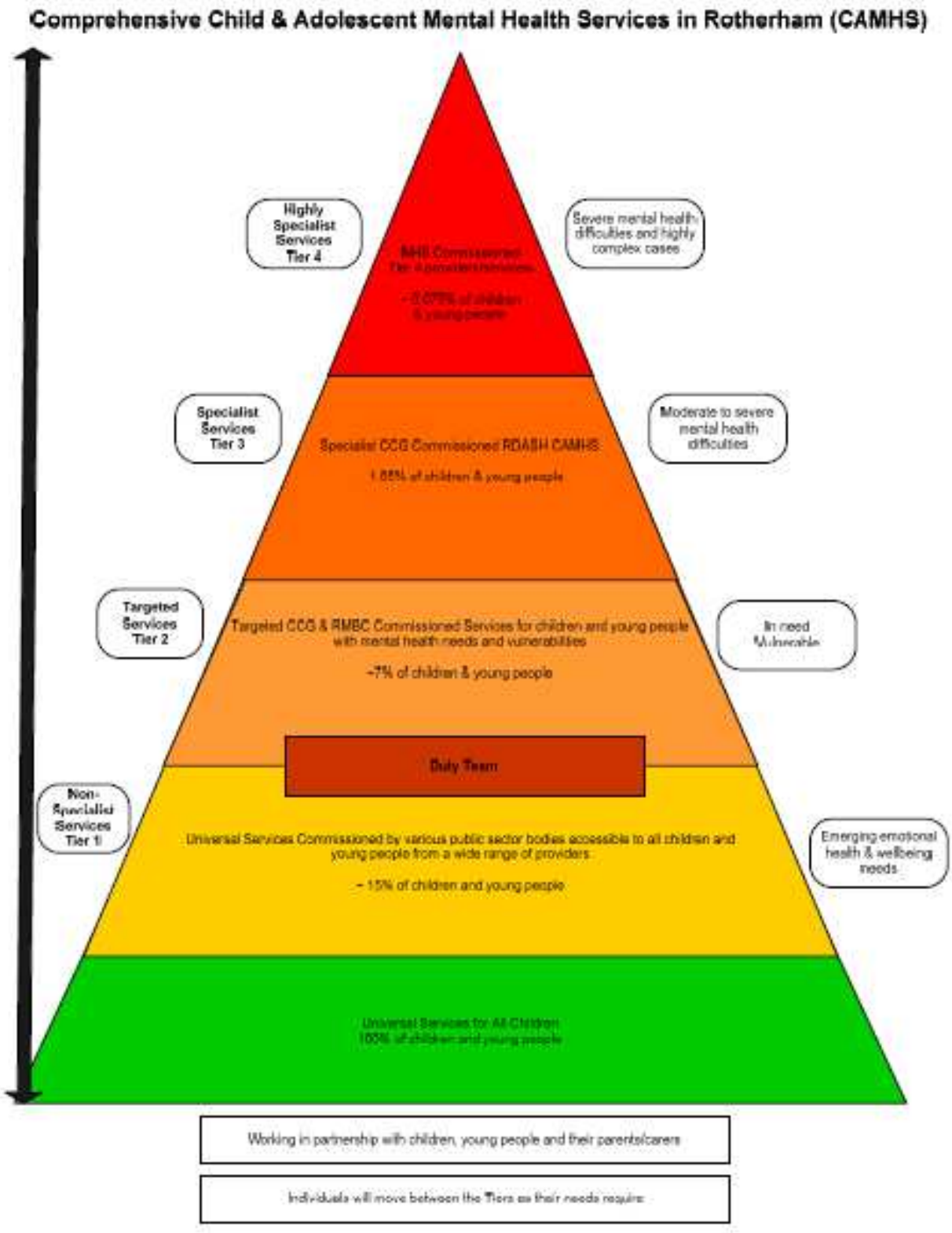
Targeted services Tier 2 - services provided by professionals with training in mental health, usually 1:1. From RDaSH CAMHS this includes social workers, therapists, nurses, doctors and psychologists. Services include assessment, brief mental health interventions, advice for C&YP with mental health problems, and support to GP's and workers from universal services.

Specialist services Tier 3 - services for more severe, complex or persistent conditions, usually by a multi-disciplinary team. Professionals involved may be child psychiatrists, clinical child psychologists, child psychotherapists, nurses, occupational therapists, speech and language therapists, family therapists, and art, music and drama therapists. Tier 3 includes specialist therapeutic interventions, services for those with established problems, diagnostic assessment pathways for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), and mental health interventions for children with a dual diagnosis (learning disability and mental health).

Highly specialised services Tier 4 - such as day services, specialist out-patient teams and inpatient units provided by a range of professionals as in Tier 3, but these are not provided by RDaSH in Rotherham.

Rotherham's 0-19 Population

0-4	5-9	10-14	15-19	Total
16,300	15,400	14,900	15,700	62,300



Kurtz Z, 1996.

4. Context

4.1 National Policy Framework

No health without mental health, a cross-government mental health outcomes strategy for people of all ages was launched by the Government in February 2011, setting out its vision for improving mental health and wellbeing in England in the longer term based on six core objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The strategy was followed by the *Mental Health Strategy Implementation Framework* and *Suicide Prevention strategy* in 2012. In February 2014 *Closing the gap: priorities for essential change in mental health* was published by the Department of Health. This "seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems". It identifies 25 areas where people can expect to see and experience the quickest changes, with four specific issues for children and young people being:

- There will be improved access to psychological therapies for children and young people across the whole of England.
- We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services.
- Schools will be supported to identify mental health problems sooner.
- We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18.

The Children and Families Act 2014 introduced reforms for disabled children and young people and those with Special Education Needs through the introduction of new Education, Health and Care Plans from birth to 25 years. This latest legislation adds to other longer standing policy and guidance on services for children and young people as outlined in the *Analysis of Need*.

4.2 Children and Young People's Mental Health and Wellbeing Taskforce

NHS England published its *CAMHS Tier 4 Report* in July 2014, looking at concerns regarding inpatient services and drawing attention to the complex commissioning arrangements for CAMHS. As a result the Government established a taskforce comprising experts on children and young people's mental health, including children and young people themselves, and key organisations from health, social care, youth justice and education.

The Commons Health Select Committee also undertook an inquiry into CAMHS and their report *Children's and adolescents' mental health and CAMHS* identified problems across the whole of CAMHS. The Committee made a number of recommendations, many directed to the taskforce to address.

The taskforce published its report *Future in Mind* in March 2015 outlining changes and improvements necessary to bring about better access to support and to improve the commissioning and provision of CAMHS. The report identified five key themes viewed as "fundamental to creating a system that properly supports the emotional wellbeing and mental

health of children and young people". These are Promoting resilience, prevention and early intervention; Improving access to effective support – a system without tiers; Care for the most vulnerable; Accountability and transparency; and Developing the workforce.

4.3 Local strategy

Health and Wellbeing Strategy
Rotherham Joint Health and Wellbeing Strategy, together with the Joint Strategic Needs Assessment (JSNA), guide commissioning plans and priorities in order to improve health across the borough and reduce health inequalities. Following a life course framework the "starting well" and "developing well" stages cover ages 0-19. High levels of emotional, behavioural and attention deficit disorders at 4-19 years and high levels of depression from 20+ are key issues that emerged from the JSNA and consultation. The strategy is being refreshed in 2015, providing an opportunity for renewed focus on mental health and wellbeing and in his annual report last year the Rotherham Director of Public Health recommended: "Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems."

Emotional Wellbeing & Mental Health Strategy for Children and Young People 2014-19
A comprehensive strategy and action plan was developed by RMBC and RCCG in partnership with provider services, drawing upon research, national guidance and a detailed needs analysis. Consultation with stakeholders, including parents/carers and young people informed the final version. The strategy contains 12 recommendations (see Appendix B) and has taken account of the Attain review commissioned by RCCG and the RDaSH CAMHS review by Healthwatch.

The Child and Adolescent Mental Health Services Strategy and Partnership Group meets quarterly and oversees the implementation of the strategy and action plan. Representatives from all areas of commissioning and service provision across CAMHS are involved, plus Healthwatch and the Parents Forum. The immediate focus has been on care pathway development, including for ASD and ADHD where specific concerns have been raised, and developing a new website with dedicated sections for young people, parents and professionals.

Other initiatives and plans
Workstreams address mental health and wellbeing across all ages, such as the *CARE about Suicide* guide which follows the principles of Concern, Ask, Respond, Explain developed by Public Health. Specific to young people are the excellent work by Rotherham Youth Cabinet on self-harm in 2014 and a new pathway for support for C&YP bereaved by suicide.

5 Findings

5.1 Impact and prevalence of mental health problems

Impact
Higher levels of deprivation in Rotherham mean the prevalence of mental health disorders is estimated to be 14% above the UK average. This has a significant impact on our community and for individual people and their families and friends, as well as creating more demand for services and support. There is also a substantial financial implication as the annual short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 years in the UK was estimated to be £1.58billion in 2012.

Key facts
- 1 in 4 adults in the UK experience a mental health disorder in the course of a year
- 1 in 5 children have a mental health problem in any given year
- 1 in 10 children aged 5-16 years has a clinically diagnosable mental health problem

- 50% of adult mental health problems occur before the age of 14
- Mental ill health is the largest single cause of disability in Rotherham
- People with serious mental health problems have their lives shortened by 14-18 years on average
- Mental health affects people's academic achievement, employment opportunities and economic activity
- Poor physical health also impacts on mental health with children experiencing a serious or chronic illness twice as likely to develop emotional disorders
- 11–16 year olds with an emotional disorder are more likely to smoke, drink or use drugs
- Around 60% of Looked After Children and 72% of those in residential care have some degree of emotional and mental health problem
- 1 in 10 people wait over a year for access to talking therapies

Prevalence

Although a broad needs analysis informed the development of the EWS it is difficult to maintain an accurate overall picture of C&YP's mental health and the prevalence of mental health disorders/conditions across the borough, including comparisons over time. This is due to the complexity of multiple providers, different IT systems, variations in data recording, and young people moving between or in and out of services as their level of need changes, or potentially not accessing support.

Prevalence rates of mental health disorders in the population are estimated on the basis of national studies, taking account of the impact of socio-economic and demographic factors. However the current national prevalence rates were published by the Office of National Statistics (ONS) in 2004 and are likely to be out of date. This is best illustrated by the scrutiny review of autism spectrum disorder (ASD) which found that the higher than predicted rate of ASD in Rotherham was due to good work locally in raising awareness and successfully identifying ASD as a condition. The ONS rates pertain to ages 5-16 rather than 0-19, so further extrapolation across the full age range was carried out in Rotherham for the needs analysis.

During the course of the Health Select Committee inquiry in Parliament the Government committed to fund a refresh of the national prevalence rates. Members welcome having more up to date research to inform local need and future commissioning plans to ensure effective support and services for children and young people.

The National Institute for Health and Care Excellence (NICE) also publishes clinical guidance on mental health topics and conditions. Other useful sources of local information include:

- annual Rotherham Secondary Schools Lifestyle survey
- numbers of C&YP under 18 who are entitled to Disability Living Allowance for a mental health condition
- numbers of children with a Special Educational Need

In Rotherham, there are an estimated 6,800 children and young people aged 0-19 with a diagnosable mental health disorder, 2,600 with an emotional disorder (anxiety or depression), 4,100 with a conduct disorder, 1,100 with a hyperkinetic disorder (ADHD), 640 with ASD and 280 with a rare disorder. Marked gender differences in prevalence show a much higher incidence of conduct and hyperkinetic disorders and ASD in boys than girls across all age groups and a higher incidence of emotional disorders in girls aged 11-16. Services and support should meet the needs of both male and female C&YP and be sensitive to any specific needs in relation to their other equality protected characteristics or additional vulnerabilities such as homelessness or being a looked after child.

