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

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Derbyshire County and Derby City

Eating Disorders Transformation Plan 2015-2020

Submitted as separate document to main transformational Future in Mind plan

Final Version 30 October 2015

(Commissioners check list / easy find guide for assessors -Appendix 4)

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Eating Disorders Transformation Plan 2015-2020

Development of a countywide, all-age, seamless Eating Disorder Service with one specification and two Units of Planning North and South Derbyshire

1. Executive summary

Our Vision for children's and young people's eating disorder service

Under one service specification, Derbyshire County and Derby City will have an expert Children and Young People's (C&YP) Eating Disorder Service that will reduce the negative impact of eating disorders and work towards the recovery of a child or young person by providing effective interventions as early as possible.

This document sets out our responsive action plans to provide a model that embraces the concept of whole system care. **We are committed to investing the Future in Mind funding allocation on support for the under 18 population and this is made clear in the Finance section.**

The baseline audit of our two providers establishes different stages of development; therefore the detailed plan is split into two sections (North and South units of planning). We demonstrate bespoke responses and actions required to meet the access, waiting times, treatment and referral standards. In partnership with our service users, wider stakeholders and with support from NHS England, we have identified steps to improve early identification with an emphasis on plans to skill the workforce and increase capacity.

There will be one Children and Young People's commissioner-led steering group for eating disorders that includes membership from:

- The Clinical Commissioning Groups;
- Derbyshire County and Derby City Children's Services Departments (local authorities);
- Parents, young people, service users ;

- Adult Services;
- A Paediatrician (representing Derby Teaching Hospitals NHS Foundation Trust (DTHFT) and Chesterfield Royal Hospital NHS Foundation Trust);
- Head of Service;
- Derbyshire Healthcare NHS Foundation Trust (DHCFT) and Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) senior representatives (the providers),
- Social Care and specialist voluntary organisations.

The role of the steering group will be to ensure that the agreed Eating Disorder service specification is implemented, waiting and treatment times are achieved, children and young people have access to evidence-based treatment models and that integrated partnership arrangements are working in the best interests of our service users and their care.

The steering group will be accountable to the Joint Commissioning Board, which works across the four CCGs and two local authorities and will ensure compliance with the quality and performance standards.

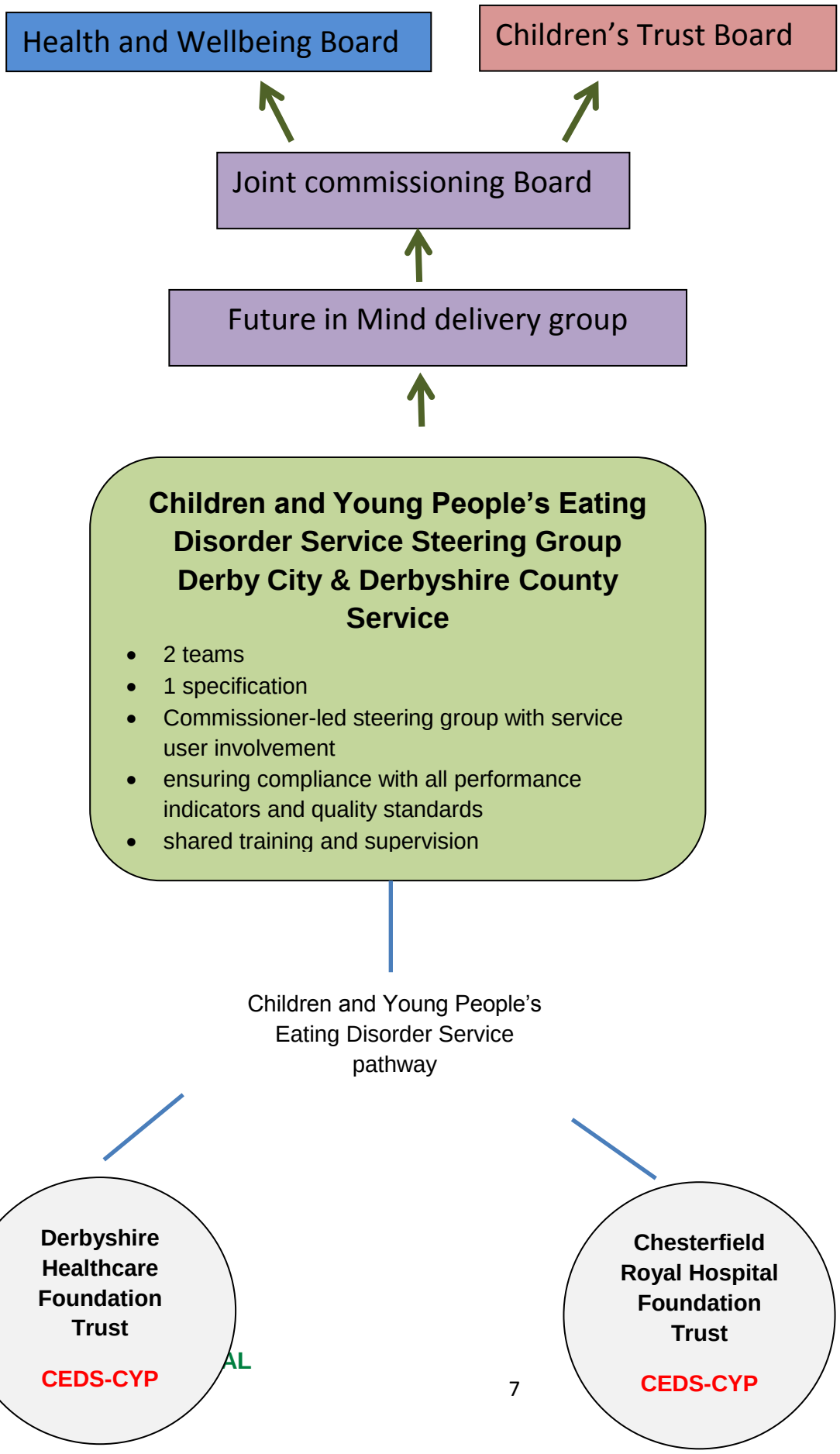
A combined model including both units of planning would provide us with a target population of 1 million. We anticipate seeing approximately 100-120 referrals by 2016-2017 across the two CAMHS Services in accordance with the NHS England Eating Disorders guidance. With investment in early detection and prevention, we anticipate a reduced dependency on in-patient beds by 2020 and an increase in numbers of children and young people using the service in primary care and community settings. These children and young people will be supported by third sector workers and Multi-Agency Teams with professional supervision and support from our specialist eating disorder service.

2. Resource allocation by CCGs

Initial allocation of funding for eating disorders and planning in 2015/16 (Annex 4: Allocation of Mental Health Funding to CCGs 2015)

Clinical Commissioning Group	Initial allocation for eating disorders £
North Derbyshire unit of planning	
Hardwick CCG	60,397
North Derbyshire CCG	157,846
South Derbyshire unit of planning	
Southern Derbyshire CCG	293,875
Erewash CCG	55,042

3. Governance Model for Eating Disorder Service



4. The Transformation of our Specialist Eating Disorder Service

Summary of Priorities

4.1 Shared Priorities for first 6 months November 2015 –April 2016

a) We will develop a commissioner-led steering group with a joint working agreement between DHCFT and CRHT

b) We will develop a service specification that is responsive, practical; value for money, evidence based and meets the standards for waiting times and a skilled work force. We have taken into account the model specification for child and adolescent mental health services: Targeted and Specialist levels (Tiers 2/3)

c) We will commission a specialist eating disorder service from the voluntary sector to develop peer education, GP awareness training, peer support, skills for carers and liaison with schools and support educational attainment of young people being seen in the Children and Young People's Eating Disorder Service –

d) We will publish our plans and declarations on CCG, local authority and key local partners' websites including the third sector

e) We will continue to engage and value service user and carer engagement across the county and city to support commissioning and monitor our eating Disorder Service. *Appendix 1, details an engagement event held in July 2015 with service users –"they say we do" – to shape an improved Children and Young People's Eating Disorder Service"*

f) We will commission the third sector to support home treatment, meal time support, develop peer education, GP awareness training, peer support, skills for carers and liaison with schools and support educational attainment of young people being seen in the Children and Young People's Eating Disorder Service*.*

g) We will ensure that the IT systems and data collection capability is fit for purpose to track key performance indicators and outcome measures.

h) We will strengthen needs assessment to include data on age, gender and ethnicity of service users

4.2 Shared Priorities for April 2016- March 2020 -*When plan is assured*

a) We will skill the workforce and increase capacity to support evidence based home treatment from a crisis team who will wrap bespoke care bundles around the children and

young people enabling them to be closer to home, reduce social isolation and reduce dependency on Tier 4 admissions

b) We will increase workforce capacity and, based on historical data and serving a population of 1,000,000, we anticipate seeing approximately 100-120 referrals by 2016-2017 across the two CAMHS Services in accordance with the NHS England Eating Disorders guidance. With investment in early detection and prevention, we anticipate a reduced dependency on in-patient beds by 2020 and an increase in numbers of children and young people using the service in primary care and community settings. These children and young people will supported by third sector workers and Multi-Agency Teams with professional supervision and support from our specialist eating disorder service

c) We will continue to develop an integrated pathway with the Adult Eating Disorder Team to ensure there is a smooth transition from the C&YP ED service to the adult service with an aspiration to become an all age service. ***(We pledge and will evidence that the Future in Mind funding for the CYP Ed service finances the under 18 end of the spectrum.*** (refer to Appendix 2)

d) We will develop joint training plan across South and North CED Teams on service standards, pathways and outcomes.

e) We will provide a supportive eating disorder treatment for some milder presentations; this will be will be provided in a primary care setting with treatment by trained eating disorder staff. CEDS-CYP will oversee treatment and provide consultation and supervision as part of the commissioned service.

f) We will develop a 7 day 24 hour service with opportunities to provide flexible and cross cover arrangements across the county.

g) We will commission local Paediatric stays at DTHFT and CRHFT where medical stability needs to be strengthened before discharge home to a home treatment care bundle reducing dependency on Tier 4 referrals.

h) We will develop a culture to promote self-esteem and build resilience in children and young people to feel more confident with their appearance to prevent eating disorders- This will be supported by the role of the voluntary sector

i) Commissioners to develop with key stakeholders - a communication plan with detail on how young people can access services with families and carers being supported -*Plans and direction of travel outlined in Appendix 2. Journey of a child through the system*

j) Commissioners to develop benefits realisation plan with the providers , Focus on benefits of investment and NICE evidence based care on reducing dependence on in patent beds,

financial benefits to service by earlier detection and prevention reduction in the numbers of young people presenting with an eating disorder , service user satisfaction,

5. Outcome measures and Key Indicators to be integrated into service specification when developed

Outcome	Key Indicators
Access and wait times Urgent - 1 week to treatment Routine – 4 weeks to treatment	Performance reports Service reports
Improve Access	Development of online web information and a self-referral form Promotion of CED's and a whole pathway model including our third sector partners
A measurable improvement in the mental health of young people using the service informed by CYP IAPT clinical outcome measures (This will include the severity of those young people accessing the service)	Clinical outcome measures - SDQ RCADS SYMPTOM and IMPACT Trackers Honosca) CGAS) Social Functioning Scale (including access to employment, training and education)
A self-assessed improvement from the young person's perspective	Patient Outcome Measures: Goal based outcomes – GBO's User satisfaction surveys from young people and parents and carers. Chi Esq. – Patient service questionnaire `How are you doing? 'At all stages during treatment.
Longer term a reduction in the length of Tier 4 admissions. This would be accelerated if the Innovations Fund application were successful.	Comparison of past 4 years use of inpatient facilities (Thorneywood, and other external providers).
Reduce the number of young people accessing Tier 4 inpatient facilities.	Evaluation of outcomes - Reference costs to possible inpatient v community services.
NICE Compliance -	ROM's

	Performance reports outlining treatment received Service user feedback NICE compliance audit Implementation of Care Bundles
Development of CAMHS Core Competency	Phase 1: - Full implementation of the ED care Bundles Training to all teams ED competency included on CAMHS training passports Supervisors feedback ROMs - Performance

6. North Unit of Planning
CAMHS Chesterfield Royal Hospital NHS Foundation Trust

6.1 **Summary of Current Provision**

Children and young people with eating disorders in North Derbyshire are currently referred to CAMHS according to the protocols of the generic CAMHS service. The referrals are read on the day of receipt by a senior CAMHS clinician and if there is concern about a possible eating disorder this would be reviewed by a clinician with experience of eating disorders and who works within the eating disorder clinic. The clinic can offer a first assessment within 1 week if required. The service benefits from being based within an acute hospital and from the close working relationships it has developed with the paediatric department. There is swift and easy access to paediatric assessment and if required admission to the paediatric ward. This is detailed in a fully operational pathway between CAMHS and the paediatric ward. This reduces the dependency on Tier 4 beds.

