NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

MENTAL HEALTH SERVICES PROGRESS REPORT

Date of the meeting	18/05/2016
Author	K Florey-Saunders, Head of Mental Health K Halsey, Senior Programme Lead
Sponsoring Clinicians	Dr P French, Clinical Lead MH CDG Dr K Kirkham, Clinical Lead MFH CDG
Purpose of Report	Update on progress for S117 and CAMHS following the previous report to the March meeting.
Recommendation	The Governing Body is asked to **note** the report.
Stakeholder Engagement	N/A: update from previous report
Previous GB / Committee/s, Dates	N/A

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Services designed around people • Preventing ill health and reducing inequalities • Sustainable healthcare services • Care closer to home

	Yes [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/Regulatory	✓		✓
People/Staff	✓		✓
Financial/Value for Money/Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials : KFS

1. Introduction

1.1 This report aims to provides further detail, progress and future plans concerning key areas as requested in regard to the provision of mental health services and specifically in relation to Section 117 Aftercare and Child & Adolescent Mental Health Services (CAMHS).

2. Update on Mental Health Services

2.1 Section 117 Aftercare

2.1.1 Background

Section 117 aftercare in the Mental Health Act 1983 states that aftercare services must be provided to patients who have been detained in hospital:

- for treatment under Section 3
- under a hospital order pursuant to Section 37: this enables courts to transfer people to appropriate in-patient units (with or without a restriction order) or
- following transfer from prison under Section 47 or 48.

This also includes patients on authorised leave from hospital and patients who were previously detained under Section 3 but who stayed in hospital after discharge from section.

People who are living in the community subject to a community treatment order and restricted patients who have been conditionally discharged are also included.

The aftercare is applicable only on discharge from hospital and it is a statutory right, similar to continuing healthcare.

2.1.2 Section 117 in Dorset

Funding for s117 aftercare is agreed though a virtual panel arrangement between Dorset CCG and the three local authorities. The Pan Dorset s117 funding agreement has been in place since 2013 and it outlines the percentage funding split on all cases as 42.5% CCG and 57.5% local authority.

Prior to this each application was discussed on a case by case basis and a split agreed where possible or a dispute resolution process was adopted in many cases which was highly inefficient.

The demand for s117 aftercare has risen consistently since the CCG came into being:

Year	CCG spend	Increase
2013/2014	£5.785m	
2014/2015	£6.573m	13%
2015/2016	£7.182m	9%

In 2015/16 a total of 355 cases were jointly funded with our local authorities, with 93 of these being new cases.

2.1.3 **S117 Eligibility and Formal Discharge**

The CCG has sought to develop definitive list of individuals in Dorset who are s117 entitled, and has been working with the local authorities and Dorset Healthcare to develop this together. In addition to assisting the system to plan more effectively, an assessment will also be made on whether people are able to be formally discharged from their s117 entitlement. Unless this process of formal discharge is completed, s117 eligibility continues and could and has brought about funding implications for LAs and the CCG. It must be noted that s117 eligibility is not arbitrary or subject to a panel decision, it is based on detention under the MHA as outlined above.

As part of the activity to analyse the s117 situation and growing cost pressure, the CCG has put sent a short FOI to all CCGs across the southern region regarding s117 demand and spend. Only one CCG has responded to date (New Devon CCG) and it appears they fund fewer cases but spend more per case. Once we have received other responses we will be able to position ourselves comparatively.

2.1.4 **Delayed Discharges**

The CCG have been made aware that there are s117 cases that are ‘delayed discharges’. This is not due to delays in funding decisions as clear arrangements are in place to agree interim s117 funding requests and these are normally approved within 24 hours. This was specifically introduced to avoid funding linked delayed discharges.

Further work will be undertaken with our local authority partners to identify how to reduce the s117 delays which are thought to be the result of the increased demand for both community placements and domiciliary care and a limited supply of this the market. People’s needs are often highly challenging to manage, especially people with complex dementia presentations and the weekly costs to health and social care reflect this complexity.

2.2 **CAMHS Update**

2.2.1 **Performance**

In 2014, Dorset CCG commissioned an independent review of local CAMHS provision to inform future planning and commissioning activity. As part of the review, the service provided by Dorset Health Care (DHC) was benchmarked against a range of national data sources.

While it is recognised that this was undertaken a year ago, the summary findings of this benchmarking were that the local CAMH Service:

- Provides, to some degree, the full range of services described by NHS Benchmarking
- Has a service model that incorporates a very wide range of support offers, delivered by staff with a wide range of skills
- Has a higher rate of referrals than national modelling would predict
- Is performing well in respect of waiting time for initial assessment, but has challenges with internal waits for therapy
- Has a DNA rate that is not acceptable, although a remedial action plan is in place
- Has a stable workforce
- Struggles to provide a full range of support, training and consultation to Tier 1 colleagues
- Has further work to do to enhance multi-agency planning processes for complex children and young people

2.2.2 Improving Access and Waiting Times

An area of significant concern is in regard to access to services including waiting times for both assessment and treatment. The following section details performance trends over the last six months as well as the current position as of March 2016.