5.2 Costs, value for money and quality of current services

Costs and value for money

It is a challenge to obtain a detailed breakdown of overall spending on CAMHS provision across all the tiers and on respective spending on the three areas of prevention, promotion and treatment as in the World Health Organisation framework. Much activity at lower levels forms part of workstreams that are not dedicated entirely to mental health and emotional wellbeing. Similarly it has been hard to unpick RDaSH areas of spend within its overall contract and RCCG are progressing this with them. Understanding spending will become more significant if there is a move away from the current position of a block contract to a payment by results system for mental health, which is on the horizon. In terms of value for money and the efficiency and effectiveness of spending it is also critical to understand the cost base and to have a robust set of outcome measures.

National

NHS net expenditure was £109.721bn in 2013/14, with planned expenditure for 2014/15 increasing to £113.035bn (NHS confederation). Dawn Rees[1] commenting on the Chief Medical Officer's Report in September 2014 stated that "CAMHS receives only 0.7% of the total NHS budget and only 7% of the total mental health budget is spent on CAMHS. Mental health care receives only 13% of the NHS spending but mental health accounts for 25% of total morbidity in England. The CMO's report shows that there has been a real terms fall in investment in CAMHS since 2011".

Local

The following table shows current spending by RMBC and RCCG within each tier of CAMHS provision.

Tier	Service	Commissioner	Annual cost
1	Families for Change Intensive Family Support	RMBC	112,946
2	IYSS Youth Start	RMBC	128,000
2	Rotherham & Barnsley Mind	RMBC	60,000
2	LAAC Support & Therapy Team	RMBC	229,000
2/3	RDaSH CAMHS	RCCG	2,101,080
		RMBC	139,166

Via a partnership agreement with RMBC the CCG is the lead commissioner for Tier 2 and 3 RDaSH CAMHS services. RMBC contributes £139k p.a. through the CAMHS grant and also funds Know The Score (KTS), the YP's substance misuse service (£218k p.a.). £20,000 of the Public Health budget is specific to mental health for activity such as mental health awareness raising and stress management training. However other workstreams such as promoting healthy lifestyles, occupational health and the work of health trainers also contribute to mental health and emotional wellbeing. For the current partnership agreement period April 2014 - March 2015, RMBC has stipulated that its funding is to be utilised for three CAMHS Locality Workers and workforce development (universal services and RMBC), which aligns with agreed priorities in the EWS.

In terms of mental health spend RCCG is within the top 20 CCGs, spending £30.9m in 2013-14 (including learning disability services) with planned spend for 2014-15 of £31.3m, or just under 10% of the budget. Of this the contract with RDaSH is £28m for services across all age groups, including the £2.3m approx. for CAMHS. The remainder funds out of area and continuing healthcare placements, plus some other smaller providers including VCS.

As with all health providers RDASH has had to make 4% efficiencies in 2014-15 (equating to £1.1m achieved through savings in non-pay expenditure and non-clinical posts) and again in 2015-16. 4% efficiency means a reduction in real income of 1.9% as there is a 2.1% allowance for inflation. There is scope for RCCG to reinvest savings realised in wider services.

Quality of current services
RDaSH was fully compliant in a CQC inspection of Trust services in October 2013 and fully compliant with the Essential Standards of Quality and Safety inspected by the CQC since July 2012, including care planning and record keeping.

'Fit 4 the Future' is RDaSH's organisational development programme, which includes modules dedicated to quality, innovation, culture and leadership. This quality priority is aligned to the Strategic Goal of 'Continuously improving service quality (safety, effectiveness and patient experience) for our patients and carers'. A relatively new quality review team comprising staff from across the trust, equivalent to a "mini Care Quality Commission", has been formed to consider all services. The Strategic Leadership Team in Rotherham meets every two weeks and monitors improvements. Other internal processes include team meetings, business division monitoring, looking at plan delivery, and consideration of complaints and any serious incidents.

Following a contract query RCCG has worked closely in partnership with RDaSH to address certain issues in relation to the CAMHS contract. Through the implementation of a detailed action plan improvements have been made, with positive feedback from GPs. RDaSH provides regular performance data to RCCG as part of the contract monitoring arrangements but there is scope for further development in this area. Monthly contract performance meetings and bi-monthly CAMHS Service Development and Improvement Plan meetings consider performance and quality of services. As stated above the CAMHS Strategy & Partnership group also meets quarterly.

RDaSH engages with families and C&YP to obtain feedback on services and their experiences, which is covered in more detail in section 5.4.

5.3 RDaSH services for children and young people in Rotherham

RDaSH is commissioned to deliver Tier 2 and 3 generic CAMHS services for specific issues including self-harming behaviours, suspected psychosis, mood disorder/depression, eating disorders, severe behavioural problems, anxiety disorders, gender dysphoria, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, suspected ASD and suspected ADHD. The trust also delivers Learning Disability CAMHS and Know the Score. There is no internal step up and down process within RDaSH for C&YP moving between Tier 2 and Tier 3 as the service is an integrated one with interventions delivered dependent on assessed needs. Appendix C provides an overview of staffing and the service model.

"A gentleman visited the shop to tell us the support he receives from CAMHS was excellent. His daughter is currently using CAMHS. " *(Source: Healthwatch Feb 2015)*

"Difficult to access support when someone has a dual diagnosis ..... "

In answer to question 'what worked well?' at Fair's Fayre:
"Talking about problems and working out health related issues." *(Source: Fair's Fayre)*

RDaSH is also participating in the national Improving Access to Psychological Therapies initiatives (also known as talking therapies) for both adults and children and young people. C&YP's Improving Access to Psychological Therapies services are not available in GP surgeries and there is a focus on more use of ICT in delivering the services.

Snapshot of caseload

In December RDaSH provided the review group with a useful snapshot of their current caseload at that time and key information from this snapshot is included throughout this section in addition to the graphs below.

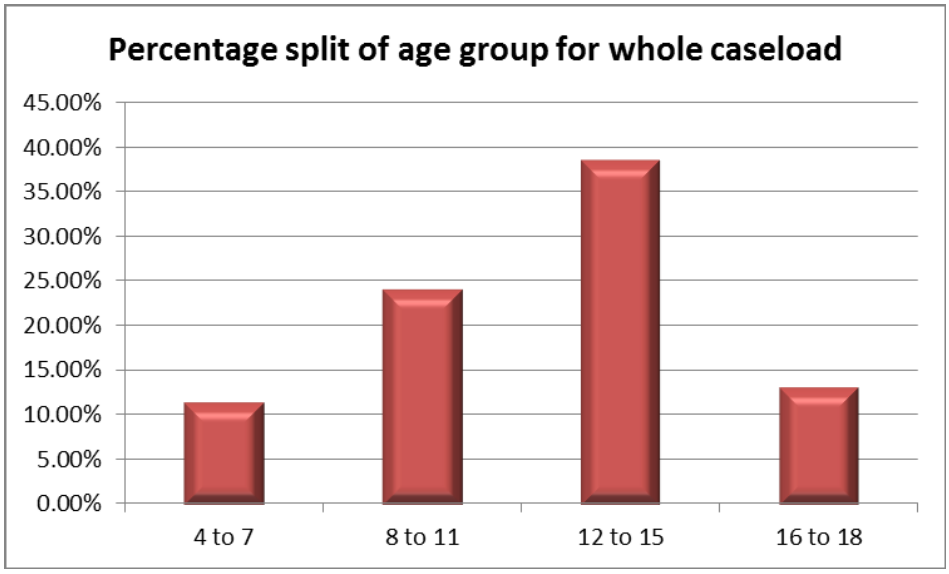
- The caseload includes C&YP from various ethnic communities, although the vast majority (where ethnicity is recorded) are White British. Ethnicity recording is an area for improvement in helping to develop a broader picture of C&YP's mental health across the borough.

- 493 (38%) cases of the open caseload were female and 799 (61.6%) male with five cases where the gender was not recorded, 1297 cases in total.

- LD CAMHS have an on-going case load of approximately 100 service users and KTS 101 cases.

- The 12-15 age group accounts for just under 40% of the caseload.

- The service currently has 12 Looked After Children on its caseload, 23 young people being worked with who are children in need and ten on a child protection plan. None of the Looked After Children had made a self-referral into the service



Referrals by postcode area	Postcode area	Number of referrals	% of caseload by postcode
	S25	119	9.2%
	S26	113	8.7%
	S60	135	10.4%
	S61	190	14.6%
	S62	74	5.7%
	S63	94	7.2%
	S64	83	6.4%
	S65	205	15.8%
	S66	238	18.4%
	Other	46	3.6%
		1297	

Further information provided in February 2015 gives an overview of the numbers of young people within various care pathways but also illustrates where data is not currently collected and reported on at present.

<table>
<tr><th rowspan="2"></th><th colspan="2">On diagnostic pathway</th><th rowspan="2">Comments</th></tr>
<tr><th>Waiting for diagnostic assessment</th><th>At some stage of diagnostic assessment</th></tr>
<tr><td>ADHD</td><td>14</td><td>78</td><td>Plus 274 on the post diagnostic ADHD pathway who are monitored for medication.</td></tr>
<tr><td>LD</td><td colspan="2">90</td><td rowspan="2">In addition to the individual ADHD, LD and ASD figures there are 517 YP currently in treatment with the service who will be receiving interventions from those pathways and may be involved with multiple pathways at any given time e.g. a YP on the ADHD pathway may also be receiving interventions from the self-harm or emotional disorders pathway.</td></tr>
<tr><td>ASD</td><td>57</td><td>45</td></tr>
<tr><td>Self-harm</td><td colspan="2" rowspan="3">RDaSH do not currently collect data</td><td>Anecdotally staff in the core and duty teams observe that an increasing number of YP are presenting with self-harm.</td></tr>
<tr><td>Depression</td><td></td></tr>
<tr><td>Conduct Disorder</td><td>Anecdotally CYP-IAPT trainees say that for YP meeting the NICE criteria for conduct disorder it was often challenging to maintain sessional work with the families to provide interventions due to the wider nature of the social/welfare issues.</td></tr>
</table>

RDaSH CAMHS Duty Team

Following a service reconfiguration in November 2014 the team comprises four experienced clinicians on a permanent basis rather than being staffed in a less structured manner, including with agency staff. Three of the clinicians are on duty each day supported by a medical member of staff as necessary. The team is available between 9am and 5pm Monday to Friday for families and professionals to contact them for advice and guidance on referrals and support. The aim of the reconfigured service is to improve the consistency of decision making for referrals and build expertise, as well as being an access pathway.

The team members will also link with and signpost to other agencies if referrals do not meet RDaSH criteria. They lead the weekly clinic at the IYSS Youth Hub (see below) and liaise with paediatricians and A&E at the hospital. Another role of the Duty Team is to build links with GPs through attending the GP locality meetings. The next phase of locality based work to roll out will be in schools and other youth and community settings in line with the CAMHS grant funding and EWS.