The current eating disorder clinic is led by a consultant child and adolescent psychiatrist who works in partnership with a clinical social worker, both with a special interest and having developed skills and knowledge through experience, supervision and training. Work with eating disorders forms a part of their generic CAMHS duties. In addition to this, service capacity is adapted according to demand and systemic family therapy and cognitive behavioural therapy are provided by generic CAMHS clinicians.

Medical intervention, during both community and inpatient care is provided by paediatric clinicians with a special interest and who access support and supervision from CAMHS. This includes limited availability of a dietician and support for multi-disciplinary care planning from the paediatric matron.

6.2 **Prevalence and numbers**

North Derbyshire
391,782 population
ED Referrals seen by CRHFT CAMHS– 39

6.3 **Specific Service Development**

CAMHS recognise the care and commitment shown by colleagues in the paediatric department at Chesterfield Royal Hospital in offering a high standard of service during inpatient admission. Whilst there is no plan to add resources to the ward, the development of CEDS and the consequent provision of a robust service around the needs of young people and their carers in the community will result in a reduced requirement for lengthy inpatient episodes.

In order to meet the recommendations specified in the Access and Waiting Time Standard for Children and Young People with an Eating Disorder, (*NHS England August 2015,)* CAMHS would need to develop the existing service using additional resources to form a dedicated and specialist CEDS-CYP. CAMHS considers

additional resources to develop the delivery of specialist and intensive therapeutic interventions to be a priority and proposes a two phase programme.

We will invest in training, building on the existing accredited CBT and Systemic Family Therapy by accessing training in eating disorder specific interventions.

CRHFT have been successful in their bid to join the CYP IAPT program and once the IT systems are procured and fit for purpose they will join the program in 2016-2017.

The investment required by CRHFT in fit-for-purpose IT software has been acknowledged by their management board as a high priority for to capture data and evidence outcome measures making their system of care more efficient.

6.4 **North Derbyshire: Finance and the proposed Model**

Additional staffing required to deliver the service:

Post	Band	Phase 1 wte	Cost	Phase 2 wte	Cost
Admin support	2	0.5	£9,650	0	
Support Workers – (Voluntary Sector)	4	0	0	2	(indicative only) £50,156
Assistant Psychologist	4	0.5	£12,539	0	0
Dietician	7	0.4	£17,537	0	0
Mental Health Worker	6	1	£36,567	0	0
Intensive Home Treatment Worker	6	1	£36,567	0	0
Therapist/Team Lead	7	1	£43,842	0	0
Paediatrics	7	0.2	£8768		
Pay Cost			**£165,470**		**£50,156**
Non Pay			**£18,876**		**0**
Overheads			**£27,652**		**0**
Total Cost			**£211,998**		**£50,156**

Appendix 3 outlines job responsibilities for the above roles in the Children and Young People's Eating Disorder model

Eating Disorders - Transforming Services Baseline Data and Action Planning

North Unit of Planning Chesterfield Royal Hospital Foundation Trust CAMHS

7. Needs assessment /baseline data and action plans

7.1 **Treatment**

Recommendations	Where we are /baseline	Where we need to be and action plan
A. How is service is improving early identification	• Current re-writing of referral guidelines to be distributed widely • Structured education offered to local GP's	• A more proactive programme of advertisement including website etc., with personnel linked to GPs, schools and Multi Agency teams. Addition of CAMHS liaison worker and voluntary sector support workers to work in partnership.
B. Offer evidence-based family interventions that directly address the eating disorder	• Systemic Family Therapy offered with eating disorder focus- limited capacity.	• Increased capacity of dedicated Systemic Family Therapy to be able to offer more consistently. • Multi-Systemic Family Therapy Training and Systemic CYP IAPT needed. • Home treatment family intervention needed – 7 day • Capacity to offer family group meetings

C. family members including siblings should normally be included in treatment	• Family assessment undertaken for all referrals and family included in treatment- limited capacity.	• Regular availability of group/family support, advice and training sessions.
D. interventions may include sharing of information, advice on behavioural management and facilitating communication	Included in current practice guidelines – confidentiality and information sharing policy. Consistent advice on behavioural management from dedicated clinicians.	• Need increased capacity to deliver home support and liaison with schools, MATs, GPs. Training and awareness rising from voluntary sector.
E. Offer age-appropriate care to address rise of early-onset eating disorders in those under 13	• Currently available within service and also a family approach to care	• Increase in availability of individual therapy for children less than 13yrs such as Creative Therapy – consider voluntary sector provision.
F. accessible to females and males and culturally appropriate	• Predominantly female workforce	• Need to consider gender, race, ethnicity and difference, currently no dedicated male clinician available
G. Clinicians will need to continue to offer NICE-concordant treatment within the framework outlined in this guide	• Systemic Family Therapy (SFT) and Cognitive Behaviour Therapy (CBT) currently available	• increased capacity of dedicated SFT and CBT
H. Treatment should include specialised community family interventions for anorexia nervosa and specifically adapted forms of CBT for bulimia nervosa, in particular CBT-E	• CBT and SFT available- limited capacity	• Increased capacity of dedicated SFT and CBT • Multi-Systemic FT Training and Systemic/ CBT CYP IAPT • Home treatment family intervention needed – 7 day • Capacity to offer family group meetings • CBT-E training

I. Use up-to-date evidence-based interventions to treat the most common types of coexisting mental health problems (for example, depression and anxiety disorders) alongside the eating disorder	• Holistic intervention currently available using evidence base • Psychiatric medical review process	• Increased capacity of dedicated SFT and CBT to enable increased provision for co morbid presentations.

7.2 **Creation of a service to meet waiting time standards**

Requirements for a viable and dedicated Eating Disorder Service

Recommendations	Where we are/baseline	Where we need to be and action
(NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.	• Currently compliant where there is evidence of eating disorder e.g. sufficient referral information	• Increased capacity at the point of referral in order to respond to concerns proactively – e.g. follow up on referral information. Dedicated admin support and additional resource for 'duty response' on receipt of referrals.
A. ***Move away from small teams... 1 team preferred*** B. A 'hub and spoke' model or local network model may be appropriate, with a clearly defined structure and strong leadership.	• Service currently provided by dedicated staff at 2 locations (Chesterfield & Buxton) • Team supervision monthly- when all clinicians involved with ED's meet to maintain consistency – invitation extended to DHCFT ED clinicians. A common pathway from referral to	• Ensuring continuity of current best practice at local level. • Steering group. Common service specification.

	treatment is followed. • MDT approach to care when children are referred via paediatrics	
C. Receive a minimum of 50 new eating disorder referrals a year, which are likely to include anorexia nervosa, bulimia nervosa, binge eating disorder and related diagnoses	• Not currently recording this although we estimate that this number is met when including 'related disorders'.	• Current eating disorder pathway does not have capacity to meet the requirements to include 'related disorders'. Increased capacity is required for comprehensive service
D. Cover a minimum general population of 500,000 (all ages)	• Not met	• To form one team of a county wide service following one pathway.
E. Include medical and non-medical staff with significant eating disorder experience	• Currently available • Also training environment for Specialist Registrars	• need to develop CBT E and increase capacity for SFT
F. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Self-referral not currently available. Direct referral from primary services. • Telephone duty professional 9-5 for urgent referrals	• A proactive programme of advertisement including website referral option. • Electronic systems to facilitate liaison and rapid communication with primary services and service users. • Develop relationship with voluntary sector
G. Most children and young people should be treated in the community with inpatient admission considered where there	• Access to urgent medical input as co-located with paediatrics • Admission available through CRH paediatric ward for short term focused	• For paediatric admissions to be fully commissioned for those where compensatory behaviours are limited and medical stability will be

is high or moderate physical risk	admission in keeping with Jnr Marsipan guidelines. • A MDT approach with weekly meetings, ED care plan and dietetic input, daily CAMHS review.	strengthened by a slightly longer admission to in order to support a robust discharge home for further home treatment and avoid tier 4 referral
H. Admission should be to appropriate facilities with access to educational provision and related activities.	• Education base on Paediatric ward. Teaching staff and play specialist staff attend ward rolling programme of CAMHS teaching re ED's and join MDT meetings for children, liaising with child's school to ensure continuity of education provision • Staffing of play specialists adjusted as needed for admissions.	• Needs to be acknowledged through investment.
I. When in-patient admission is required, this should be **within reasonable travelling** distance	• NO PROVISION	• Psychiatric inpatient care not currently available within reasonable travelling distance.
J. User involvement in commissioning	• Service user group developed in the north of the county and strong links made with Derbyshire Youth Council	• Service user involvement vital – build on the engagement events for Future in Mind - local group set up and will meet with commissioners and providers a minimum of 6 month intervals – however during the first year of transforming services will meet quarterly

7.3 **Referral Process**

Recommendations	Where we are /baseline	Where we need to be and action
A. The CEDS-CYP should have clear online referral forms.	• Do not have infrastructure presently to manage on line referral forms	• Needs to be developed. Dedicated staff time to develop.
B. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Self-referral not currently available. Direct Referral from primary services. • Telephone duty professional 9-5 for urgent referrals	• A more proactive programme • Advertisement including website referral option.
C. Each service should have clear, accessible contact details on a website, which are easy to find via main search engines, with clear instructions in appropriate languages on how to call the service, send an email or complete an online self-referral form.	• Not currently available	• A more proactive programme of advertisement including website referral option.
D. **Avoid lengthy referral in-house processes**	• There is a fast track route into the service	NA

CAMHS team is required to make contact with the CEDS-CYP as soon as the possibility of an eating disorder is raised. This should be done by telephone or electronically following discussion with the child or young person and their parents or carers	• Assessment available within a week of internal referral	
E. **The causes for missing an appointment** should be investigated carefully, and the referrer and the GP/trusted adult informed. This is recorded in the child or young person's clinical notes. An appointment should be booked to take place within 2 working days of the missed appointment.	• Current practice meets requirement to make contact following missed appointment. However appointment in 2 days not always available and would be dependent on clinical presentation	• Review appointment service and make appointments available within 2 working days

7.4 **Classifying risk and urgency**

Recommendations	Where we are /baseline	Where we need to be and action
A. Telephone or in-person contact to be made with the child or young person and the parent or carer *on the same day* to clarify risk.. This rapid response is essential when it is not known if the child or young	• Not routinely available unless concerns are identified in the referral.	• increased capacity to respond to referrals on the same day regardless of referral information

person is under the care of a healthcare professional and the level of risk remains unclear		
B. For some milder presentations supportive eating disorder treatment may be provided in a primary care setting with treatment by trained eating disorder staff. If treatment is delivered in a non-eating disorder, supportive setting, the CEDS-CYP must oversee treatment and provide consultation and supervision.	• Not currently available	• Need to develop a training programme for schools, MATs and capacity for ongoing support and supervision- liaison and collaboration with 3rd sector provider

7.5 **Information sharing with parents / carers**

A. Guidelines referenced in The Working together to safeguard children website and Paragraph 12 and 13 of the Mental Capacity Act 2005 Code of Practice are followed re: sharing information with parents and carers with respect of 16 and 17 year olds.	• Current guidelines met.	• Will involve children and young people to develop service specific guidelines.