This is followed by detailed information regarding actions to date and those planned to support further developments to address performance.

2.2.3 Performance Trends

Figures 1 to 3 show the monthly compliance for each CAMHS team for the three key target indicators between October 2015 to March 2016.

Figure 1: Tier 2 monthly compliance figures as percentage
(95% target for referral to assessment within 8 weeks)

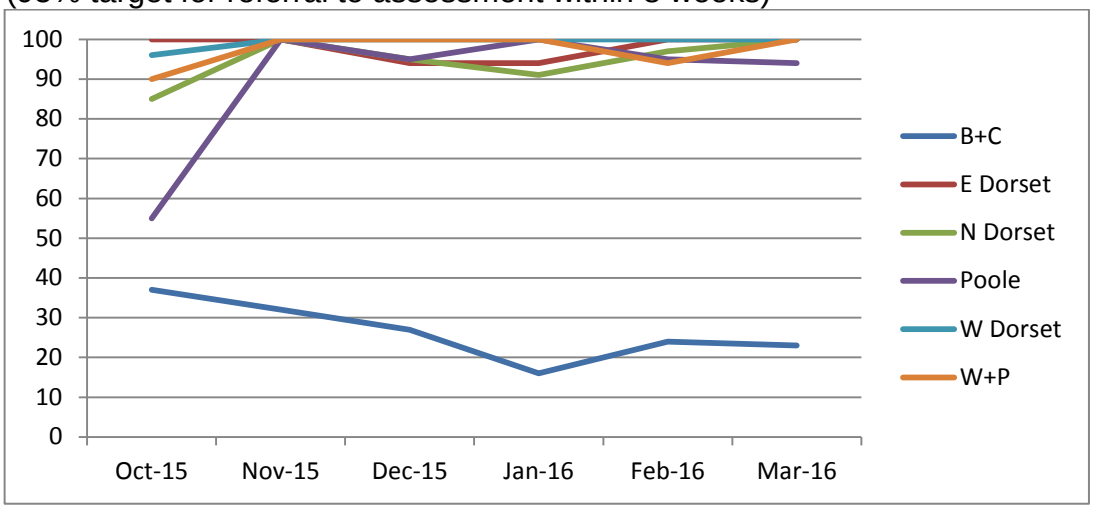


Figure 2: Tier 3 monthly compliance figures as percentage (95% target for referral to assessment within 4 weeks)

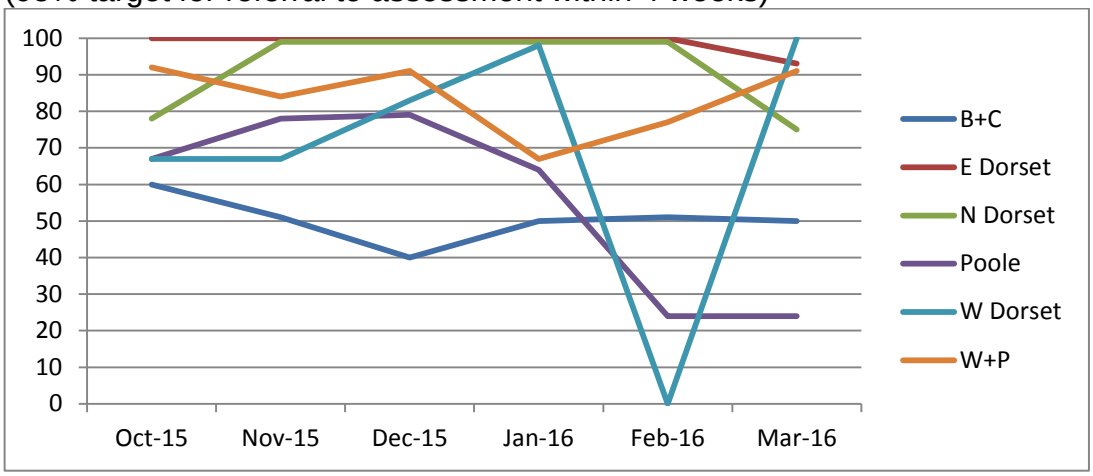
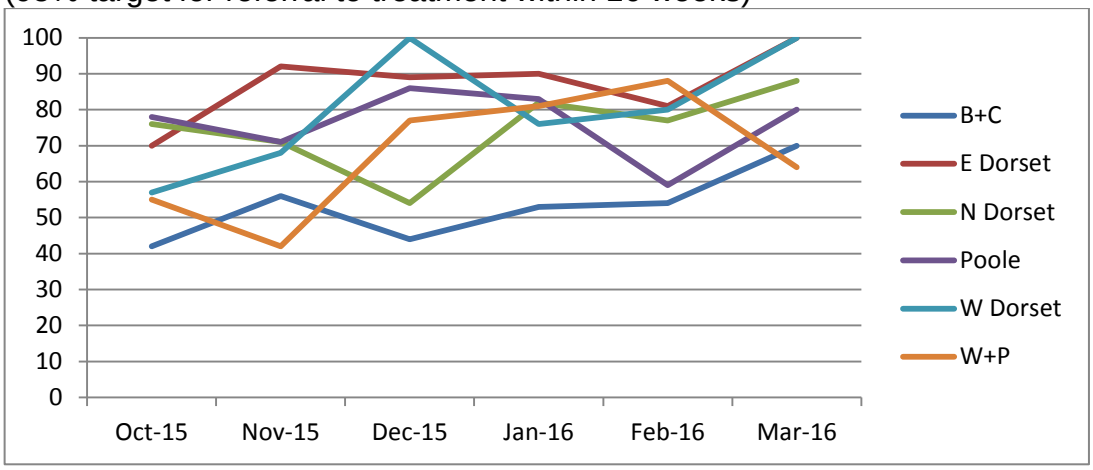