Staff are supported through clinical supervision to manage their caseload workload with fortnightly clinical meetings for multi-disciplinary discussions around complex cases and risk management.

Further developments through the EWS are to look at developing a single point of access for services with an RDaSH Duty team member working with RMBC Early Help team. In this way

people presenting to community services or GPs with a low level of need that is inappropriate for RDaSH CAMHS can be referred promptly to the right support, with less likelihood of C&YP slipping between tiers or providers. RDaSH suggested that to ensure gaps are minimised a series of locally agreed standards for services would enable each referring or transitioning agency to be assured that the care of the YP had been accepted.

Self-referral
RDaSH CAMHS initiated a self-referral system for young people aged 14+ to refer themselves to their service in September 2013. In the period Jan-Nov 2014 there were 17 self-referrals, numbering between 0 and 3 each month.

The IYSS Youth Hub at Eric Manns Building in Rotherham hosts a joint Youth Start and RDaSH weekly drop-in clinic for assessment and self-referral into the most appropriate CAMHS to meet the needs of the young person. Between April and November 2014 37 young people aged 12-17 years, mainly female, had attended. Joint decision making takes place with the young person regarding their support. Young people have also phoned the Duty Team directly to self-refer rather than go through the joint clinic.

GPs are informed following assessment as with any other referral, but not necessarily the family. This will be dependent on the wishes of the YP and their competency to consent although RDaSH try to persuade all YP to involve their family. In any cases where the risk assessment suggests there are risks the family need to be aware of (and the YP does not wish RDaSH to inform them), discussion would take place with the safeguarding nurse.

Pilot - Additional Psychiatrist
Concerns were raised by practitioners and GPs regarding access to consultant psychiatrists, leading to long waiting times for diagnostic appointments and treatment. Another issue was in relation to access to suitable staff by ADHD clinic users who have a medication review every 3-6 months. In response it was decided to pilot having an additional 1.0 WTE Consultant Psychiatrist (through non-recurrent funding at present) so that service users, families and GP's would benefit from better and timely access to specialist expert knowledge and skill. A locum Consultant Psychiatrist was recruited in June 2014 to support the duty team, paediatric liaison and ADHD clinics. This will be reviewed during the discussions regarding service planning and funding for 2015-16. Members would like to see this additional funding become recurrent.

Out of hours
As part of the service specification RDaSH must provide a 24/7 emergency assessment service by a CAMHS clinician for children and young people experiencing acute mental health difficulties. Another pilot project has established an out of hours on-call service staffed by CAMHS clinicians on a rota at weekends, with the clinician on duty at Rotherham Hospital. Referrals may be by other professionals or people may arrive at A&E initially. In addition the Crisis Team provide 'out of hours' support to CAMHS patients aged 16 to 18.

Sickness absence
RDaSH staff turnover is very low in Rotherham but there has been high sickness absence in the last 12-18 months (5.4% in 2013). Longer term absences will be covered by agency staff but sometimes on the day appointments have to be cancelled if no-one else is available. There is a robust monitoring system with triggers for both short- and long-term absence. Counselling and staff workshops such as stress busting are available for support if staff have difficulties. The trust is working to tackle sickness absence but it is another factor that has impinged on access to services.

Referrals
A key concern has been referrals made to RDaSH CAMHS that do not meet their criteria and in the past this has led to referrals being bounced back rather than referred on to another service.

On the other hand RDaSH have tried to signpost to other agencies only to find that some provision is no longer available or the thresholds have changed.

One of the issues that emerged during the review was the lack of core information provided on many of the referrals to RDaSH from partner agencies. This is causing delays in triaging the referral as the Duty Team waste time chasing up the requisite information on which to make a decision. RDaSH calculate that a lack of sufficient information results in an additional average of 90 minutes time spent, per referral, contacting various parties. Between 1 Nov – 18 Dec 2014 RDaSH received 11 GP referrals that provided little or no clinical information that would allow the duty team to triage the referral. This will be fed back to the commissioners through existing reporting processes.

Common Assessment Frameworks (CAFs) are a comprehensive source of information but are not appropriate for all referrals and would be too time consuming for GPs to complete. The service does not currently record whether or not a CAF is received with the referral and anecdotally this is thought to be less than 5% of all referrals received.

Although RDaSH assured Members that all agencies may contact the Duty Team and make referrals the review heard of schools not making direct referrals themselves but referring families to their own GP first. This contributes to further delays in the YP receiving support and potentially means an unnecessary GP appointment when it is widely documented that GPs are struggling with the volume of demand for appointments. Conversely information shows referrals from health professionals seemingly being rejected by RDaSH because schools had not been involved. Members learned that for ADHD and ASD diagnosis RDaSH need to take account of reports from Educational Psychologists. This may sometimes cause delays as the service is now commissioned in a different way and is no longer universal although the vast majority of schools do buy in the non-statutory element.

"Eight year old who has been referred to CAMHS once by a consultant from RGH and twice by her GP. CAMHS have refused to assess her son stating that it has to be the school who refer. School have also refused to refer to CAMHS."

"Son has been referred three times to CAMHS and three times CAMHS have refused to assess him." *(Healthwatch)*

'Top Tips' documents developed through the CAMHS Strategy and Partnership Group provide guidance for GPs and partners (Appendix D) respectively to assist them in referring young people to the appropriate mental health service. In essence these outline the access criteria for services depending on the issues or symptoms presented. Complementing these is a directory of services outlining emotional health and wellbeing provision and the level of need (universal, vulnerable, complex or acute) at which the services operate.

Members emphasised the importance of awareness raising and training with partners and schools to resolve the issues for making and accepting referrals and to ensure the right information is provided at the outset. Using the top tips guidance and maintaining the directory of services up to date is also vital to ensure referrals are made to the right service as provision and access thresholds change over time.

It is understandable that parents will not always agree with decisions made regarding support and assessment for their children, especially when they are struggling. Tensions and upsets have arisen in particular when RDaSH have said that a case is a parenting issue. This is where clear communication and sensitivity is called for with parents/carers and C&YP, explaining the reasons why a referral to a particular service is not judged to be appropriate and ensuring that the YP or their family are signposted or referred on correctly.

Waiting times for assessment and treatment
RDASH CAMHS have key performance indicators (KPIs) for waiting times for assessment and treatment to meet as part of their contract specification. All referrals are triaged within 24 hours by the Duty Team, who also assess the urgent cases within 24 hours of receipt of referral, with face to face follow up within 7 days. The KPI for assessing routine referrals is 15 days, which is a higher target than many areas in the country. Waiting times for both assessment and treatment have been reduced after a concerted effort to address them and additional short term funding but the service is struggling to meet demand. As at December 2014 the number of C&YP awaiting assessment was 245 with new referrals coming in each month. Appendix E provides detailed statistics on waiting times for assessment and for treatment on a monthly basis and weekly data with regard to the three week target. In June/July 2014 C&YP were waiting over 14 weeks for a generic appointment, but this is now down to five weeks.

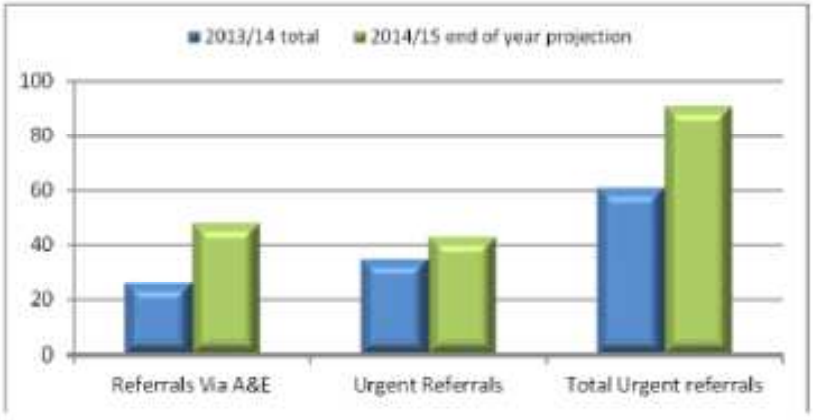
At the evidence session in November the following data was presented.

Target	Performance
100% of patients receiving initial Mental Health Assessment within 24 hours in A & E	100%
100% of referrals triaged for urgency within 24 hours	73.6% due to a recording issue (but usually above 97%)
100% of Urgent referrals assessed within 24 hours	80% (family reasons such as not wanting assessment)
95% of triaged referrals assessed within 3 weeks	11.2% - current wait 8 weeks (since reduced to 5)
95% of patients treated within 18 weeks	93% (at September).

Overall RDASH CAMHS is receiving a high level of referrals, which impacts on the numbers waiting for a service, particularly C&YP waiting for routine assessments as the urgent referrals will be prioritised first. Service capacity is for 131 referrals per month with an average of 91 referrals accepted into the service, the remainder referred on or signposted to other services. Averaging 158 referrals per month on top of those still waiting adds to the difficulties. In addition urgent referrals have averaged 12 per month, plus the small number of self-referral assessments. Extra agency staffing has augmented the number of assessment and follow up treatment slots available each month to try and reduce the backlog. Appendix F has more details of capacity and demand.

Numbers of referrals reduce in August and December and rise again after the school holidays. Contacts with the duty team and referrals also increase during the build up to school exams and coping with exam stress is an area the Youth Cabinet are discussing with RDaSH.

The graph below shows the projected total of urgent referrals for 2014-15 compared to 2013-14 (based on data to the end of October 2014) – a projected increase of 50%. Urgent referrals via A&E had already passed the total for last year by October.



Health partners believe reductions in provision in universal Tier 1 services have had a knock on effect on services at Tier 2 and above, evidenced by greater numbers of referrals, especially urgent referrals. A shortage of inpatient beds at Tier 4 also creates pressures at Tier 3 and RDaSH has had to redirect resources to provide a safe, appropriate service for some YP.

Other factors contributing to increased referrals are benefit reform and long-term sickness absence from work through stress and mental health disorders during the economic downturn in recent years. Financial pressures and parental mental health and wellbeing issues tend to increase the risk and vulnerability for their children's emotional health and wellbeing.

RDaSH undertook a detailed capacity and demand review, working with individual clinicians, reviewing their caseloads and developing a job plan that fits with the requirements for their current post. This has been shared with commissioners and discussions are taking place regarding possible additional funding to meet the increased demand.

Members did discuss the overall resourcing of CAMHS services across the board and in particular at the lower levels to support prevention and early help and support, which is central to RMBC's policy framework for C&YP and the Joint Health and Wellbeing Strategy. C&YP benefit as they receive support and/or treatment earlier before their needs increase, including also hopefully preventing escalation into adulthood, and saves money in the longer term. Members recognise the squeeze on resources and the negative impact this has had on some services but hope their recommendations will help to deliver change through more effective use of existing resources coupled with the positive changes made by RDaSH and through the implementation of the new EWS.

"Waiting long time between getting to speak to someone and getting help – 2 month backlog"

"Daughter getting worse whilst waiting for treatment." (Fair's Fayre Oct 2014)

Length of time in RDaSH CAMHS

One point discussed with health partners was the length of time some C&YP are engaged in services and whether there was scope to move patients/service users on more quickly, reducing waiting times for other YP to gain access to services. This is a difficult issue as there are always judgements to be made about prioritisation of need and how ready people are to move on safely to other services or to be discharged. Such decisions have to be made by the clinicians with patient/service user and family/carer involvement, ensuring that adequate support is in place for the next phase of their recovery. RDaSH say that if young people form an attachment it can be hard for them to cut links. Members did not request data on this issue so it is not clear if length of time in services is routinely captured to inform a borough wide profile.