7.6 **Workforce competencies and experience**

Recommendations	Where we are /baseline	Where we need to be and action

The team's collective membership needs the following expertise:		
A. Psychiatric assessment for children and young people	• Meeting the standards	N/A
B. Medical assessment and monitoring	• Meeting the standards	N/A
C. Rapid response to referrals- outlined in the care pathway	• Not meeting standards of contacting young person on day of referral.	• Need to develop same day response Crisis repose in a service available 24/7
D. Staff trained to supervisory level for evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• Not available currently – shortage of available supervisors.	• Develop capacity for CBT E and SFT supervision
E. Staff trained in the delivery of evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• CBT and SFT available	• We need to develop resources and for dedicated provision for the eating disorders pathway
F. Community care: the team should have the experience to be able to provide home treatment and family support	• limited availability available via Outreach team	• Need to develop dedicated home treatment service. Additional outreach work.
G. There should be lead consultant/champion for acute eating disorder care, as advised in the Junior MARSIPAN.	• **There is at present no dedicated consultant champion for acute eating disorder care,**	**The specialist eating disorders service would provide appropriate psychological and medical and social support interventions aimed at recover and the reduction of risk in accordance to the**

		NICE guidelines and the junior MARSIPAN.. this will be achieved by the recruitment of the paediatrician and the integrated of care being developed with the CRHFT It is anticipated that the psychological interventions delivered will be a minimum of 6 months duration, as identified by NICE 2004 .The presence of a specialist service is expected to facilitate earlier discharge of patients from specialist inpatient units. This service would be a tertiary service accessed via the CAMHS team.
H. Acute service and paediatric support: support should be provided to these services 7 days a week	• Generic CAHMS psychiatric support currently available via on call system however they are not eating disorder specifically trained.	• Explore options for training specialist psychiatric support.
I. Administrative and management support; by experienced staff with training in relevant areas including data entry.	• limited availability as part of generic Tier 3 CAMHS	• Dedicated admin and managerial support. • Electronic records system

7.7 **Disciplines**

A CEDS-CYP should be a multi-disciplinary team of medical and non-medical staff with significant training and experience in the assessment, risk management and treatment of children and young people with anorexia nervosa, bulimia nervosa and their variants.

These teams require a high level of expertise (both medical and non-medical) to be able to manage the level of medical risk safely and to provide continuous high-quality supervision for the psychological treatments.

Recommended WTE Staff Broken Down by Profession

Number of referrals per annum	**150**	**100**	**50**
	Whole time equivalents		
Head of service (psychiatry/psychology)	1.8	1.2	0.6
Speciality Doctors (psychiatry) (Registrars)	2.4	1.6	0.8
Paediatric medical treatment (Consultant)	0.3	0.2	0.1
Senior Clinical Staff (Bands 8a and 8b)	2.5	1.7	1.3
Eating disorder therapists (Band 7)	10.1	6.7	3.4
Home treatment specialists (Band 6)	3.8	2.5	1.3
Dieticians (Band 6)	2.3	1.5	0.8
Support Staff/Assistant Psychologists (Band 4)	2.7	1.8	0.9

Discipline	***Wte Actual September 2015***	**Comment Number of referrals per annum**
A. Head of service (psychiatry/psychology)	0.5	The present IT infrastructure does not permit for this data to be collected accurately. We are developing an interim manual system in readiness for CYP IAPT. Trust procuring a comprehensive IT system that fulfils requirements.
B. Speciality Doctors (psychiatry) (Registrars)	0	
C. Paediatric medical treatment (Consultant)	0	
D. Senior Clinical Staff (Bands 8a and 8b)	0.1	
E. Eating disorder therapists (Band 7)	0.4	

F. Home treatment specialists (Band 6)	0.2	
G. Dieticians (Band 6)	0	
H. Support Staff/Assistant Psychologists (Band 4)	0	

Recommended WTE Staff Broken Down by Role

Number of referrals per annum	**150**	**100**	**50**
	Whole time equivalents		
Therapists	16.8	11.2	5.6
Supervisors	4.8	1.6	0.8
Dietician	4.8	1.6	0.8
Medical	6.0	3.0	1.5
Administrative staff	7.8	2.6	1.3

Discipline	***Wte actual September 2015***	Comment Number of referrals per annum
A. Therapists	We presently do not have a dedicated workforce for eating disorders. The generic workforce meet the needs of young people on a case by case basis	
B. Supervisors		
C. Dietician		
D. Medical		
E. Administrative staff		

7.8 **Competencies/training**

Recommendations	Where we are /baseline	Where we need to be and action
A. Develop multi-disciplinary eating disorder teams	• Currently managed by generic CAMHS clinicians	• Need to develop dedicated specialist team.
B. Understand the complex nature of eating disorders. Develop early intensive skills training and support and supervision	• As a service we understand the complex nature of ED	• Need to develop dedicated specialist team to deliver evidenced based training
C. Develop a strong team culture	• Strong team culture currently which benefits from the paediatric input and established structures for care planning and supervision	
D. Adopt core CYP IAPT principles	• Action plan developed	• Needs IT infrastructure (planned 2016)
E. Evaluate the impact of training on transformation of services	NA	• Outcome measurements as per CYP IAPT
F. Local Education and Training Board to be aware of the number of professionals provider has identified who need training and link with regional plan to meet local need	Whilst training has had a positive impact in supporting young people we acknowledge the need for a strategic approach to ensure investment is driven by need in communities for specialist provision	• To be developed as part of wider strategic plan to ensure that resources meet local need- top be driven by the FIM delivery group

8. South Unit of Planning
Derbyshire Healthcare NHS Foundation Trust

8.1 Summary of Current Provision

We are a CYP IAPT compliant CAMHS service that has been on a service transformational programme to introduce the IAPT themes and principles over the past 4 years. We are therefore committed to strive towards evidence based interventions, care pathways, routine outcome measures, improving access and service user participation. Following a service review across the specific CAMHS pathways and in preparation for the transformational investment, we supported 2 staff on the Specialist CYP IAPT Systemic Family Practitioner training for eating disorders and 1 accredited Family therapist on CYP IAPT supervisory training. In support of this training we had to put together a small Community Eating Disorder Team. As a requirement of the training programme, and in accordance with the transformational service model, we invested and developed a specific Eating Disorder pathway supported by care bundles which provide a framework for safe and effective practice. The training team has been developed which includes the staff identified in table 2 below which is currently targeted at 15 - 20 cases per year (as a requirement of the training programme). Other young people with an eating disorder can access the specialist team via consultation from the generic CAMHS clinician.

Generic CAMHS provides services for approximately 90 young people who have been referred with an Eating Disorder (5% of CAMHS accepted referrals per annum) including anorexia nervosa, bulimia and EDNOS. Currently we are able to offer a first assessment within 1 week if required (not always an ED specialist or treatment). For none urgent an appointment can be up to a 6 - 12 week wait for a first assessment (not always treatment). There is currently then a wait to treatment depending on severity of presentation and availability of current specialist resources.

8.2 Prevalence and numbers

South Derbyshire
630,000 population
Eating disorder referrals seen by CAMHS (5% of all referrals accepted by CAMHS) - 90 (pa)
Currently 15-20 cases per annum seen in training team - meeting NICE guidelines
Current workforce resource for eating disorder training team – 3.4 staff (8% of total staffing exc. admin)

Note: *Children and young people current team resource is 3% above the parallel prevalence data. Which is an additional resource only provided for the purposes of the training team and is not sustainable once the CYP IAPT backfill runs out in January 2016.*

Young people with eating disorders in South Derbyshire are currently referred to the generic CAMHS service primarily from other Health professionals. The referrals are read on the day of receipt by a senior CAMHS clinician and if there is concern about a possible eating disorder this would be reviewed by a clinician with experience of eating disorders and a clinical judgement will be made whether an urgent or routine appointment is provided via the single point of access (SPOA). Further information may be requested at this point (blood tests / current weight and height) from the referrer if this is not provided and it is not urgent.

The current eating disorder team is led by a Consultant Child and Adolescent Psychiatrist who works in partnership with a clinical team manager, specialist nurse, dietician and the two SFP trainees. In addition our work with young people with an eating disorder forms a part of the generic CAMHS duties and is supported by the Specialist Eating Disorder care bundle.

Please note that following a recent skills audit there is a recognised skills deficit across the teams (CAMHS Skills Audit 2015). There is a workforce plan to address this and will be part of the Community Eating Disorders Team role to support in the development of CAMHS core competencies in relation to eating disorder presentations. The service is also under capacity by approximately 60% according to the Royal College of Psychiatry CAMHS workforce model 2014; DH CAMHS Service Spec.2015. This therefore impacts on our ability to provide NICE compliant treatments within a compliant time frame for some of the young people accessing CAMHS.

8.3 **Staffing - Current Specialist Community Eating Disorder Team**

South Derbyshire	**WTE**	**Band**
Dietician	0.6	6
Specialist Eating Disorder - Systemic Family Practitioners in training	2	7
Specialist Nurse	0.3	7
Clinical manager	0.2	7
Family therapist	0.1	7
Consultant Psychiatrist	0.2	
Total	3.4	

The current service model is supported by the CAPA (Choice and Partnership Approach) which provides a framework from which to provide a Maudsley based treatment service that also includes Group Family Therapy, systemic family interventions, dietician support, meal time support and observations, medical assessment and monitoring, support to paediatric care, case management, clinical and patient outcomes used throughout practice and service user involvement. The service also benefits from a close working relationship it has developed with the paediatric department at the Derby Royal Hospital; clear working arrangements are still in development however this is an area that continues to strengthen as a result of the specialist CED Team.

The specialist CED team meets weekly to discuss all cases, review all referrals and assessments and provide an opportunity for the development of a shared formulation and care planning process within a multi-disciplinary team.

8.4 **Service Development**

In order to meet the recommendations specified in the Access and Waiting Time Standard for Children and Young People with an Eating Disorder, NHS England July 2015, and CAMHS would need to develop the existing service using additional resources to form a dedicated and specialist CEDS-CYP. Due to the specific targets in the Eating Disorder Specification regarding reduction of Tier 4 placements, improved access, equality of provision, waiting time and access to NICE compliant treatment targets and percentage improvement through paired outcomes it is proposed that the additional resource is required to develop the delivery of the specialist and intensive therapeutic service. This would enable the South CAMHS CEDS to accept an increased number of referrals.

CAMHS recognise the care and commitment shown by colleagues in the paediatric department at Derby Teaching Hospitals NHS Foundation Trust in offering a high standard of service during inpatient admission. Whilst there is a plan to add a minimal amount of resources to the ward, the development of CEDS and the consequent provision of a robust service around the needs of young people and their carers in the community will result in a reduced requirement for lengthy inpatient episodes.