Appointment times and missed appointments (DNAs)

Concerns had been raised that CAMHS deleted children's names from the waiting list if they missed the first appointment but RDaSH made it clear that this does not happen. However, if a family DNA then their waiting time re-calculates to the date of the missed appointment so their position on the waiting list changes in line with the revised date. The waiting list is refreshed and monitored daily, and also forms an integral part of weekly performance monitoring meetings and monthly divisional performance meetings.

A Trust Policy deals with the process for both DNAs and families who are disengaging from the service. A revised Standard Operating Procedure and flow chart details the process to follow after a DNA for an initial assessment. A clinician assesses the risks and action needed if either the family cannot be contacted or they have been contacted and do not want a further

appointment. Members also noted in one of the case studies determined efforts made by RDaSH to remain in contact with one YP who had missed an appointment.

RDaSH CAMHS are primarily delivered from 9-5 at Kimberworth Place, which can be a barrier to access as this is during standard working hours for parents/carers and within the school or college day for young people. This is also reflected in satisfaction scores for convenience of appointment times which was the lowest score on the questionnaire (see Appendix G Figure 1). RDaSH would prefer to have the current 15 day target for routine assessments raised to 20 days feeling that this would enable them to offer families more choice of appointment time and venue. This issue is currently under discussion with RCCG.

Members sought feedback via the Parents Forum around the timing of appointments, with the following response:

"The general consensus is that in the main families appreciate a quick appointment and value the short time scale, alleviating fear and feeling relieved that the process has begun. However, they were also anxious that should they not be able to make the appointment offered because of other commitments they would be 'put to the bottom of the list' (direct quote from experience of a parent when offered an appointment). In light of this, once contact is made with the family for an appointment, a mutual time/date arranged would be valued. Quite often the appointments are set in stone and offered with no alternative rather than mutually agreed."

Members spent some time discussing the 15 day target and current performance on waiting times for treatment and assessment. Their view was very clearly that C&YP need to be assessed and receiving treatment and support at the earliest opportunity and that every effort should be made to reduce delays in the system to reduce the risk of the young person's mental health deteriorating. Plans to roll out services to a wider range of locations across the borough and with more flexibility over times were welcomed by the review group and this should be prioritised as part of service reconfiguration and development. However Members recommend that the 15 day target remains in place during 2015-16 as some of the recent positive changes being made by RDaSH and through the EWS action plan should be bedding in.

Communications and information

Clarity on what the various providers deliver and their respective access criteria is paramount for all agencies, C&YP and their families. This is best illustrated again by ASD, as although RDaSH CAMHS carry out diagnosis of ASD their remit is not post diagnosis support unless the young person also has a mental health problem that meets their criteria. As the Autism Communication Team is a school based resource RDaSH cannot refer YP to the team post diagnosis. To this end the pathway development planned for a number of conditions within the EWS will be positive and as stated earlier the CAMHS Strategy & Partnership group has prioritised its work on this.

A new website with sections for C&YP (with involvement from Youth Cabinet members), parents/carers and professionals respectively is under development and due to go live from April. Members expect the website to be accessible and include a mechanism for feedback from users and that it will be capable of recording the number of hits each section receives so partners know the extent to which it is being used.

Transition

Transition refers to YP leaving CAMHS services when they reach 18 years and transferring into Adult Mental Health Services (AMHS) if required. Nationally and locally transition has been recognised as an area for improvement and the quotes show two very different experiences.

"Long time still in CAMHS when should be in AMHS"

"CAMHS ended and AMHS not commenced, information wasn't shared." (Youth Cabinet research)

Currently six young people have a referral to AMHS ADHD Clinic, plus 27 potential transitions that may be required to this service, depending on whether they require medication reviews or therapy post 18 years of age. Five young people within the Learning Disability Pathway Team are at various stages of transitioning to adult services. Within the core team three young people have had a joint transition plan meeting and are in the process of transitioning to adult services, two of whom currently have a referral to AMHS. Another three young people may also require transition to adult services and discussions are currently taking place.

Peer Support Workers
In this award winning initiative the trust has recruited people who have a lived experience of mental health problems to support young people through the transition process if they require on-going mental health support beyond their 18th birthday. Transition work commences at 17½ years when the worker will meet with the YP, talk about the transition, provide support in meetings with AMHS and advocate on behalf of the YP. In conjunction with Speak Up one of the Peer Support Workers supports YP who also have learning disability who will need to transfer to Adult learning disability services. Service user evaluation of the benefits of the Peer Support Worker role has been positive.

Outcome Measures
Routine outcome measures and session by session feedback are being introduced to improve the quality and experience of services, with CYP-IAPT trainees initially being the main providers of data. Peer Support Workers are also using sessional feedback. Figure 2 in Appendix G shows good average feedback scores for four questions. Some outcome measures particularly promote the principles of recovery, mainly goals based outcomes with young people identifying their own goals and measuring progress against them each session.

This is a positive step and an area for further development. Outcome measures also need to be linked to the definition of treatment which is currently classed as the second appointment by RDaSH. The service is working with RCCG on this matter to ensure new definitions are agreed that are meaningful for both the individual and in general for mental health services.

5.4 Engagement with young people and their families and carers

'Listen to Learn', is the Trust's Patient, Carer and Public Engagement and Experience Strategy. It is defined as the active participation of citizens, patients and carers and their representatives in the development of health services and as partners in their own health care.

RDaSH employ a range of methods to engage with service users and their families and to elicit feedback on their experiences of using services. Examples include:

- 'Experience of Service' questionnaires - as part of capturing service evaluation parents/carers are invited to complete anonymous surveys, available at Kimberworth Place and community settings. Results are collated every quarter (see Appendix G Figure 1).
- Patient feedback is received via the Patient Advice and Liaison Service (PALS) and local Your Opinion Counts surveys
- Rotherham Parents Forum Ltd. – parents/carers from across the borough who work in partnership with RMBC and RCCG to influence policy and improve the quality, range and accessibility of services for C&YP who are disabled or who have additional needs.
- RDaSH created a new Parent Support Officer post as a result of the Healthwatch report to set up support groups for parents/carers.
- The Peer Support Workers designed a poster campaign to recruit children, young people and families to engage in service planning and consultation; and led various consultation events in local colleges and schools which have informed service development.

- Young people have been involved in interview panels for clinicians.

The Healthwatch report did identify engagement and communication with families as an issue, including parents/carers not feeling listened to or not being involved in their child's care and discharge planning. RDaSH responded positively to their findings and are working with them on further improvements, so this report will not replicate further details from the Healthwatch report.

5.5 Rotherham Youth Cabinet

Like the Health Select Commission Rotherham Youth Cabinet (RYC) have a focus on mental health this year, following on from their recent work on self-harm. They have carried out their own research to gather the experiences of YP who have used RDaSH CAMHS and are currently working with RDaSH clinicians to discuss ways to improve services and information.

> "Better to have counselling in youth centres as this is a more comfortable setting for YP and they are more likely to open up." (Youth Cabinet research)

Key issues they have identified include long waiting times, uncertainty about available services, support with exam stress, feeling uncomfortable at Kimberworth Place and transition to AMHS, especially if YP have only started using CAMHS at 16 or 17.

Members recognise the valuable input that RYC will have in helping to inform service development and will request an update report later in the year to see how RDaSH have responded to their research and suggestions.

From meeting with RYC during the review Members learned that Personal, Social, Health and Economic education (PSHEE) in schools seems to be reducing, despite good resources being available through the Health Schools co-ordinator. This is a concern as schools do have wider social responsibilities and should be working with young people on a range of issues such as domestic abuse and healthy relationships, mental health and wellbeing, bullying and CSE - providing support, via the curriculum and through PSHEE. The recent House of Commons Education Committee report *Life Lessons: PHSE and SRE in schools* recommended that PSHE and Sex and Relationships Education (SRE) should be given statutory status.

In addition to identifying and responding to C&YP with behavioural difficulties or potential ASD or ADHD schools are well placed to identify any emerging emotional wellbeing issues.

5.6 RDaSH Case studies

As requested prior to one of the review sessions RDaSH brought anonymised case studies with them to discuss in depth, which included different complex issues for three young people, two female and one male. Referral routes to RDaSH had been through the GP and by self-referral. A range of factors were covered which had contributed to the young people becoming unwell and/or needing support. These case studies included difficult personal and family relationships or home environments, being a looked after child, the YP's sexuality, attachment issues, bullying at school and issues arising from the YP developing their gender identity. YP presented to services with issues that included low mood, self-harm, trauma, suicidal thoughts, and possible ADHD.

All three cases involved services and support from multiple agencies and two of the three showed very clear involvement of the YP in decisions about their care. The third was at an earlier stage so the focus was on engagement and support to manage risk. One case necessitated a very intensive intervention in the first few days to deal with the immediate crisis

and ensure the young person's safety before starting to deal with the underlying issues. Two cases resulted in a referral by RDaSH CAMHS to the child sexual exploitation team.

Members recognised the good interventions in these case studies to ensure the young people were safe and the multi-agency partnership working approaches to provide support, manage risk and ensure continued engagement by the YP with the service.

5.7 Partnership working

Multi-agency work
RDaSH confirmed that once more than one partner is involved in a case multi-agency meetings usually take place even if the case is not at the level of safeguarding. Different agencies call the meetings including RDaSH, and social care will call them if there are legal issues. As there are potentially so many meetings RDaSH staff seek advice over which to prioritise and this is decided on a case by case basis. Sometimes meetings are called with very tight deadlines and if someone is on leave or off sick a written report is submitted. Commitment from all agencies is improving but there needs to be clear outcomes, actions and respective responsibilities.

Partnership working on child sexual exploitation and support for looked after children are covered in sections 5.8 and 5.9.

Multi Agency Safeguarding Hub
Data provided by the Multi Agency Safeguarding Hub (MASH) shows the origin of contacts to the team. Between 1 January – 24 March 2015 17,845 contacts were logged from 79 sources such as self-referral, members of the public, family members, schools and a range of partner agencies including RDaSH. 46% of contacts were from the police. Contacts with the team relate to many issues and include messages about current cases and requests for information, not only referrals. From 1st April 2015, when the MASH is fully established, further work is planned with regard to logging contacts as currently there is some grouping under broad headings such as "Other health services" so this will provide a more precise overview.

Mental and physical health
Members were keen to explore how RDaSH works together with other partner agencies to improve both the mental and physical health of C&YP, given the impact that one has on the other. The expectation of RDaSH is that every care plan will address the issues identified in the initial assessment and risk assessment and be holistic, addressing physical, mental, social, personal relationships, spiritual, cultural, emotional, educational and daytime activity needs. The care plan should draw on any available wider multi-agency assessment information such as a Common Assessment Framework, Early Help Assessment or Core Assessment and be shared effectively with those who are part of it.

All YP are assigned a care coordinator or lead clinician who would take responsibility for their overall mental health care whilst involved with RDaSH CAMHS. The care coordinator liaises with other agencies such as school or CYPS if needed and also informs the GP about the assessment information, plan of care, any changes whilst in treatment and a discharge letter outlining the intervention and treatment received. Whilst the care coordinator will be expected to deliver a holistic plan of care the GP would be expected to retain oversight of wider health issues. Where there are co-existing or potential concerns related to physical health or development, systems are in place to ensure GP's and paediatricians can assess and treat physical health needs as part of the overall care delivery. There is also weekly dietician input into the service.