We aim to build on the integrated care pathway with the Adult Eating Disorders Team, by sharing resources, joint training and group family treatment models. (See APPENDIX 2)

8.5 South Derbyshire: Finance and the proposed Model

Additional staffing required to deliver the service:

Post	Band	Phase 1 (wte)	Cost	Phase 2 (wte)	Cost
Admin support	2	1	£19,300	0	
Support Workers – Third Sector	4	0	0	2	£53,167 (indicative only)
Specialist Transition Worker	6	1	£36,567		
Psychologist/Senior Clinician	8a	0.5	£44,261	0	
Therapists	7	0.5	£21,921	1	
Senior Therapist / Team Manager	7	1	£43,842	0	
Family Therapist Supervisor / Clinical	7	0.2	£8,768	0	
Paediatrician / paediatric support	Cons	0.1	£11,020	0	
Psychiatrist (Head of Service)	Cons	0.4	45,162	0	
Pay Cost			**230,841**		
Non Pay			**26,333**		
Overheads			**38,576**		
Total Cost			**295,750**		**£53,167**

Eating Disorders - Transforming Services Baseline Data and Action Planning

South Unit of Planning Derbyshire Healthcare National Health Service Foundation Trust (DHCFT)

9. Needs assessment /baseline data and action plans

It is recommended that CCG commissioners establish how eating disorder services are currently provided and if they meet the standards highlighted below. If they do not meet these requirements, CCGs should work together to either commission a new CEDS-CYP or alter our current service provision in-line with requirements and should reference this in our Transformation Plans.

9.1 **Treatment**

Recommendations	Where we are /baseline	Where we need to be and action plan
A. How is service is improving early identification	• Currently working towards all referrals being processed by a single point of access. Referrals are not currently made directly to CAMHS eating disorder from outside the CAMHS service.	• Improved links with primary care, schools and voluntary sector to improve identification of potential cases of eating disorder and promote prompt referrals. Easily accessible information needs to be available regarding referring directly to specialist team.
B. Offer evidence-based family interventions that directly address the eating disorder	• Two members of staff are currently completing CYP IAPT Systemic Family Practice for Eating Disorders training due to be completed January	• Offering family based interventions to all cases of eating disorder where this type of intervention is clinically indicated and accepted by the family.

	2016. We also offer family therapy as a service to a limited number of families with eating disorders.	
C. family members including siblings should normally be included in treatment	• As a service we seek to include family members in treatment routinely.	• The increase in availability of family based interventions alongside systemic thinking about care planning should ensure that family involvement is paramount.
D. interventions may include sharing of information, advice on behavioural management and facilitating communication	• This has been built into the Eating Disorder Care Bundle which provides guidance to both generic and specialist ED clinicians.	• Robust early assessment should ensure that psycho-education and behavioural advice is given in a timely and effective manner. An extended and skilled team will aid effective communication with families, GPs, schools, voluntary and other agencies
E. Offer age-appropriate care to address rise of early-onset eating disorders in those under 13	• We currently accept referrals from any child or young person under the age of 18 years	• Improved recognition and identification of eating disorders should help to identify those with an eating disorder at an earlier stage. Evidence based therapies including SFP will be offered to this age group.
F. accessible to females and males and culturally appropriate	• We currently accept referral from both females and males	• Training and education would aim to encourage identification of males with eating disorders as they are likely to be under recognised and stigma may be greater.
G. Clinicians will need to continue to offer NICE-concordant treatment within the framework outlined in this guide	• Partially met via the training team – no current access to CBT-E, CAT, Family Group therapy, limited resource for meals observation and limited home treatment support	• Focus on providing evidence based treatments within the defined time periods such as family based interventions, CBT-E and treatment of any co-existing mental health problems
H. Treatment should include	• Our service currently offers a limited	• Staff to be trained in CBT-E with

specialised community family interventions for anorexia nervosa and specifically adapted forms of CBT for bulimia nervosa, in particular CBT-E	population of our patient's systemic family practice for eating disorders through the training team. Although we offer CBT when appropriate we are not currently offering CBTe.	appropriate supervision arrangements.
I. Use up-to-date evidence-based interventions to treat the most common types of coexisting mental health problems (for example, depression and anxiety disorders) alongside the eating disorder	• Our service follows NICE guidance and offers evidence based interventions for depression, anxiety disorders and other co-existing mental health disorders – currently limited due to resource capacity.	• We are further developing a treatment pathway model so that there is streamlines access to evidence based therapies and treatments for co-existing mental health conditions

9.2 **Creation of a service to meet waiting time Standards**

Requirements for a viable and dedicated eating disorder service

Recommendations	Where we are /baseline	Where we need to be and action plan
(NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.	• We currently do not meet this target to treatment. An initial assessment with physical health assessment are priorities for urgent referrals within one week. For routine cases assessment and then time to treatment can very across the service (4-12 weeks). Access to the training team is limited and has strict eligibility criteria Fifteen young people have been accepted by the team and treatment has been	• Additional resources would enable us to achieve this target. The training team is not working at full capacity, but we will require additional staff to achieve this target.

	provided within 4 weeks of referral	
A. ***Move away from small teams - 1 team preferred*** B. A 'hub and spoke' model or local network model may be appropriate, with a clearly defined structure and strong leadership.	• We have developed 1 centralised Specialist training team that can be access by the other generic CAMHS teams.	• Single provider model would work well in the future. However a potential model of two providers under 1 steering group with clear policies regarding governance, accountability and an agreement of shared resources when appropriate to attain the required targets, KPI's and NICE concordant treatment.
C. Receive a minimum of 50 new eating disorder referrals a year, which are likely to include anorexia nervosa, bulimia nervosa, binge eating disorder and related diagnoses	• We do not have capacity currently to meet this target. The training team working at full capacity and meeting the NICE concordant treatment would only be able to hold about 30 cases.	• We would envisage the proposed team to work with 65 referrals per year. In addition to providing support and consultation to eating disorder cases within the generic CAMHS, ensuring concordance of the ED care bundle.
D. Cover a minimum general population of 500,000 (all ages)	• We currently cover the population of South Derbyshire and Derby City – population of 630,000	• To extend to cover the Derbyshire the population of around 1,000,000 to include North Derbyshire with population of 380,000
E. Include medical and non-medical staff with significant eating disorder experience	• We currently have established an eating disorder team to support training for CYIAPT SFP for eating disorders. This is a multidisciplinary team containing a child and adolescent psychiatrist, dietician, 2 CYIAPT trainees, family therapy supervisor, dietician and nursing. The capacity of this team is currently limited.	• We wish to increase the capacity of the specialist eating disorder team by increasing the clinical time of the multidisciplinary team.

F. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Some areas of the CAMHS service accept self-referrals –primarily 16-18 year olds can access the drop in at City Connexions.	• Extend access by allowing self-referral and direct referrals from primary care, schools and voluntary sector for all patients with a suspected eating disorder. This role historically was partially achieved through the PMHWs. It is our wish that access to this pathway can additionally be supported by the development of social media and web based information.
G. Most children and young people should be treated in the community with inpatient admission considered where there is high or moderate physical risk	• A 2015 sample audit found that our admission rate to adolescent inpatient psychiatric care was 35%. The baseline data for 2014-2015 (12M) from the EMSCG suggested that there were 83 admissions for the whole of Derbyshire (Inc. North) with an average length of stay of 106days. We estimate that the admission rate is approx. 50% of this figure for ED's.	• A specialised eating disorder team would aim to both reduce admission rate and length of stay due to earlier access to evidence based treatment and increased ability to liaise with inpatient units to facilitate earlier discharge
H. Admission should be to appropriate facilities with access to educational provision and related activities.	• Adolescent psychiatric units are required to have educational provision. There is also an educational provision for patients on the paediatric ward	• The specialist CED Team will have the opportunity to develop the specialist links and pathways to support educational attainment whenever possible.
I. When inpatient admission is required, this should be **within reasonable travelling** distance	• Currently patients are placed at nearest appropriate inpatient unit however due to lack of Tier 4 beds this can lead to placements at a considerable distance.	• It is unclear if this will be modified with increased resources in a specialised eating disorder team.
J. User involvement in commissioning	• A service user group is already in	• Service user engagement to continue

	place	regularly

9.3 **Referral Process**

Recommendations	Where we are /baseline	Where we need to be and action plan
A. The CEDS-CYP should have clear online referral forms.	• Currently not available	• Our aim is that this is supported the development of online self-referrals and access to detailed information across the NHS and our partners web pages.
B. Enable direct access to community eating disorder treatment through self-referral and from primary care services (for example, GPs, schools, colleges and voluntary sector services)	• Currently not available	• Extend access by allowing self-referral and direct referrals from primary care, schools and voluntary sector for all patients with a suspected eating disorder.. • Access to this pathway can additionally be supported by the development of social media and web based information.
C. Each service should have clear, accessible contact details on a website, which are easy to find via main search engines, with clear instructions in appropriate languages on how to call the service, send an email or complete an online self-referral form.	• DHCFT and CAMHS have a web site that is accessible. This is currently being reviewed by young people with the proposed development team to include young people and families to make it more accessible and user friendly.	• Introduce one direct contact point for referrals for suspected eating disorders • Our aim is for the development of online self-referrals and access to detailed information across the NHS and our partners' web pages.

D. <u>Avoid lengthy referral in house processes</u> CAMHS team is required to make contact with the CEDS-CYP as soon as the possibility of an eating disorder is raised. This should be done by telephone or electronically following discussion with the child or young person and their parents or carers.	• Currently access to the CED training team is limited and presentation is specific to training criteria and therefore there is not a full and equitable service being provided.	• Additional resources would enable us to achieve this routinely.
E. The causes for missing an appointment should be investigated carefully, and the referrer and the GP/trusted adult informed. This is recorded in the child or young person's clinical notes. An appointment should be booked to take place within 2 working days of the missed appointment.	• There is not capacity within the team to provide this as standard. Good practice regards recording of missed appointment and a follow up telephone call is routinely carried out.	• The CED-CYP will have the ability to directly investigate missed appointments and inform GP/trusted adult. Appointments will be rescheduled within 2 working days.

9.4 **Classifying risk and urgency**

Recommendations	Where we are /baseline	Where we need to be and action
A. Telephone or in-person contact to be made with the child or young person and the parent or carer *on the same day* to clarify risk. This	• We currently offer a generic CAMHS duty system which is available should the referrer request information. Via SPOA (often not on the same day of	• Greater staffing levels within the specialist eating disorder team would allow professional to contact to be made on the same day to clarify risk.

rapid response is essential when it is not known if the child or young person is under the care of a healthcare professional and the level of risk remains unclear	referral) a request by a non-specialist may be made to the referring agency for clarity or request urgent information regarding risk, for example, weight, height, and blood test results. • There is no system as yet for this to be followed up by the specialist CED team.	
B. For some milder presentations supportive eating disorder treatment may be provided in a primary care setting with treatment by trained eating disorder staff. If treatment is delivered in a non-eating disorder, supportive setting, the CEDS-CYP must oversee treatment and provide consultation and supervision.	• Not available	• Consultation and supervision to GPs and school nurses to be provided by members of the CEDS-CYP. It is also our aim that we will be developing our online resource to facilitate this and improve access.

9.5 **Information sharing with parents / carers**

Recommendations	Where we are /baseline	Where we need to be and action
A. Guidelines referenced in the Working together to Safeguard Children website and Paragraph 12 and 13 of the Mental Capacity Act	• Current guidelines met	• N/A

2005 Code of Practice are followed re: sharing information with parents and carers with respect of 16 and 17 year olds.		

9.6 **Workforce competencies and experience**

Recommendations	Where we are /baseline	Where we need to be and action plan
The team's collective membership needs the following expertise:		
A. Psychiatric assessment for children and young people	• We aim to offer comprehensive assessment within a team approach. This focuses not only on concerns regarding eating difficulties but also a broad based mental health assessment. • The broader service has a mental health liaison team and we work with this team to provide continuity of service in relation to assessment and risk management. We also, where appropriate, link with other health care professionals working with family members e.g. parents or siblings.	• The Consultant Psychiatrist along with other staff with appropriate mental health training will complete this as part of initial assessment and on-going treatment and review within the CED-CY team.
B. Medical assessment and monitoring	• Medical assessments are carried out in the community CAMHS teams mainly by a Consultant Psychiatrist. Requests for blood tests are often made to the GP at time of referral to assist with the assessment.	• Earlier medical assessment as part of a comprehensive early initial assessment alongside other members of the multidisciplinary team. More input from Consultant Psychiatrist, liaison with GP and when necessary paediatric assessment.
C. Rapid response to referrals- outlined in the care pathway	• Referrals are screened within Community CAMHS teams and urgent	• Referrals to be screened by member of the CEDS-CYP on day of receipt and

	response taken if necessary	action taken according to risk.
D. Staff trained to supervisory level for evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• Currently there is some capacity for supervision of targeted family interventions and limited CBT. • CYP IAPT trained Systemic supervisor (0.1 per week)	• Increased supervisory staff including in family therapy/practice to support both the clinical delivery of family based interventions and to consider the systemic networking requirements of working in an intensive treatment modality, supporting all families accessing family based interventions. There is an identified need to increase CBT capacity, in particular there needs to be supervision for CBT-E.
E. Staff trained in the delivery of evidence-based psychological interventions for eating disorders (to include CBT/CBT-E and targeted family interventions)	• Some staff have already been trained in CBT through CYP IAPT. Currently 2 members of staff are training in CYP IAPT Systemic Family Practice for eating disorders – there is currently limited access to all therapies as a result of demand and capacity.	• More training is needed for CBT-E specifically and SFP to allow for staff changes and absence to ensure a robust service.
F. Community care: the team should have the experience to be able to provide home treatment and family support	• Limited interventions in the home environment currently taking place where necessary.	• An increased capacity to support home treatment where this is identified as a benefit – we aim that this role could be developed in partnership with our third sector providers.
G. Acute service and paediatric support: support should be provided to these services 7 days a week	• Currently cases are managed within on call service which includes general hospital paediatric service if necessary, on call trainee and	• Involvement of a named Consultant Paediatrician within the CED-CYP. This would allow co-ordinated paediatric assessments for complex

	Consultant psychiatrist. There is currently no specialist eating disorder service out of hours.	community cases and effective management for any short term inpatient paediatric admissions. We would aim to gradually work towards providing assessments from the CED-CYP within 24 hours of referral.
J. There should be lead consultant/champion for acute eating disorder care, as advised in the Junior MARSIPAN	• There is at present no dedicated consultant champion for acute eating disorder care,	The specialist eating disorders service would provide appropriate psychological and medical and social support interventions aimed at recover and the reduction of risk in accordance to the NICE guidelines and the junior MARSIPAN.. this will be achieved by the recruitment of the paediatrician and the integrated of care being developed with the CRHFT It is anticipated that the psychological interventions delivered will be a minimum of 6 months duration, as identified by NICE 2004 .The presence of a specialist service is expected to facilitate earlier discharge of patients from specialist inpatient units. This service would be a tertiary service accessed via the CAMHS team.
H. Administrative and management support; by experienced staff with training in relevant areas including data entry.	• Some limited administrative support provided to training team	• Increased administrative staffing of CED-CYP to ensure effective referral process. There also needs to be effective on-going communication with primary care, school health and other agencies

9.7 Disciplines

A CEDS-CYP should be a multidisciplinary team of medical and non-medical staff with significant training and experience in the assessment, risk management and treatment of children and young people with anorexia nervosa, bulimia nervosa and their variants. These teams require a high level of expertise (both medical and non-medical) to be able to manage the level of medical risk safely and to provide continuous high-quality supervision for the psychological treatments.

Recommended WTE staff broken down by profession

Number of referrals per annum	150	100	50
	Whole time equivalents		
Head of service (psychiatry/psychology)	1.8	1.2	0.6
Speciality Doctors (psychiatry) (Registrars)	2.4	1.6	0.8
Paediatric medical treatment (Consultant)	0.3	0.2	0.1
Senior Clinical Staff (Bands 8a and 8b)	2.5	1.7	1.3
Eating disorder therapists (Band 7)	10.1	6.7	3.4
Home treatment specialists (Band 6)	3.8	2.5	1.3
Dieticians (Band 6)	2.3	1.5	0.8
Support Staff/Assistant Psychologists (Band 4)	2.7	1.8	0.9

Discipline	*Wte actual September 2015*	Within the CED training team we estimate 20 referrals this year will be seen. In January 2016 this team will be able to see between 25 and 30 cases per year but with limited access to NICE compliant therapies.
I. Head of service (psychiatry/psychology)	0.2	
J. Speciality Doctors (psychiatry) (Registrars)	0	
K. Paediatric medical treatment (Consultant)	0	
L. Senior Clinical Staff (Bands 7)	0.6	
M. Eating disorder therapists (Band 7)	2 (in training) (actual only 2 days in service)	
N. Home treatment specialists (Band 6)	0	
O. Dietician (Band 6)	0.6	
P. Support Staff/Assistant Psychologists (Band 4)	0	
Total	3.4	

Recommended WTE staff broken down by role

Number of referrals per annum	150	100	50
	Whole time equivalents		
Therapists	16.8	11.2	5.6
Supervisors	4.8	1.6	0.8
Dietician	4.8	1.6	0.8
Medical	6.0	3.0	1.5
Administrative staff	7.8	2.6	1.3

Discipline	*Wte actual September 2015*
F. Therapists	2
G. Supervisors	0.1
H. Dietician	0.6
I. Medical	0.2
J. Administrative staff	0.0

9.8 **Competencies/training**

Recommendations	Where we are /baseline	Where we need to be and action plan
A. Develop multidisciplinary eating disorder teams	• In recognition of the proposed transformational funds we established a training CED team in January 2015 to enable us to develop pathways, and specialist models pf practice to meet a small number of young people with eating disorders accessing the service.	• The full CED team will be established in January 2016 but with limited capacity. The proposed additional staffing will make this a NICE compliant CED team
B. Understand the complex nature of eating disorders	• All generic CAMHS staff have a basic knowledge – this is an area that was highlight in a recent skills audit as an area of further development	• Training to all staff. Access to the specialist CED team for consultation and support. The implementation of the ED Care Bundle.
C. Develop a strong team culture	• In development	• Ongoing
D. Develop early intensive skills training and support and supervision	• This is proposed and highlighted in the skills audit	• Training to all staff. Access to the specialist CED team for consultation and support. The implementation of the ED Care Bundle.
E. Adopt core CYP IAPT principles	• We are a CYP IAPT CAMHS who have been in transformation for over 4 years to fully implement and comply with the CYP IAPT principals. The	• We will continue to transform CAMHS in line with the CYP IAPT principals and are working towards fully integrated care pathways, supporting

	CYP IAPT outcomes are routinely collected, evidence based pathways have been developed, increased access to evidence based interventions, fully service user participation models throughout the service and up to Exec Board level.	workforce development strategies across all CYP services.
F. Evaluate the impact of training on transformation of services	• We currently provide quarterly reports to the Department of Health on our transformational progress. We have regular visits from senior DH staff to evaluate our performance. We have recently commissioned an independent skills audit and had a full service evaluation carried out by the DH.	• Ongoing
G. Local Education and Training Board to be aware of the number of professionals provider has identified who need training and link with regional plan to meet local need	Whilst training has had a positive impact in supporting young people we acknowledge the need for a strategic approach to ensure investment is driven by need in communities for specialist provision	• To be developed as part of wider strategic plan to ensure that resources meet local need- top be driven by the FIM delivery group

APPENDIX 1 Engagement Event User feedback – 23rd July , 12th August and 20th August 2015

(Stakeholder participation list : refer to: appendix 1 FIM main submission)

They say we do…

- Training for youth workers, school nurses, sexual health service and GPs
- More joint multidisciplinary training
- We want a link worker with our school who knows us and help us through our journey to recovery

- We want more face to face support in a range of ways. Web sites are not always the answer
- More peer support groups please
- Involve my: sports clubs, dance schools, gymnastic club..give them the knowledge and skills to spot the signs ..and help

We want our own shared record –a single record that everyone can see – but we own and carry ..like my baby brothers red book.

.

- Training for GPs need to improve communication
- Talk to me sensitively.
- Less focus on my BMI, more on my mind-set.
- Treated as a person, not just a problem.

- More Preventative work: in school from Y8/Y9.
- Drama groups in schools
- Assembly's led by First steps so useful .. from service users with ED

APPENDIX 2

Developing a single all age eating disorder pathway
What will it look like?

A service user's journey

1. Description and Aims

An adult pathway is already in place. It has achieved significant benefits to service users and delivered savings to commissioners by reducing expenditure on inpatient provision achieved through better, including intensive, community-based provision. A partnership with a specialist third sector provider delivering a wide range of non-clinical support has been a key component of that pathway.

There is both a moral (parity of esteem) and financial imperative to achieve a single pathway/single specialist eating disorder service for young people mainly age 14+ but we acknowledge some service users may be younger.

We will increase awareness and understanding amongst young people, and those who provide them with services, of the issues associated with eating–related problems and to provide them with good information and signposting to where they can get help. We will support the delivery of high quality, accessible non-clinical advice and support to those who might be affected by their own, or another person's, eating disorder but whose needs are below the threshold for specialist clinical services. Such support also provides an additional means of identifying those who need to be referred for assessment. It is also important as part of a care plan to those who are in treatment or recovery from eating disorders.

This will include a partnership with a specialist third sector organisation commissioned to provide:

- A range of information and signposting to services;
- Opportunities for young people and their families to both seek information and advice including the opportunity to participate in workshops and training events to improve their understanding of the nature of eating/food-related illnesses,
- Support C&YP to help themselves and when to seek specialist help; training workshops agreed with CAMHS providers , and supported by and other similar commissioned services, with related functions to build confidence and capacity within the wider workforce and reduce dependency of specialist services;
- Increase opportunities for those affected to be considered for volunteering and to improve their self-esteem and build personal resilience through participation.

2. Anticipated benefits

Staff in universal and targeted settings will:

- have good information about body image, eating disorders and associated problems amongst children and young people for their own use and to display/distribute;
- Be alert to eating disorders and associated problems amongst children and young people;
- Know how to recognise behaviours and other symptoms that may indicate eating related/body image problems;
- Know how to get advice and help and where to refer children, young people and their parents carers;
- Know how to respond to concerns and signpost young people parents to services that can provide advice and information;
- Encourage and assist schools and services to develop their internal own policies and procedures to support young people receiving help and treatment for eating disorders, or who are in recovery;
- Generate requests for information and advice and referrals for help;
- Increase the numbers of referrals for advice, information and practical help and support in the community;
- Identify those requiring specialist assessment/treatment before their needs become urgent;
- Ensure Early Help Assessments are completed to ensure wider needs are not overlooked;
- Provide community support to young people and their carers who have low-moderate levels of need to prevent the development of more serious/complex problems.