Clinical staff represent the service on the multi-agency pathway development meetings which take a multi-agency approach to care. The service is also represented at the clinician to

clinician meetings where all partners discuss and explore solutions for the delivery of joined up multi-agency care.

5.8 How child sexual exploitation is integrated within RDaSH CAMHS provision

Overview and Scrutiny Management Board (OSMB) undertook in-depth scrutiny of Rotherham's plans to tackle child sexual exploitation (CSE) in December 2014 following publication of the Jay Report. Therefore in this review Members did not intend to duplicate that work but wished to be clear on the current position. OSMB established that RDaSH will ask direct questions of service users, which may uncover issues of historical abuse for some people.

RDaSH work with C&YP who are vulnerable and have been abused when there are known or suspected emotional or mental health needs that meet their service criteria. However they are not commissioned specifically to provide post abuse support. Currently there are 30+ C&YP in the service with mental health problems who have experienced CSE and they tend to be in either generic CAMHS or Know the Score. Additional disclosures have been made recently.

RCCG have provided RDaSH with additional short term funding for 0.4wte clinical psychotherapist to March 2015 as part of the local response to CSE. The extra clinician is providing therapeutic work and consultation (specific to CSE victims) across child and adult mental health and providing support for other practitioners.

RDaSH are represented on the Local Safeguarding Children Board and involved in the multi-agency safeguarding arrangements. Two of the three case studies discussed during the review involved referrals from RDaSH to the CSE team. Information was fed back that RDaSH needed to keep the YP safe but not all information is shared by the CSE team if it could impact on investigations or evidence.

Staff are trained to recognise the signs of CSE but as Members learned during the review C&YP will present with one issue but often have other underlying issues which it may take time to uncover and it is not easy for C&YP to disclose abuse to a stranger.

Ongoing work is taking place on CSE by Scrutiny, which will include support to victims and survivors, and the evidence gathered as part of this review will feed in and inform the further scrutiny of services.

5.9 Support for Looked After and Adopted Children

Following a service reconfiguration seven years ago RMBC established the Looked After and Adopted Children's Support and Therapeutic Team (LAACSTT), providing a dedicated service based around the needs of LAAC in the areas of emotional and developmental health and attachment. The service provides training, resources, advice and support to foster carers and adoptive parents, residential staff, social workers and other professionals. Support and direct interventions offered include art therapy, parenting advice, attachment based care, life story work, trauma based work, theraplay, counselling and solution focussed work. The LAACSTT operates mainly at Tier 2 with a clear focus on prevention through training, but also deliver some Tier 3 work in clinics. All the LAC have experienced abuse or neglect otherwise they would not be in care, therefore they all need therapy but not all will want it.

The team work with carers so they better understand why a child might be acting up or rejecting them. This entails teaching and training with carers to skill them up in being able to offer therapeutic care to C&YP and to be able to talk about issues as a family. Group work enables work with larger numbers but some carers prefer 1:1s. Others prefer to ring for advice without wishing to attend a course, or being able to because of work commitments for example. Health

visitors can help when children are under 5 and it is important that all parents and carers are able to access telephone advice. The LAACSTT also wishes to develop the therapeutic skills of staff in residential care homes to work with C&YP in a similar way to foster carers.

The team has to complete an annual Strengths and Difficulties Questionnaire for each individual LAC as a government performance indicator. Over 11s complete their own version of the form and once analysed the LAACSTT ring the YP back to discuss it. The key is to capture information with regard to outcomes and if the C&YP are doing better in care.

RDaSH provide services for LAAC with more complex needs at Tier 3 but there is liaison between the two services, and with Education Psychology where needed, to ensure appropriate interventions. LAAC at risk of self-harm or with suspected autism would be referred to RDaSH CAMHS as they are specialists in these areas. .

"Young people have felt that the waiting times are too long."

"Waiting 18 weeks to be seen isn't good enough, she was in a bad place, however when she was seen she felt positive about the support she received" (*Youth Cabinet research)*

One local gap is that RDaSH do not have a forensic team for work with YP who have committed offences but are not under the Youth Offending Team, for example YP who could be sexually harmful to other children. Special assessments are in Sheffield and often the LAACSTT arranges to take the YP rather than incur higher costs of the clinician coming to Rotherham.

The LAACSTT ensures Rotherham C&YP in care placements out of the borough, or who have been adopted and moved to another area, receive the right service. If other CAMHS services are needed the team has worked well with RCCG who will commission the necessary services. One example was a YP out of area whose local CAMHS had a seven month waiting list so arrangements were made for RDaSH to see the YP.

The Departments of Health and Education published new joint statutory guidance in March 2015, *Promoting the health and wellbeing of Looked After Children*, for local authorities, NHSE and clinical commissioning groups. It reflects changes to the NHS following the Health and Social Care Act 2012, the reform of the special educational needs legislative framework and the need for parity of esteem between mental health and physical health. Partners will have to take account of this guidance in their work. A recent CQC inspection of RCCG with regard to LAC and Safeguarding is also likely to make recommendations about future services and support.

Child Sexual Exploitation
The LAACSTT takes clinical psychology trainees from university, who are close to qualifying, on placement. One of whom recently worked with the CSE team, helping to devise their in-school strategy and working with them on evaluating their work on CSE to help them think more therapeutically and about needs.

Training for foster carers to spot any signs of CSE and training for in house staff as to why YP are vulnerable was highlighted as being vital. The LAACSTT have worked with victims and survivors of CSE, providing some with therapy for the trauma they have experienced and others with support for anger management to deal with their anger towards their abusers.

6 Conclusions

Although the principal focus of the review was RDaSH CAMHS these services are not provided in isolation but are part of a complex system of service commissioning and provision. As a result the review group has made a number of wider recommendations besides ones which are pertinent only to RDaSH.

The new Emotional Wellbeing and Mental Health Strategy for Children and Young People is a positive development and good example of partnership working. Implementing the supporting action plan should address key issues Members explored in this review and help to resolve many of the barriers and difficulties C&YP and families are experiencing in accessing mental health services. Data quality remains an issue and it is important that once the initial activities in the strategy are carried out there should be greater attention on improving and measuring outcomes for C&YP.

Similarly changes to RDaSH CAMHS provision are also positive, such as the reconfigured Duty Team, joint clinic with IYSS and self-referral. As some changes are still quite recent they will take time to embed and should be reviewed and their impact evaluated in due course. More flexible services available across a range of community settings, and greater links to youth services and schools are a priority to progress further.

Reduced provision within universal Tier 1 services has had a knock on effect on demand for services at higher levels of the pyramid and C&YP's problems are likely to become more acute through not being able to access earlier support. Shortages of inpatient beds at Tier 4 also increase pressures at Tier 3 to provide a safe, appropriate service.

Although RDaSH has succeeded in reducing waiting times for routine assessments the target is still being exceeded and the service is likely to continue to face high volumes of referrals. Nevertheless with the potential for the improvements mentioned to relieve some of the pressure on RDaSH CAMHS, and taking account of parent and YP's views, Members recommend that the target waiting time for routine assessments should remain at three weeks.

In line with the strategic framework for C&YP in the Children's Plan and Early Help Strategy prevention and early intervention work should still be the focus to try and reduce the number of young people needing support at higher levels or continuing into adulthood, given the emergence of many lifelong conditions during adolescence. The refresh of the Joint Health and Wellbeing Strategy with its core priority of prevention and early intervention provides an opportunity to revisit provision in Tier 1 and to focus more on the role of schools in early identification of problems, pastoral care and Personal, Social, Health and Economic education.

Improved communication and information sharing between agencies and with families, clarity over access criteria and pathways, and renewed attention on health promotion, self-help and early support/treatment will help to reduce the number of young people with deteriorating mental health and emotional wellbeing, or in crisis.

Clearly it is better for C&YP's health and wellbeing if they receive support and treatment early before their problems increase or their condition worsens, but it also saves money on costlier interventions at a higher level or later in life. This issue is the focus of action 4.5 in the EWS and is a key one in the context of ensuring early support within ongoing financial pressures.

A single point of access to CAMHS, with the young people then referred to the most appropriate service based on their level of need through effective triage, seems a positive step towards building services with the needs of the YP at its heart and surmounting some of the operational difficulties noted in the evidence to this review.

Members discussed vulnerability and additional needs of YP at length during the review. They emphasised that the care pathway development needs to take account of equality protected characteristics and potential additional vulnerability such as being a looked after child.

7 Recommendations

1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on the service users and patients:
    a. to help maintain a detailed local profile of C&YP's mental health over time
    b. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

5. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

6. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)*

    Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

7. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

8. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

9. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

10. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

8. Thanks

Our thanks go to the following for their contributions to our review:

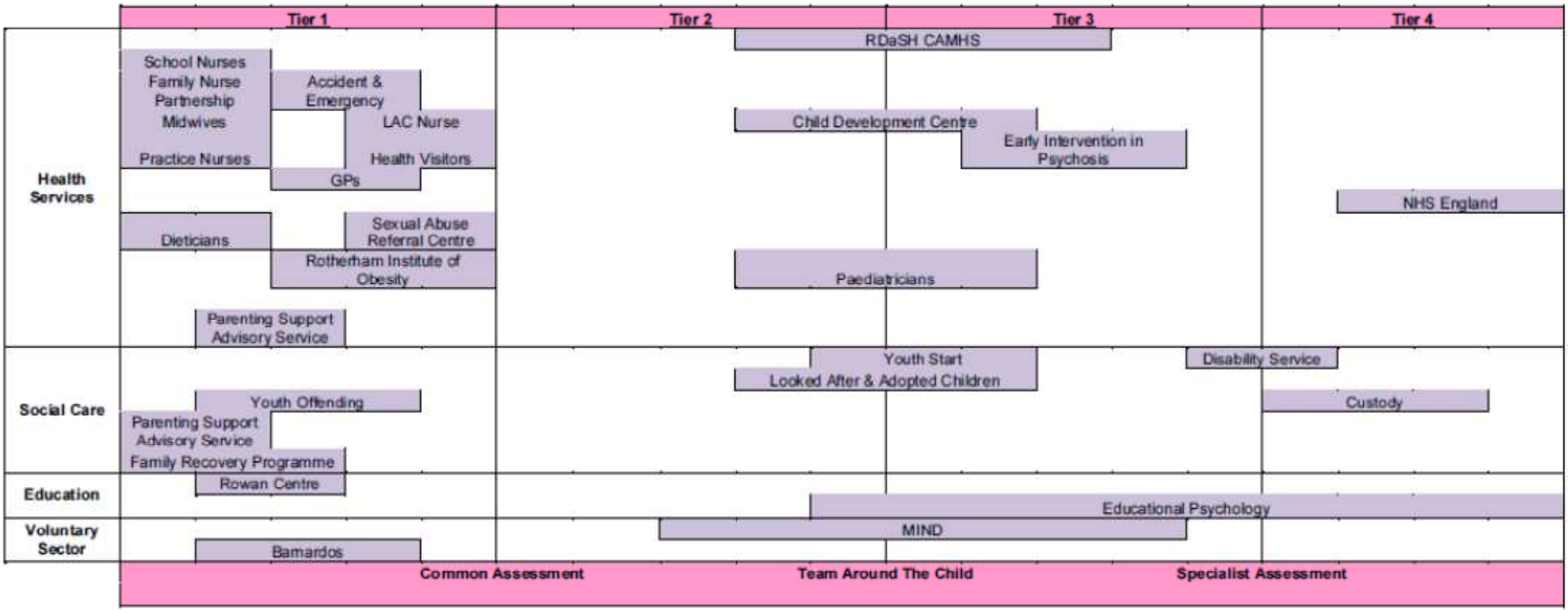
Partners and RMBC

Nathan Batchelor - Rotherham Healthwatch
Dr Russell Brynes - Rotherham Clinical Commissioning Group
Dr Robin Carlisle - Rotherham Clinical Commissioning Group
Dr Alison Davies - Rotherham, Doncaster and South Humber NHS Trust
Karen Etheridge - Rotherham, Doncaster and South Humber NHS Trust
Ruth Fletcher-Brown - RMBC
Melanie Hall - ex Rotherham Healthwatch
Nigel Parkes - Rotherham Clinical Commissioning Group
Neil Power - Rotherham, Doncaster and South Humber NHS Trust
Sharon Schofield - Rotherham, Doncaster and South Humber NHS Trust
Rotherham Youth Cabinet members: Ashley, Avumile, Emilia, Katie, Koukab, Leah, Mark, Oliver, Owen, Paige, Rebecca, Tom, Toni and Zakki (supported by Sarah Bellamy from IYSS)
Paul Theaker - RMBC
Dr Sara Whittaker - RMBC