3. Requirements - help and support for workers, services and community groups

A rolling programme of education and support

- In partnership with schools, a programme of body image workshops targeting year 6 and year 9
- Weekly drop in sessions in colleges
- Family empowerment workshops which enable parents/carers to develop their knowledge and skills/build resilience to enable their family to cope with the stress and difficulties caused by eating disorders

Occasional/bookable /bespoke

- CPD courses for professionals accredited by British Association for Counselling & Psychotherapy (BACP)

Workshops for

- GP's and health care professionals to help ensure that they are correctly able to diagnose people with an eating disorder
- Workers involved in training and health promotions to ensure a consistent approach to eating disorder issues within broader programmes – this includes schools nurses and children in care nurses and workers with health promotion roles
- Those working with vulnerable groups such as children in care, children with special educational needs, children who are out of school (e.g. Multi-Agency

Teams, youth clubs) and for those services which are well placed to identify young people with possible early signs of eating disorders such as sports clubs, gyms, swimming clubs, etc.
- Presentations to community, voluntary and faith groups, leisure centres, dance groups

4. Requirements - for those affected by eating disorders and their families

A range of services that aim to build self-confidence and self-esteem and resilience amongst those at risk of developing/who have developed eating disorders, including:

- the provision of information, advice and guidance for young people and their parents/ carers especially in accessible on-line and web-based formats;
- 365 days per year online support in the form of one to one befriending and (private and confidential) online support forums which will be regulated and monitored;
- weekly structured self-help support groups across the county incorporating skills and strategies to help them to overcome their eating difficulties and disorders ;
- complimentary groups that include expressive arts, drama, dance, information and relaxation;
- the targeting of information and support to help young people and their families to identify when they need help and to encourage self- referrals for clinical assessments;
- one-to-one and peer support as part of care plans;
- a range of volunteering opportunities and work placements that enable those who have used the services to engage with it as providers in ways commensurate with their abilities;
- In partnership with CAMHS and the Specialist Community Eating Disorder Service, weekly family support and sibling support groups to help family members to gain peer support and develop their own support networks.

5. Bundles of Care – outcome focused

The CYP ED service will be outcome /outcome focussed delivering “bundles” of care that use recommended interventions to address all problems for which there is a proven intervention, not just the main presenting problems. This evidence is becoming increasingly sophisticated in relation to what works, for whom and in what circumstances and on how best to implement these new approaches. Central to this is an approach based upon:

- Shared decision making to support patient preference (for example Choice and Partnership Approach [CAPA]); and
- Rigorous use of Routine Outcome Measures (ROM’s)

6. Anticipated Outcomes

- Improved outcomes through early intervention and multi-method for those with moderate difficulties and where ED is part of a broader range of needs

- Improved outcomes through early access to a specialist service for those with acute/urgent needs
- More young people identified
- Access to evidence based interventions
- Reduction in the numbers requiring a specialist and an intensive home treatment service
- Improved patient experience/better engagement
- Fewer young people requiring intensive interventions
- Shorter recovery time
- Evidence of (some level of recovery) by 67% of young people referred
- Improved patient experience/better engagement
- Fewer and shorter hospital admissions
- More young people receiving help in their local community

7. Referrals via a single point of access (SPOA) for Young people and children with eating disorders

We aspire to have a single point of access across Derby City and Derbyshire county by 2020 . The pilots are documented in the main FIM plan and are presently being rolled out across Southern Derbyshire and been very successful in Derby city.

- Referrals are reviewed by Specialist ED clinician
- Appropriate appointment is provided
- Waiting time standards met

(Note: detail about roll out of SPOA 1.6 main FIM submission accompanying this document by email)

8. General Criteria

The criteria that are used to determine both suitability and urgency must have due regard to physical health needs, to the psychological impact and an assessment of the risks faced by the young person.

- Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Eating Disorder Not Otherwise Specified (ENDOS) will be the primary disorders the service will work with.
- Other conditions if compounded by serious physical/psychological harm and other presenting problems may meet the services' general criteria for referral.
- The suggested criteria for access/thresholds set out below are written with Anorexia Nervosa in mind but have relevance for other presentations with similar symptoms.

Other referrals will recognise an eating disorder as part of a wider spectrum of needs presented by a young person

9. Referrals for routine assessment (response within agreed KPI waiting times)

- Typically these will be non-urgent and timely referrals to CAMHS which should ideally not be made directly but should follow established best practice, namely:
- Schools and other services should refer via the MAT in the first instance to ensure that an Early Help Assessment can be completed, perhaps including

liaison with a PMHW, and onward referral to a specialist third sector provider and/or the GP or CAMHS as appropriate.

- They should use the Early Help/Team around the Family process to identify whether or not any services are already involved, or should be.
- Other agencies (e.g. a specialist third sector provider) should enquire of the family/young person which other agencies they are involved with and seek permission to make contact with CAMHS.

Self -referrals – young people and parents/carers can refer directly to the service

- Extend access by allowing self-referral and direct referrals from primary care, schools and voluntary sector for all patients with a suspected eating disorder..

Access to this pathway can additionally be supported by the development of social media and web based information.

10. Early referrals where weight loss is rapid.

Early referrals should be made where weight loss is rapid and the history suggestive of an eating disorder, such as:
80-90% *of median BMI for age and gender*

Additional criteria:

- *either:*
- Consistent and steady weight loss over a period of 3 months *and* loss of 5% of body weight over a 1 month period
- *or two or more of the following:*
- avoidance of some calorific foods ;
- aversion but not necessarily avoiding eating in front of others (if this is a change from their usual presentation);
- irregular self-induced vomiting/purging;
- actively attempting to continue with weight loss;
- self-perception of being too fat;
- minor increase in exercise ;
- Minor physical abnormalities with blood tests/ECG such as inconsistent menstrual cycle.

11. Referrals for urgent Assessment (within 2 days):

Typically these will be:

- Where immediate help is needed an urgent referral should be made to the GP, CAMHS or paediatrics.
- Where referrals are made to GP's, they should consider the need to undertake physical health checks in order to identify the symptoms of eating disorders and, where appropriate, check body weight and initiate physical health assessments including:
- height, weight and BMI measurement
- Pulse rate and blood pressure, and baseline blood tests, with an ECG for underweight individuals or where there is concern regarding continuing weight loss.

- Urgent referrals for initial assessment should be made directly to:
- CAMHS where a young person's body weight is below 80% of median BMI for age and gender
- to paediatric services if it is below 70%

With either:

- Consistent weight loss over a period of 3 months
- *or:*
- Loss 5-10% of body weight lost over a 1 month period

Plus three or more of the following:

- With avoidance of most calorific foods ;

- avoiding eating in front of others (if this is a change from their usual presentation);
- actively attempting to continue with weight loss;
- regular self-induced vomiting/purging;
- self-perception of being too fat;
- moderate increase in exercise ;
- Moderate physical abnormalities with blood tests/ECG such as recent stop of menstrual cycle, irregular dizziness, headaches, postural hypotension, and pulse less than 50.

- There should also be consideration of a referral to a specialist third sector provider for non-clinical support.

12. Referrals for Emergency Assessment (within 8 hours)

- Young people should be referred immediately for hospital admission :
- following result of intentional dehydration/starvation;
- Less than 75% of weight for height,

- *with either:*
- Loss of 10% of body weight or more lost over a 1 month period;

or three or more of the following:

- Avoidance of all calorific foods ;
- Actively avoiding fluid intake;
- Unable to cope without self-induced vomiting/purging;
- Severe increase in exercise (near constant level);
- Cold extremities and increased body hair growth;
- Refusing to eat in anything front of others (if this is a change from their usual presentation);
- Actively attempting to continue with weight loss with a weight goal set that would risk life ;
- Severe physical abnormalities with blood tests/ECG and amenorrhea for period of more than 3 months, regular dizziness, fainting, significant postural hypotension, reduction in cognitive ability, pulse less than 40 (consider A&E/emergency GP)

13. Assessment

Physical examination

Except for emergency/life threatening scenario requiring immediate medical attention, the first priority will be an urgent referral to a GP or a paediatrician for a physical examination to ascertain the young person's physical condition - weight/height/% BMI, bloods, ECG and any other necessary assessment with be requested urgently.

Engagement with the CAMHS service

The allocation of a worker/ engagement with the young person and his family in a collaborative partnership approach and the provision of information/education on

the nature of the condition. The young person and family will be given opportunity to book an appointment at a time and place to suit. An in depth assessment is likely to take more than one appointment.

Clinical assessment

- The assessment should be collaborative and strengths based and include the following:
- Insight and understanding.
- Psycho-education.
- Goal setting.
- Things to try at home.

Discussions with parents/carers to ascertain the extent to which they are able to be a resource to treatment plans as well as their views on /level of distress caused by the young person's presentation – confidentiality and capacity of the young person to consent need to be considered within this.

- Full mental state assessment and basic physical monitoring (weight, height, blood pressure and pulse) to include risk in relation to the criteria above as well as other co-morbidities such as OCD, depression, deliberate self-harm. Consideration to developmental disorders such as Autism should also be considered.
- The Specialist Community Eating Disorder Service should be consulted or actively engaged in the assessment process.

Risk assessment

This may indicate problematic eating behaviour that is not an eating disorder per se but part of another clinical condition. At this point a young person is likely to be in denial even when entering an acute phase

Consultation with the Specialist Community Eating Disorder Service

They can provide important advice, consultation and support throughout the referral/assessment process

Interventions by CAMHS – *this is most likely where the eating disorder is not the main presenting problem and is not so serious as to require a referral the Specialist Community Eating Disorder Service*

Nevertheless they will still be informed by informed by NICE Guidance, Junior Marsipan and the Maudsley Model.

14. A collaborative and flexible approach

- The approach should be collaborative and participatory such as Choice and Partnership (CAPA) that improves outcomes by:
- Focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning;
- Improving access by ensuring timely appointments that are fully booked i.e. no waiting lists;
- Ensuring service users are seen by a clinician with the right skills;
- Use of Outcome measures;

- Facilitates commissioning and provision of services by transparency of capacity and care packages;
- Being transparent demonstrating what is being done and with whom.

15. Treating an eating disorder as part of a multi-intervention approach such as Care Bundles

Care bundles are a systematic way of measuring and improving clinical care processes by grouping together interventions that are more effective if given together than alone. They are an agreed set or cluster of clinical treatments that a team will provide for a particular condition, based on best practice and/or local clinical opinion. Written in a clear and straightforward way, they should be quick and easy to monitor regularly. The aim is to ensure everyone receives the best care, based on evidence or logic, 100% of the time. They are more than a care pathway or package. Parents and young people need to be able to make informed choices of treatments.

This approach is likely to be of benefit primarily to young people with complex needs including an eating disorder of low-moderate severity which is not the primary cause for concern. The eating disorder element within the overall care plan should be overseen by the Specialist Community Eating Disorder Service.

16. The care plan

The care plan will be developed in collaboration with the young person and their family/carer. It will require close working with paediatric/dietetic colleagues to ensure the young person is provided with an individualised meal plan that takes account of their nutritional requirements. This should include joint sessions so as to support both the young person and parents/carers but also non mental health trained colleagues in relation to the mental health aspects of the young person's presentation.

It will include:

- weekly family/individual intervention
- a focus on management of the condition and a concern for the physical health of the patient
- intensive monitoring of physical wellbeing - weight, height , blood pressure and pulse – and liaison with primary care and education, including dietetics
- Providing interventions aimed at weight restoration (target = average 0.5kg per week) and the reduction in abnormal weight control behaviours
- Providing weekly psychological interventions, for example, CBT and family interventions that directly address the eating disorder
- Working with parents/carers in order to support young people in their home environment.
- Liaising with schools and other agencies to ensure their support for the care plan
- Taking a directive approach at a time when the family are anxious and uncertain
- Referral to (or continued involvement of) a specialist third sector provider for non-clinical support which should be incorporated into the care
- a directive approach at a time when the family are anxious and uncertain

- careful consideration of issues of consent and confidentiality/information sharing with the wider family especially during the handover process from CAMHS

17. Transfer to the Specialist Community Eating Disorder Service

Where the need for a specialist intervention is indicated, management of the case is to be transferred the Specialist Eating Disorder Service without delay. This will be where the primary concern is confirmed as a serious eating disorder and especially where:

- engagement is difficult;
- the risks are high;
- there is the likelihood of long term intervention and, perhaps, hospital admission.

CAMHS will have liaised with the Specialist Community Eating Disorder Service from the outset and actively involved it in decision-making.

Specialist Community Eating Disorder Service - Description and Aims
The Specialist Community Eating Disorder Service is commissioned to provide further and specialist help to young people aged typically from 13-17 at the request of the CAMHS and specialist help to those young adults typically aged 18 -25 on referral.