9. Background papers

- Mental Health Scrutiny Reviews, Report to Health Select Commission, 11 September 2014
- Notes and presentations from review evidence sessions
- Emotional Wellbeing and Mental Health Strategy, Report to Health and Wellbeing Board, 12 November 2014
- Notes from Youth Cabinet meeting 20 November 2014
- Notes and information from Youth Cabinet meeting with CAMHS 17 February 2015
- Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-2019
- Analysis of Need: Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014
- Children and Adolescent Mental Health Services, Produced by Parents and Healthwatch Rotherham, May 2014
- Executive Summary of NHS Rotherham CCG Mental Health, Child and Adolescent Mental Health, and Learning Disabilities Review, May 2014
- NHS Rotherham CCG – Review of CAMHS Services Project Initiation Document
- Service Specification for RDaSH CAMHS
- RDaSH Quality Account 2013-14
- NHS Rotherham CCG Commissioning Plan 2014-19
- Closing the Gap: Priorities for essential change in mental health, Department of Health, February 2014
- Children's and adolescents' mental health and CAMHS Third Report of Session 2014–15 House of Commons Health Committee, November 2014
- Parity of Esteem, Centre for Mental Health October 2013
- Child and Adolescent Mental Health Services Tier 4 Report, NHS England, July 2014
- Promoting the health and wellbeing of Looked After Children Statutory guidance for local authorities, NHS England and clinical commissioning groups, March 2015, Departments of Health and Education
- Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing, Department of Health and NHS England March 2015
- CSN policy briefing *Life lessons: PSHE and SRE in schools* – Commons Education Committee, 25 March 2015
- Diagram on front cover - Source: Annual Report of Chief Medical Officer 2013 - model based on WHO framework

Appendix A **Model of CAMHS providers in Rotherham**



Appendix B

The recommendations from the Emotional Wellbeing and Mental Health Strategy for Children and Young People

Recommendation 1
- Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2
- Develop multi-agency care pathways which move service users appropriately through services towards recovery.

Recommendation 3
- Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4
- Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5
- Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6
- Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7
- Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8
- Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9
- Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10
- Promote the prevention of mental ill-health.

Recommendation 11
- Reduce the stigma of mental illness.

Recommendation 12
- Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

Appendix C **RDaSH staffing and service model**

50.6 wte staff cover whole service provision as follows:-

- 21.8 wte staff including nurses, a social worker, art and occupational therapists provide tier 2 and 3 CAMHS services
- 5.0 wte employed on Learning Disability CAMHS pathway
- 4.5 wte on the substance misuse pathway
- 9.7 wte admin across the service
- 5.25 wte medical:
  - 1.85 wte Consultant Psychiatrists
  - 0.4 wte Specialist Consultant Psychiatrist LD CAMHS
  - 1.0 wte Associate Specialist doctor
  - 2.0 wte trainee Medical staff

- Duty team
- CAMHS generic clinicians:
  - routine referrals and follow up treatments weekly for 6 sessions (non-specialist)
  - manage and support mental health pathway (anxiety, phobias, depression, psychosis)
  - link with tier 4 and adult services
- Cognitive Behaviour therapist provides specialist cognitive behaviour interventions mainly to mental health pathway
- Family therapists work across pathways
- ASD Pathway - assessment and diagnosis
- ADHD pathway - diagnosis and follow up clinics

  If the YP reaches 6 sessions then there is a review to see what else is needed.

  RDaSH have one CB therapist so the YP would go on their list for a 1hour session; the therapist then reviews the situation.

Appendix D "Top Tips" guidance

Guidance for Universal Workers and targeted workers on Referral of Children & Young People with Emotional Wellbeing Issues		
Referrals to **Universal Services** and **Routine CAMHS** and **Urgent CAMHS** referrals.		
Issue	**Symptoms/presenting problems**	**Refer to:-**
Behavioural Difficulties	• Poor behaviour at Home only	**Evidence Based Parenting Programme.** For under 5s please contact Health Visiting Team in the first instance
	• Poor behaviour at School only	School (Learning mentor, SENCO, Behaviour Support Team) Integrated Youth Support Service (IYSS)
	• Severe behaviour in both home & School Note – The CDC will accept referrals for behaviour difficulties where they are associated with additional development concerns, e.g. social communication differences, speech and language delay, gross or fine motor problems.	Discuss with Health Visitor first. Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.
Eating Disorders	• Eating Issues (Low Level) – Will only eat certain foods	**Health Visitor if under 5 or GP if over 5**
	• Anorexia: evidence of self induced weight loss and/or fear of fatness • Rapid and sustained weight loss • Bulimia: Persistent binge & purge behaviour.	**CAMHS (Routine) & also GP (for physical assessment)**
	• Obesity	**Rotherham Institute for Obesity (RIO)**
Anxiety Disorders	• Worrying about specific situations	**School Nurse, School (learning mentor, Behaviour Support Team etc.), Youth Start, MIND, MAST**
	• Severe, persistent anxiety. • Panic attacks. • Attachment disorders • Severe and disabling phobia where it is impacting on a young person day to day life and ability to functions (Social and specific phobias).	**CAMHS (Routine)**
Mood Disorder or Depression (Refer if symptoms present for at least 2 weeks)	• Low mood, not impacting on daily life and no risk evident (no suicidal thoughts or self harm)	**School (learning mentor pastoral support, Behaviour Support Team), Youth Start, MIND, School Nurse, MAST**
	• Persistent low mood. • Physical symptoms – poor sleep (or early wakening) or loss of appetite and weight • Cognitive symptoms inc. pervasive negative thoughts • Loss of interest/Social isolation/withdrawal seen at home and school. • Suicidal thoughts without planned intent (discuss urgency of referral with team)	**CAMHS (Routine)**
	• Suicidal thoughts with planned intent **REFER URGENTLY.** • Suicidal thoughts without planned intent (discuss urgency of referral with team) • Previous attempts to end life	**CAMHS (Urgent)**
Post Traumatic Stress Disorder – Symptoms Following an event very traumatic to the individual	• Avoidance of reminders of the traumatic event. • Persistent anxiety. • Repeated enactment of reminders of the traumatic event. • Intrusive thoughts and memories – e.g. nightmares. • Sleep disturbance. • Hypervigilance. • Symptoms continuing longer than three months following event.	**CAMHS (Routine)**
Self-Harm	Always discuss case with duty team to help guide urgency • Presenting with maladaptive coping strategies but less severe/frequent/recent.	**CAMHS (Routine), Youth Start, MIND and MAST**
	• Presenting with maladaptive coping strategies (e.g. self-cutting and **where recent occurrence**).	**CAMHS (Urgent)**
Obsessive Compulsive Disorder (OCD)	• Repetitive, intrusive thoughts, images or behaviour affecting daily life & activity. • Obsessions/compulsions causing functional impairment.	**CAMHS (Routine)**

Relationship Difficulties	• General relationship difficulties	**Youth Start, School (Learning Mentors, pastoral support, Behaviour Support Team), School Nurse, Family Recovery Programme, Grow (15-19 years), MIND, MAST**
	• Persistent patterns of abnormal functioning in interpersonal relationships. • Where family dynamics are fractured and conflicts unresolved.	**CAMHS, Intense Family Support**
Suspected Autism Spectrum Disorder (ASD)	• Persistent and severe problems with communication & social & emotional understanding in 2 or more settings – e.g. Home, School. Consider whether referral would be better made by school and/or Educational Psychologist.	**Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.**
Suspected Attention Deficit Hyperactivity Disorder (ADHD)	For Children aged 6 years & above only. Initially refer to parent training. Refer if symptoms persist after parenting work. • Poor concentration • Over-activity • Distractibility • Impulsivity All the above onset before 12 years old and persistent and evident in at least 2 settings, e.g. home, school.	**CAMHS (Routine)**
Psychosis or suspected psychosis	Criteria for Routine / Urgent referrals – Always discuss with duty team to assist decision making re urgency. If child over 16 refer to early intervention in psychosis team • Active symptoms inc.; Paranoia, delusional beliefs & abnormal perceptions, (hearing voices & other hallucinations). Fixed, unusual ideas. • Negative symptoms inc.; deterioration in self-care & social & family functioning.	**CAMHS (Routine)** **CAMHS (Urgent)**
Conduct Disorder	• Very severe and persistent behavioural problems, at home, school and in the community, and unresponsive to parent training. • If school related – preferable for school/ Educational Psychologist to make referral with relevant background information.	**CAMHS (Routine)**
Gender Identity Disorder	• Initial exploration of issues	**LGBT Youth Worker, LGBT Youth Group & Youth Start,**
	• Strong, persistent cross-gender identification. • Persistent discomfort in gender role. • Above causing impairment in social, family and school functioning.	**CAMHS (Routine)**
Chronic Fatigue/Somatisation Disorder (When physical symptoms are caused by mental or emotional factors it is called somatisation)	Criteria for Routine referrals – refer to GP in first instance. • Excessive fatigue. • Unexplained medical symptoms.	**CAMHS (Routine)**

A Directory of Services – **'Emotional Wellbeing Services for Children & Young People Living in Rotherham'** has been produced which gives further information on the **Universal Services** referred to above.

Process to be followed for CAMHS referral:-

1. In order to effectively triage a referral, please provide the contact telephone number for the child/young person and parent/carer
2. **Referrals** will be **acknowledged within 5 working days**, with the aim to have an **initial appointment within 15 working days** of receipt of referral. **Urgent referrals are seen within 24 hours.** If available, a copy of the Common Assessment Framework (CAF) should also be provided and parent/carer/child/young person permission demonstrated.
3. Following **Initial Assessment** – Needs are identified & where appropriate a management plan communicated to the referrer.

Where appropriate, referrals may be **signposted to other services** but only where child/young person and parent/carer contact details and consent is provided with the referral.