Its role is:

- To provide a multi-disciplinary intensive community treatment for young people/adults aged 13-25 on referral presenting with acute or severe and enduring eating disorders, primarily:
- Anorexia Nervosa that addresses the physical, psychological and social aspects of an individual's eating disorder for young people who are diagnosed as suffering from:
- Bulimia Nervosa;
- Eating Disorders not otherwise specified (EDNOS) including Binge Eating Disorder.
- using a 'hub' and 'spoke' model to deliver evidence based interventions, age-appropriate through a clinical network, with shared protocols, governance arrangements, common care pathways, information and communication systems, with access to appropriate training and supervision;
- to provide high quality pre and post inpatient preparation with service users as part of a streamlined inpatient integrated referral/discharge care pathway;
- to work in collaboration with inpatient (acute/medical) and specialist eating disorder inpatient services to deliver the seamless coordination of care and treatment ensuring the individual receives the service they require;
- To provide advice and consultation to primary or secondary care about individuals who are not currently eligible for direct treatment. Assessment is available for individuals where clarification on differential diagnosis would be helpful or where advice on medical management would be beneficial;
- work in partnership with a commissioned specialist third sector provider;
- to support other Third Sector organisations with clinical advice and support as required to support a range of self-help activities;
- Facilitate and co-ordinate information sharing and networking.

Its aims are to:

- Provide specialist early interventions to young people;
- Provide age-appropriate care and treatment as close as possible to home and equitably across the county;
- Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorders;
- To reduce the need for inpatient admissions and where clinically appropriate to reduce the length of inpatient stay;
- To reduce the length of time taken to access services;
- To carry out research and audit to improve the quality of care.

18. Referrals

These will comprise mainly young people:

- aged 13 - 17 referred to 2 x CAMHS teams;
- aged 18 -25 will be referred mainly to the Pathfinder service (The single point of entry) and will be mainly from primary, secondary and tertiary care including student health services

Young people with temporary addresses/GP registrations in Derbyshire will have the same level of access as young people resident in Derbyshire but subject to the terms of the Responsible Commissioner guidance “Who Pays? Determining responsibility for payments to providers”

19. Initial Assessments

- Joint assessments between the CYP Community Eating Disorders Service and the Pathfinder service can be arranged where this would be beneficial.
- Referral information should include:
    - summary of presenting condition;
    - detailed history;
    - any significant psychiatric or physical co-morbidity;
    - height, weight and BMI;
    - results of diagnostic investigations i.e. ECG, blood tests and serology;
    - any special needs;
    - medication.

20. Response times for referrals received by the service

Review and clinical prioritisation of referral (i.e. determining whether routine or priority) should take place within two working days
Priority will be determined by weight, rate of weight loss, physical health and information received from the referrer
Priority appointments should be offered to take place within twenty working days of being deemed a priority by the review and clinical prioritisation of the referral
Choice of first routine appointments should be offered in accordance with the trust timescales for routine first appointments
Referrals received from CAMHS will already have been assessed and prioritised.

21. Assessment and Care Planning

The care planning process will be flexible and collaborative and will take account of the needs of the individual, their families and carers as appropriate. The individual will be managed within the framework of the care programme approach (CPA) and the appropriate treatment/care plan including an assessment of risk should be agreed where possible by the multidisciplinary team in conjunction with the individual.

Care plans will take account of the intensity and frequency of treatment and define the roles and responsibilities of other clinicians, professionals and services involved in the young person's care. The care plan and risk assessment will be reviewed regularly by the Lead Professional or Care Co-ordinator to ensure validity and accuracy.
Practice in relation to individuals under 18 will be informed by NICE Guidance, Junior Marsipan and the Maudsley Model and will follow the approach set out earlier at paragraph 2.9

Practice in relation to individuals over 18 will be informed by NICE Guidance and Marsipan 2011

Additional requirements for individuals aged under 18
An individual may be in denial and difficult to engage, choosing to minimise all risks and seriousness of the condition.

In such circumstances, there will need to be consideration of powers and responsibilities under the Children Act 1989

General requirements

- The care plan will include how the individual's physical health will be managed and monitored and the Specialist Community Eating Disorder Service will:
- Work with individuals to deliver their care plan;
- Work together with carers and families in order to support individuals;
- Support carers and families;
- Provide advice and information in respect of eating disorders;
- Offer consultation and support around eating disorders issues to other services, self-help organisations.

Many young people aged 18 -21 may be living at home/be dependent upon their family for help when they are ill/in recovery – others will be living independently;

- There should be a choice of intervention style from age under 21 – family or individual focussed or both within a care bundle;
- family therapy is an intervention available to the Specialist Eating Disorder Service;
- maintaining the level of engagement of wider family members when a young person is in transition requires careful planning, especially with regard to North Derbyshire where the transfer of responsibility is not just between services but also between organisations;

- support from a specialist Third sector provider should continue, or be offered, as part of the care plan;
- consents and protocols will need to updated – where the family have been an integral part of the treatment plan, it will be important that updated agreements retain this level of engagement wherever necessary

22. Interventions by Specialist Eating Disorder Service

The Service will:

- offer high quality psychological interventions, for example, cognitive behavioural therapy, cognitive analytic therapy, interpersonal psychotherapy, psychodynamic psychotherapy, dialectic behaviour therapy, family interventions and family therapy;
- in collaboration with other services ensure that treatment is offered for all mental health conditions that are present alongside the eating disorder
- offer high quality interventions aimed at weight restoration where appropriate;
- offer a multidisciplinary approach in line with current NICE guidance, including access to psychiatric, dietetic and occupational therapy input;
- utilise the Mental Health Act 1983 (amended 2007) where appropriate;
- provide intensive community interventions (where clinically appropriate) e.g. group programmes, enhanced care packages such as home treatment or assertive outreach;
- provide support to acute medical inpatient units and psychiatric inpatient units when service users with eating disorders are admitted – where appropriate, this will include:
- GP's/primary care who will continue to monitor an individual's general health as necessary whilst they are receiving treatment
- the Specialist Inpatient Eating Disorder service to enable successful treatment outcomes which may include stabilisation of weight loss, weight restoration, improvement in physical health and the management of associated abnormal weight control mechanisms - specific individual outcomes are identified from the inpatient admission;
- a specialist third sector provider to deliver non-clinical support

Where service user is admitted to their local acute hospital for medical management or re-feeding then the Specialist Community Eating Disorder Service will provide regular input - the Specialist Community Eating Disorder Service, Acute Hospital and Specialist Eating Disorders Inpatient Unit will work in accordance to the MARSIPAN guidelines 2011.

23. Work with other agencies/services

The service will work collaboratively with other services as determined by the care plan, including:

- CAMHS
- Paediatrics
- GP's and other clinicians
- Self Help Groups
- Third Sector Providers
- Student Health Services

- Mental Health Services
- Acute Services e.g. maternity, endocrinology, gastroenterology
- Children's Services (transition standards to be followed)
- Primary Care
- Specialist Inpatient Eating Disorder Service
- CAMHS inpatient services

24. Intensive Community Interventions

- The treatment of young people/adults with severe eating disorders in the community is inherently complex and intensive. In all cases there will be a threshold beyond which either the service, the parents/carers or the young person (or indeed all of them) is unable to sustain treatment in the community.
- The purpose of intensive community interventions is to offer an alternative to specialist inpatient treatment, to stabilise or improve the physical health of clients with very low weight.
- It is not an alternative for individuals with physical health needs requiring an acute hospital admission nor to provide a step down treatment following an inpatient admission
- Intensive community treatment is a specific care package tailored to the individual available in their locality. Treatment may be carried out in the individual's own home or utilising local services (acute psychiatric services, rehabilitation services, day services, respite services and supported accommodation).
- The intensity of the intervention is determined by the individual's needs and is on a continuum between the normal community treatment and specialist inpatient treatment.
- This can be demanding and disruptive for the care plans of other patients/waiting lists and for the service which may need to be available evenings and weekends and limited capacity is available.

25. Non-clinical support in the treatment/recovery phase

There will be a Service Level Agreement with a commissioned a specialist third sector provider to:

- Assist service users in recovery and help them to "normalise" their lives again. Such individually tailored non-clinical support as part of the larger care package
- The range of support will be delivered as part of the intensive community care package determined by the care co-ordinator.
- These may include social eating, supported eating, cooking and shopping and other activities which have been compromised by having an eating disorder.
- For young people and their families this may include 1:1 support in the community and perhaps in settings such as schools.
- There may be scope for complementary roles with other third sector agencies.

26. Discharge process

- For many service users the criteria for discharge will be the improvement in the individual's situation and their ability to maintain improvement, either independently or with less specialist assistance. However, a significant proportion of service users move into a chronic course of the eating disorder.

- For them, the criteria for discharge may be when it is unlikely that further treatment within the service will give further significant benefit.

- For service users who experience difficulties in engagement, the service will seek to ensure that all steps possible are taken before the multi-disciplinary team decides to discharge an individual on the basis of their inability to engage in treatment ensuring appropriate liaison takes place with primary care. The service will adhere to the trust disengagement policy.

- Where a service user is discharged from the Specialist Community Eating Disorder Service into another adult mental health service, CAMHS or another health service, then a formal handover will take place.

- The discharge plan will include the mechanism for re-referral to the Specialist Community Eating Disorder Service should that be appropriate.

APPENDIX 3

Roles of the eating disorder team

Post	Role in service
Support workers (Voluntary Sector)	• Awareness raising • Early identification • Training and liaison with schools and GPs • Community support for young people • Developing peer support • Developing parent and carer support • Flexible working hrs in accordance with identified need • Support to engage young people in accessing the service. • Provide support to y/p at home • Support with meal times at home • Provide education and peer support in schools and within targeted services.
Assistant Psychologist	• Outcome measures • Audit project work • Initial screening response to referrals
Dietician	• Height/weight measurement and monitoring • Meal planning • Nutritional education • Parent/sibling support group • Work across paediatric department and CAMHS
Children's Mental Health Worker	• Initial assessment • Individual therapeutic intervention • Home support • Meal supervision • Parent/sibling support group • Case work – correspondence, liaison etc. • Support to parents and carers and the system around the young person
Intensive Home Treatment Worker	• Flexibile working hrs in accordance with identified need to reduce likelihood of inpatient provision

	• Support to engage high risk and young people not engaging in accessing the service. • To work with Tier 4 to support the transition of young people back to the community at the earliest opportunity.
Therapist/Team Lead	• Provision of specialist therapy • Provision of supervision to CEDS and CAMHS clinicians • Liaison and coordination of work with paediatric department • Advise on care planning for intensive family home support • Coordination of the work within the team
Paediatrics	• MDT coordination during paediatric inpatient stay • Coordination and monitoring of medical care • Medical input to care plan • Physiological screening e.g. bloods

Admin	• Support the collection and systems to collate outcome measures • Provide performance reports to support the • Initial screening response to referrals • Clinical input e.g. to group work
Senior Clinician/Psychologist (This may be different clinicians to meet the supervisory requirements of the accredited therapists)	• Provide specialist supervision • Support therapist to maintain the CBP and accreditation requirements • Specialist training in the team • Support the development of treatment pathways.
Consultant Psychiatrist	• Clinical leadership • Assessment and diagnosis • Oversee medical assessments • Ensure governance and adherence to Junior Marsipan and NICE treatment pathways

	• Design of treatment pathway with paediatric services and RDH • Share the chair peer supervision and clinical reviews across the service • Consideration of requirement for inpatient psychiatric admissions and use of the Mental Health Act
Specialist Transition Worker Outreach Worker – <u>Specialist Liaison Worker roles:</u> Possible Social worker – secondment. Target integrated care plans with MATs and Social care. Attendance at Section 117 and CPA Discharge meetings. Lead safeguarding role	• Support the integration of child and adult CED transition. • Provide continuity of care across the services • Access and develop the RO DBT pathway with the adult CED team. • Liaison with social care in support of Integrated care planning • Multi Family Therapy / Parenting worker – school liaison, case coordination and education – management of support workers.

Appendix 4
Easy Find Guide for Assessors – Commissioners Check List
Derbyshire County Council and Derby City Children and Young People's Eating Disorder Service Transformation Plan 2015-2020

Item	Yes/No	Comments	Page Number
Baseline current service provision			
Do you have a current eating disorder service ?	Yes	We have a service that needs strengthening building and skilling a dedicated specialist workforce be fit for purpose to meet standards and guidelines	12 and 26
Do you have any data about current outcomes, service user feedback and service activity?	yes	Base line data re: outcomes service activity Service user feed back	12-26 north 27- 45 south Appendix 1 46
From these data, can you identify gaps in service when comparing service provision with anticipated need?	Yes	Refer to gap analysis and action plans	12-26 north 27- 45 south
Needs assessment			
We have consulted the relevant data published by Public Health England through the former Child and Maternal Health Observatory			N/A
Do you have a JSNA?	Yes	Please click link below JSNA -state of mental health in Derbyshire. :https://www.derbyshire.gov.uk/images/Derbyshire%20Joint%20Strategic%20Needs%20Assessment%20-The%20State%20of%20Derbyshire_tcm44-260790.pdf	NA
Has the JSNA ensured that the new service satisfies all legal duties with regard to equality, health inequalities and monitoring improvement?	Yes		NA
Does the JSNA include the CAMHS Needs Assessment?	YES	The JSNA ***the state of mental health in Derbyshire*** should be viewed in conjunction with the baseline needs assessment detailed within this document.	12-26 north 27- 45 south

		Public Health and commissioners will continue to work closely with providers to focus bespoke local resources in areas of unmet need based on the local demographic features and wider determinates of health.	
Do you have a separate CAMHS Needs Assessment?	Yes	To be viewed in conjunction with JSNA	12-26 north 27- 45 south
Was the CAMHS Needs Assessment completed with local authority, public health and education partners?	YES		NA
If not, have you ensured that they have signed up to the CAMHS Needs Assessment?	NA	NA	NA
Have you created an eating disorder needs assessment in line with the CAMHS Needs Assessment and the JSNA?	YES	*We will strengthen needs assessment to include data on age, gender and ethnicity of service users*	12-26 north 27- 45 south And link above to JSNA
Does the eating disorder needs assessment include the views of children, young people and families?	Yes	Engagement ensured that views of children and young people heard – engagement events details and ***Attendance list –appendix 1 main FIM plan***	Appendix 1
Has current service provision data been included in the prediction of future needs?	Yes		12-26 north 27- 45 south
Does the eating disorder needs assessment include prevalence data on eating disorders for the population?	Yes	Based on current numbers seen by North and South Units of planning	12 and 27
Does the eating disorder needs assessment include demographic data, for example data on age, gender and ethnicity?	No	Need to strengthen needs assessment to include accurate data on age, gender and ethnicity of service users, as a priority. This will be facilitated by improved IT systems	8
Does the eating disorder needs assessment include	Yes	https://www.derbyshire.gov.uk/images/Derbyshire%20Joint%20Strategic%20Needs%20Assessment%20-The%20State%20of%20Derbyshire_tcm44-260790.pdf	NA

population data, for example data on population, projections, births, deaths and deprivation?			
Service Model			
Have you decided to commission a single service for your CCG?	No		
If no, have you decided to commission a service with other CCGs?	Yes	Single specification funded by 4 CCGs in the north and south of the county offering two units of planning north and south CCGs ***see below***	5-7
North Derbyshire unit of planning			
Hardwick CCG			
North Derbyshire CCG			
South Derbyshire unit of planning			
Southern Derbyshire CCG			
Erewash CCG			
Do you need to commission new services?	YES	As part of our Shared Priorities for first 6 months ***November –April 1015*** We will commission a specialist eating disorder service from the voluntary sector with a specific remit to support services and service users in community settings ***Our core specialist eating disorder service will build on exiting CAMHS services- recruiting and skilling the work force to provide evidence based*** **NICE** ***concordant treatment to meet the standard's required for crisis, waiting times and treatment.***	5-9 Appendix 3 *Roles page* 62
Have you tested the market in terms of potential providers and agreed the most effective procurement process for any new services identified?	Yes	Yes .. We presently have county and city wide voluntary sector specialist eating disorder provision. We link closely with 3rd sector providers within Derbyshire who support children and young people with ED In accordance with policy and procedures Derby City Council and Derbyshire County Council, in partnerships with CCG's will lead an open and transparent tender process following service specification development	5-9 Appendix 3 *Roles page* 62

Have you viewed and taken into account the Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)?	Yes	*Shared priority*	8
Have you viewed and taken into account New commissioning tools published for transitions from Child and Adolescent Mental Health Services (CAMHS)?	Yes		Na
Have you reviewed the CAMHS Payment System Project?	Yes		Na
Do you have a service specification that includes:			
The provision of age-appropriate services?	To develop	As a shared and high priority we will develop a service specification based on our vision for the children and young people's ED service outlined in plan and **Appendix 2. *Journey of a child through the system*** The county and city wide single specification will be steered through the Future in mind implementation group (see governance structure page 3.	NA
The provision of culturally appropriate services?	To develop		
Clear self-referral routes?	To develop		19, 20 , 37 ***Appendix 2 52-54***
A communication plan that includes information on how children, young people, families, carers and other professionals can access services?	To develop	Commissioners to develop with key stakeholders - As a high priority a communication plan with detail on how young people can access services with families and carers being supported Plans and direction of travel outlined in Appendix 2. Journey of a child through the system	Appendix 2
A plan outlining how families and carers will be supported, including clear guidance to ensure confidentiality is	To develop		Appendix 2

balanced by the need to keep children and young people safe?			
Services that have the capacity to support children with common coexisting mental and physical health problems?	Yes		16,33, 34
A process for managing the high risk of medical complications? (Paediatric services must be part of the proposal.)	YES	***Appendix 2 journey of a child through the system..***	APPENDIX 2
A plan for providing day care or intensive home treatment for those that need more intensive input?	Yes		29,40, ***Appendix 2*** 56,58
How the recommendations in the Junior MARSIPAN report will be embedded in service delivery?	YES		18, 23, 41, ***Appendix 2*** 53, 57, 58
Liaison plans			
Local acute paediatric teams linked into eating disorder teams for brief admissions for medical stabilisation?	Yes in North Unit of planning To develop Further in south unit of planning	Build on existing partnerships at Derby Royal Hospital FT and Chesterfield Royal hospital FT .(CRHFT) Paediatric teams to improve partnership and integrated working that can quickly facilitate brief admissions .This is well developed in CRHFT . but needs further development in the south Unit of planning	9,12,13,18, 23,30
Provision for monitoring underweight children and young people and management of re-feeding to achieve medical stabilisation?	Yes		Appendix 2 52
A lead			20 and 45

consultant/champion for acute eating disorder care, as advised in the Junior MARSIPAN?	Yes *in plan*		
Local arrangements for CEDS-CYP to work with paediatric teams and provide oversight for children and young people with an eating disorder including regular communication?	Yes		9,12,13,18, 23,30
A process to ensure that care plans will be completed on a multi-agency basis, in collaboration with children and young people and, where appropriate, their families of carers?	Yes	• Governance structure in place • Establish as a high priority Future in mind delivery group • Steering group with local service users involved /participating – strengthened service user participation in the north unit of planning	7 Appendix 2
A proposal on how different agencies will work with children and young people with an eating disorder and, where appropriate, their families of carers to enable access to education, employment or training?	To be developed	To be developed further in collaboration with wider stakeholders including schools , CAYA education department , community groups, under the stewardship of the future in mind delivery group	Appendix 2
Awareness plan			
Does Public Health England provide good 'balanced' information to children and families about healthy weight and eating disorders?	Yes	Engaged with Public health England representative Tina Smith at service user and specialist providers ED workshop.. Positive feedback about guidance and information available .	na
Does the CEDS-CYP have a plan to provide awareness-raising and first-help training to primary care and schools?	Yes	3rd sector remit ED service supervision	**8** **Appendix 2**

Care pathways and protocols			
Is there a plan to provide clear routes to a CEDS-CYP from medical and non-medical professionals?	Yes	Build on existing partnerships at Derby Royal Hospital FT and Chesterfield Royal hospital FT .(CRHFT) Paediatric teams to improve partnership and integrated working that can quickly facilitate brief admissions .This is well developed in CRHFT . but needs further development in the south Unit of planning	4, 8, 13,27,
Does the local proposed care pathway meet the Access and Waiting Time Standard?	Yes		12-14 31-33
Does this intended service provide a full range of NICE-concordant treatments for example, evidence-based family therapy and CBT for eating disorders?	Yes		9, 11-12 16-17 23 28-29 33-34
Transition plans			
Is there a plan for how transitions between services will be kept to a minimum?	Yes	Detailed in plan	8, Appendix 2 57-58 62-63
Is there a plan to ensure clear and efficient transition arrangements to adult services?	Yes		
Is there a plan to ensure clear and efficient transition arrangements across geographical boundaries?	To be developed	Closer working partnerships across geographical boundaries are being fostered between CRHFT and DCHCFT, supporting the development of more efficient transition arrangements across geographical boundaries north and south of the county as there will be one specification.	

Does your provider have appropriately trained and experienced staff to meet the recommendations in Section 4.3 of this guide?	No –	*Our core specialist eating disorder service will build on exiting CAMHS services- recruiting and skilling the work force to provide evidence based* NICE *concordant treatment to meet the standard's required for crisis, waiting times and treatment* ***Baseline audit and action plans***	North 20-25 South 39-45
If 'no', do they have a recruitment plan?	Yes	Yes – see above	
Training plan			
Is your provider part of CYP IAPT or do they plan to adopt CYP IAPT principles in the near future?	Yes	South of county DCHFT North of county application for IAPT reviewed for 2016-17 cohort(CRHFT)	Fim main document p
Is there a plan for continued training and supervision of staff in the provision of evidence-based NICE-concordant treatment?	Yes		26 31-33
Is your Local Education and Training Board aware of the number of professionals your provider has identified who need training and is there a regional plan to meet the need?	To be developed	Shared priority	27 , 46
Is there a comprehensive training programme for non-clinicians that includes awareness raising in primary care and early support?	Yes	Under development and roll out- Voluntary sector collaboration / partnership working	27, 46,
Is there a comprehensive training programme for all staff to improve the management and service delivery for all those involved in	Yes		21-22 27 38 44-46

the provision of service?			
Outcome measurement plan			
Do you have an outcome measurement protocol?	*Yes* -	We have identified outcome measures the FIM delivery group and ED steering group will have responsibility for turning measures into ratified protocol with sign up from all stakeholders	10-11
Are you monitoring the number of cases that are meeting the standard?	Yes	High priority ensure It systems fit for purpose to extract accurate data	8-9
Does your provider have an appropriate electronic records system? a) CRHFT does not have appropriate records system b) DHCFT does have an appropriate system	 No Yes		8-9
If not, do they have plans to provide the data and how will they do this in the longer term?		CRHFT is procuring an appropriate records system – and will develop an in-house interim method of data collection until system in place	8-9
Is the provider part of a quality improvement or accreditation network?	Yes	*CRHFT* *DCHFT*	NA
If not, how will the provider report on outcomes and benchmark their performance with other areas?	NA		
Benefits realisation plan			
Do you have a benefits realisation plan that the provider has signed	YES -To be developed	Shared priority	9

up to?			