CAMHS Referrals should be sent with the child/young persons and/or family's consent and using the agreed **referral form** to:- **The Duty Team, Child & Adolescent Mental Health Service, Kimberworth Place, Kimberworth Road, Rotherham, S61 1HE.** Tel. 01709 304808. Fax. 01709 302547. Please **do not** send an electronic version of referral form attached to an e-mail. The form needs to be sent via postal services or faxed.

DO NOT REFER	**Do not refer** if not included in the above list. **If in doubt please discuss with the CAMHS Duty Team**
Date Approved: December 2014	**Review Date: April 2015**

Appendix E Waiting times for RDaSH CAMHS 2013-14

CAMHS - Waiting times against the RTT (referral to treatment)
Incomplete pathway within 8 Weeks
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks -28.0wks	28.1+wks	Total Above 8 Wks	Total	% of Patients Waiting for Treatment <8 Wks	Total Waiting for Treatment <8Wks
December	32	17	6	3	16	7	7	11	**99**	3	5	1	1	0	1	0	1	1	0	1	1	1	0	11	81	**108**	207	**48%**	99
January	43	28	19	15	10	5	2	2	**124**	4	4	10	1	3	1	1	0	1	0	1	0	0	1	6	81	**114**	238	**52%**	124
February	40	21	19	19	21	10	15	6	**151**	9	3	1	6	6	4	10	5	6	1	2	2	8	1	10	81	**155**	306	**49%**	151
March	35	24	32	30	19	16	11	6	**173**	1	4	2	2	2	0	1	0	0	1	1	4	1	1	3	16	**39**	212	**82%**	173

CAMHS - Waiting times against the RTT (referral to treatment)
Completed pathway within 8 Weeks
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks -28.0wks	28.1+wks	Total Above 8 Wks	Total	% of Patients seen within 8 Wks	Total seen <12Wks
December	5	5	9	7	3	6	4	3	**42**	2	3	1	0	1	0	0	0	0	0	0	0	0	0	1	3	**11**	53	**79%**	42
January	8	7	7	10	7	4	5	1	**49**	1	2	2	0	0	2	0	0	2	0	0	0	0	0	1	10	**20**	69	**71%**	49
February	7	1	10	14	2	4	3	3	**44**	0	2	0	3	1	0	0	1	0	0	0	0	0	0	1	1	**9**	53	**83%**	44
March	4	2	2	4	10	3	4	1	**30**	0	0	2	0	1	2	0	1	0	0	0	0	0	0	0	5	**11**	41	**73%**	30

Note Incomplete pathways are where the patient is still waiting for treatment and complete pathways are where they have started treatment. Under current reporting, treatment is defined as the second appointment.

Waiting times for RDaSH CAMHS 2014-15

CAMHS - Waiting times against the RTT (referral to treatment)
Incomplete pathway within 8 Weeks (92%)
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	Total Equal to or Above 18Wks	19.1wks - 20.0wks	20.0wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total	Total Above 8wks	% of Patients Waiting for Treatment <8 Wks	% of Patients Waiting for Treatment <18Wks
April	35	32	27	21	17	16	21	19	**188**	33	22	10	11	5	3	2	4	3	5	3	**289**	2	2	2	2	87	**384**	**196**	**49%**	75%
May	31	29	18	29	27	23	20	15	**192**	16	21	16	24	10	3	9	3	3	1	4	**302**	3	4	1	9	75	**394**	**202**	**49%**	77%
June	44	31	20	9	15	20	19	14	**172**	26	21	16	13	12	12	12	3	11	2	2	**302**	3	1	0	7	71	**384**	**212**	**45%**	79%
July	26	20	17	13	33	19	10	8	**146**	15	16	13	15	13	13	7	2	9	6	4	**259**	3	7	1	12	72	**354**	**208**	**41%**	73%
August	43	32	23	23	18	19	13	15	**186**	11	25	12	4	1	5	6	7	9	7	3	**276**	6	1	5	16	45	**349**	**163**	**53%**	79%
September	48	34	43	40	26	17	13	16	**237**	13	5	8	6	9	8	8	7	3	4	6	**314**	3	6	8	25	41	**397**	**160**	**60%**	79%
October	55	37	20	18	23	19	11	14	**197**	6	8	1	10	9	5	6	5	6	7	5	**265**	6	1	1	24	45	**342**	**145**	**58%**	77%

CAMHS - Waiting times against the RTT (referral to treatment)
Completed pathway within 8 Weeks (Target 95%)
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	Total Equal to or Below 18 Wks	19.1wks - 20.0wks	20.0wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total	Total Above 8Wks	% of Patients seen within 8 Wks	% of Patients seen within 18Wks
April	7	2	3	1	8	7	5	4	**37**	4	0	2	2	1	0	1	0	1	0	1	**49**	2	0	0	0	2	**53**	16	**70%**	92%
May	5	1	1	0	2	1	2	5	**17**	7	3	2	2	4	0	1	0	1	0	0	**37**	1	0	0	0	3	**41**	24	**41%**	90%
June	7	2	0	1	0	2	0	1	**13**	0	6	9	6	3	1	1	2	1	1	0	**43**	0	1	0	0	4	**48**	35	**27%**	90%
July	5	2	0	1	1	0	1	0	**10**	1	0	2	3	5	2	2	1	2	0	1	**29**	0	0	0	2	0	**31**	21	**32%**	94%
August	5	1	2	2	2	1	0	1	**14**	0	3	3	3	4	11	5	3	2	4	0	**52**	3	0	0	1	3	**59**	45	**24%**	88%
September	6	4	1	2	0	1	1	4	**19**	1	11	5	11	3	1	2	1	2	0	1	**57**	0	0	1	1	2	**61**	42	**31%**	93%
October	3	5	0	2	6	9	13	2	**40**	5	3	2	2	4	1	2	0	1	1	0	**61**	0	1	0	2	2	**66**	26	**61%**	92%

The following relates to weekly data provided to the team regarding the waiting list for an initial assessment

CAMHS - Rotherham: Incomplete Pathway Assessment Waits - within 3 weeks - Excluding ADHD/ASD

Weeks/Data at this point in month	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	Total Equal to or Below 3 Wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total Above 3 Wks	Total	% of Patients waits within 3 weeks	% of Patient waits >3Wks
09/09/2014	27	34	22	**83**	19	10	17	12	26	17	10	6	7	7	1	0	1	0	0	0	0	0	0	0	0	**133**	**216**	**38%**	**62%**
15/09/2014	28	27	15	**70**	23	17	17	11	11	22	15	3	1	6	3	0	1	0	0	0	0	0	0	0	0	**130**	**200**	**35%**	**65%**
22/09/2014	46	21	25	**92**	15	21	16	15	11	11	20	7	2	1	3	2	0	1	0	0	0	0	0	0	0	**125**	**217**	**42%**	**58%**
29/09/2014	56	41	18	**115**	22	15	21	14	12	4	2	6	1	0	0	0	1	0	1	0	0	0	0	0	0	**99**	**214**	**54%**	**46%**
08/10/2014	70	41	52	**163**	19	21	20	9	10	3	5	2	3	4	0	0	0	0	1	0	0	0	0	0	0	**97**	**260**	**63%**	**37%**
13/10/2014	46	53	42	**141**	30	21	16	8	7	6	3	4	3	2	2	0	0	0	0	0	0	0	0	0	0	**102**	**243**	**58%**	**42%**
21/10/2014	48	43	53	**144**	39	28	11	5	5	2	4	0	3	0	3	1	0	0	0	0	0	0	0	0	0	**101**	**245**	**59%**	**41%**
27/10/2014	43	40	35	**118**	38	20	14	8	5	2	1	2	0	2	1	1	1	0	0	0	0	0	0	0	0	**95**	**213**	**55%**	**45%**
03/11/2014	38	42	36	**116**	29	24	14	4	3	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**77**	**193**	**60%**	**40%**
10/11/2014	32	32	31	**95**	23	15	15	8	3	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**68**	**163**	**58%**	**42%**
17/11/2014	53	21	21	**95**	17	19	6	9	4	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**59**	**154**	**62%**	**38%**
24/11/2014	54	35	20	**109**	17	18	8	3	5	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**55**	**164**	**66%**	**34%**
01/12/2014	46	43	22	**111**	13	6	4	6	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**34**	**145**	**77%**	**23%**
08/12/2014	42	42	33	**117**	14	3	3	3	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**31**	**148**	**79%**	**21%**

The following relates to weekly data provided to the team regarding young people that have had an initial assessment by how long they waited to be seen

CAMHS - Rotherham: Completed Pathway Assessment "Completed" - within 3 weeks - Excluding ADHD/ASD

Weeks/Data at this point in month	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	Total Equal to or Below 3 Wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total Above 3 Wks	Total	% of Patients waits within 3 weeks	% of Patient waits >3Wks
09/09/2014	4	0	0	**4**	0	0	0	0	0	0	0	1	9	3	0	0	0	0	0	0	0	0	1	1	0	**15**	**19**	**21%**	**79%**
15/09/2014	6	0	1	**7**	0	1	1	0	0	0	1	5	12	3	0	0	0	0	0	0	0	0	1	1	0	**25**	**32**	**22%**	**78%**
22/09/2014	10	0	1	**11**	1	2	1	1	0	3	6	9	13	4	1	0	0	0	0	0	0	0	1	1	0	**43**	**54**	**20%**	**80%**
29/09/2014	14	1	2	**17**	1	2	1	1	7	9	19	17	17	5	0	0	0	0	0	0	0	0	1	1	0	**81**	**98**	**17%**	**83%**
08/10/2014	1	0	1	**2**	1	0	3	4	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**	**14**	**14%**	**86%**
13/10/2014	3	3	1	**7**	1	0	6	8	3	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**22**	**29**	**24%**	**76%**
21/10/2014	4	7	3	**14**	1	5	17	12	3	1	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	**42**	**56**	**25%**	**75%**
27/10/2014	8	7	5	**20**	1	13	21	13	3	1	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	**56**	**76**	**26%**	**74%**
03/11/2014	10	11	7	**28**	2	15	26	16	4	1	2	1	0	2	1	0	0	0	0	0	0	0	0	0	0	**70**	**98**	**29%**	**71%**
10/11/2014	0	2	0	**2**	2	6	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**13**	**15**	**13%**	**87%**
17/11/2014	3	3	2	**8**	4	20	8	2	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**37**	**45**	**18%**	**82%**
24/11/2014	6	3	3	**12**	4	26	9	3	2	2	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	**49**	**61**	**20%**	**80%**
01/12/2014	14	4	6	**24**	6	41	10	4	5	3	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	**74**	**98**	**24%**	**76%**
08/12/2014	2	0	4	**6**	6	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**	**18**	**33%**	**67%**

Appendix F

Figure 1 Assessment Waiting Times Capacity and Demand

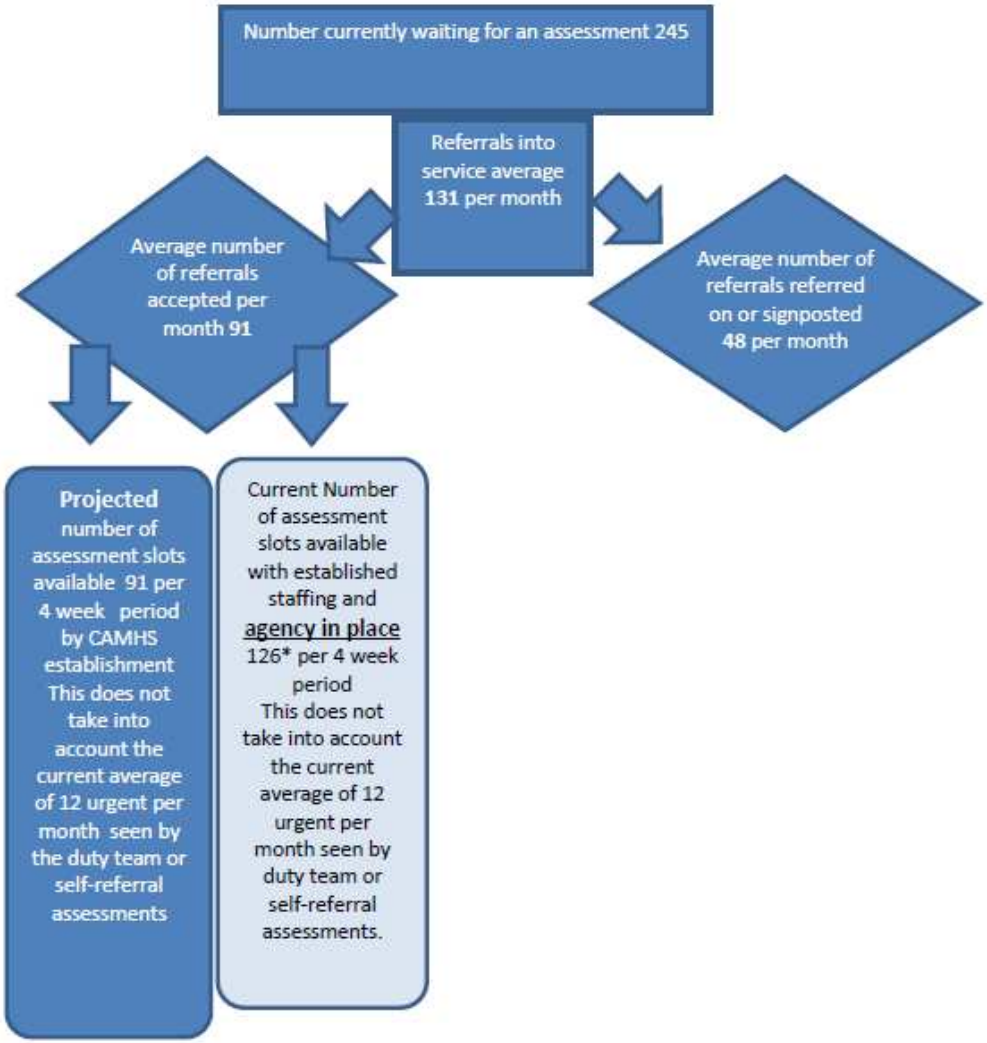
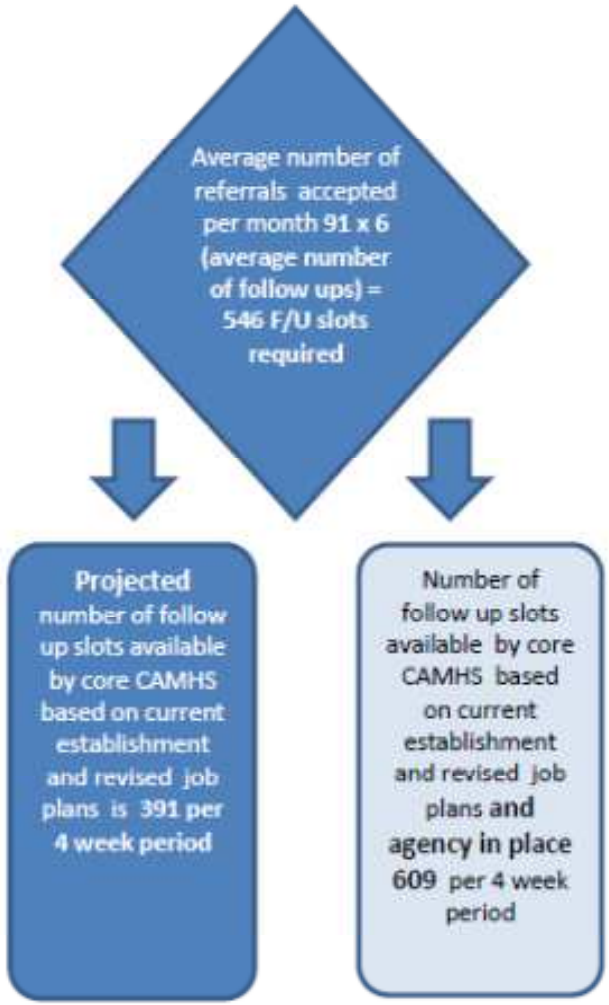
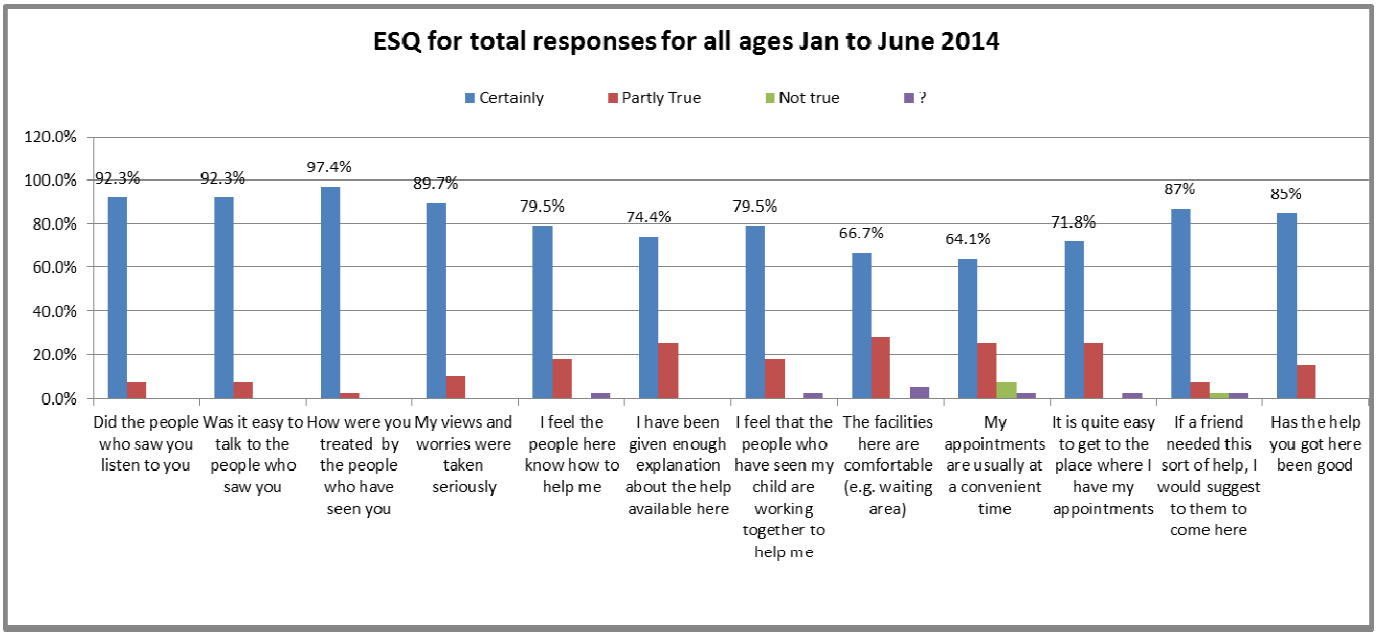


Figure 2 Treatment Waiting Times Capacity and Demand



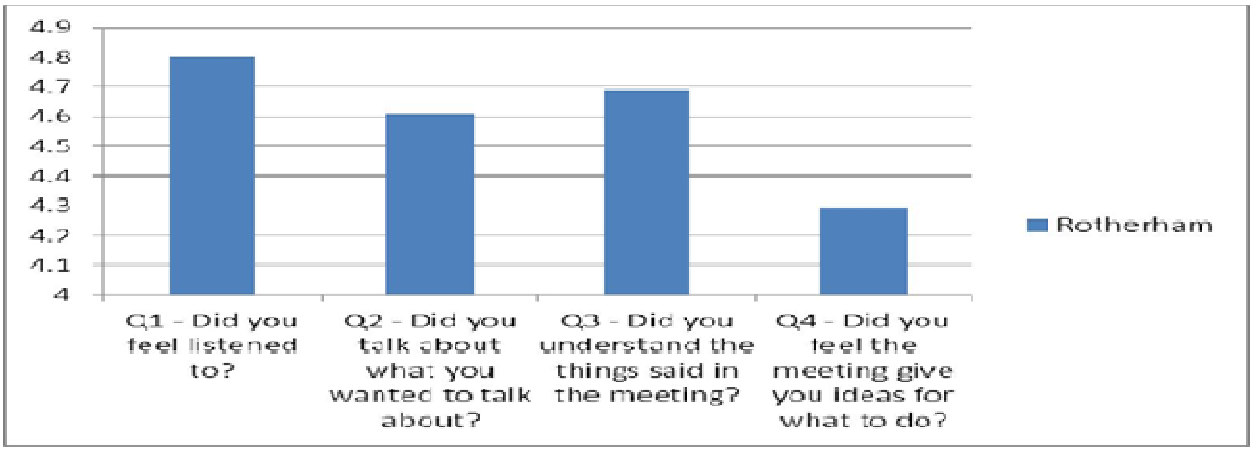
Appendix G **Satisfaction survey scores**

Figure 1 All ages Jan- June 2014 Experience of Services Questionnaire



Note - Lowest scores related to opinion of convenience of appointment time.

Figure 2 Session Feedback Questionnaires (October 13 - April 14)



Average scores for each question, possible maximum score is 5.

Key 1 – not at all
2 only a little
3 somewhat
4 quite a bit
5 totally

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
AMHS	Adult Mental Health Services
CAMHS	Child and Adolescent Mental Health Services
C&YP	Children and Young People
CYPS	RMBC Children and Young People's Services
DNAs	"Did Not Attend" – people not cancelling appointments in advance that they cannot attend or which are not needed
EIP	Early Intervention in Psychosis (EIP) is a mental health service that works with young people aged over 14, who are experiencing a first episode of psychosis
EWS	Emotional Wellbeing and Mental Health Strategy for Children and Young People
GPs	General Practitioners
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
KTS	Know the Score – drug and alcohol misuse service for young people
LAAC	Looked After and Adopted Children
LAACSTT	Looked After and Adopted Children Children's Support and Therapeutic Team
LD	Learning Disability
MASH	Multi Agency Safeguarding Hub
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OSMB	Overview and Scrutiny Management Board
ONS	Office of National Statistics
OOH	Out of Hours services
Prevalence	the number of people with a particular mental health diagnosis at a given time
P/EI	Prevention and Early Intervention
PSHEE	Personal, Social, Health and Economic Education
QIPP	Quality Innovation Productivity and Prevention - a programme to improve NHS care whilst simultaneously achieving efficiency savings
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham Doncaster and South Humber Mental Health NHS Trust
RYC	Rotherham Youth Cabinet
TRFT	The Rotherham Foundation Trust
VCS	Voluntary and community sector
WTE	Whole time equivalent
YP	Young person/people

Endnote:

1 Guest blog by Dawn Rees, Principal Policy Advisor for Health on the Office of the Children's Commissioner website 10 September 2014