Figure 3: RTT 3 monthly compliance figures as percentage (95% target for referral to treatment within 16 weeks)



Detailed analysis of this individual team activity highlights the following performance over the last six months:

- All teams, other than Bournemouth and Christchurch, have continued to perform reasonably well for Tier 2 assessment compliance, with West Dorset having achieved 95% (within 8 weeks) or above consistently.
- Tier 3 assessment waiting times appear considerably more erratic over all six CAMHS teams with just East Dorset and North Dorset teams regularly meeting the target (within 4 weeks)
- Capacity to undertake Tier 3 assessments across all teams (with the exception of East Dorset) will be urgently reviewed to ensure sufficient capacity on a recurring monthly basis to undertake Tier 3 assessments.
- Consideration should be given to the fact that small numbers will also affect the percentages more dramatically; for example in North Dorset in March, compliance with Tier 3 assessments was 75%, however this related to two assessments out of eight being breaches.

- The referral to treatment target shows that all teams, with the exception of Poole, have shown an overall improvement in the six months to March 2016.
- The detailed analysis shows significant variability between the teams in their performance for tier 3 assessment times and RTT (16 weeks) compliance. Further insight into this variance and the relative similarity (with the exception of Bournemouth and Christchurch) in compliance rates at Tier 2 will be needed.

It is important to note that the time point at which a breach is reported is the month in which the young person attends an assessment/treatment appointment and not the month in which their waiting time exceeds the target.

This means that for the next few months where appointments have already been booked, the breach rate is already determined (depending on attendance rates). Therefore, when developing future trajectories for performance improvement, this needs to be considered and planned several months ahead.

Work to further understand the current management of waiting lists has identified that teams do not differentiate between patients on the waiting list directly from assessment, and those waiting for a treatment intervention who may already be in receipt of some support. As the RTT only measures wait from referral to treatment, confounding these two groups of patients will adversely impact on RTT waiting times and therefore this needs to be addressed.

Further work has been undertaken to understand the profile of the waiting times of patients. Between September 2015 and March 2016, considerable improvement has been made in the average and longest waits for assessment both at Tier 2 and at Tier 3. The average wait for assessment at Tier 2 reduced by 55% to 7.6 weeks and for Tier 3 by 20% to 8.5 weeks and the overall average wait for treatment has reduced by 20%. In addition to this, the total number of patients waiting for Tier 2 treatment reduced by 21%, and Tier 3 treatment by 16%.

However, it is recognised that significant improvement is still required. The approach to ensure that robust planning and development work to make this happen consistently is outlined through the next sections.

2.2.4 **Current Performance (March 2016)**

Dorset HealthCare (DHC) have undertaken a detailed piece of work to understand performance at a team level and shared this with the CCG and commissioning partners. This will now become part of regular monthly reporting and will include the actual number of breaches as well as the percentages to ensure meaningful interpretation of the data. For Local Authority commissioning partners, the data will also be split out further e.g. Bournemouth and Christchurch information will be separated.

Table 1 provides the monthly CCG scorecard data broken down by CAMHS team. At service level it shows that whilst Tier 2 assessments and RTT are both above the YTD average, Tier 3 assessments remain significantly below and all three indicators are below the 95% compliance threshold.

Table 1 Extract from Corporate CAMHS monthly dashboard for March and team level data

		OVERALL	B&C	E. Dorset	N. Dorset	Poole	W.Dorset	W&P
	No of Referrals	**447**	**136**	**67**	**62**	**84**	**41**	**57**
	Average Monthly Referrals	*397*	*121*	*53*	*52*	*82*	*39*	*51*
	No of cases taken on	**275**	**66**	**48**	**37**	**45**	**37**	**42**
	Average Cases Taken On	*242*	*61*	*32*	*36*	*54*	*28*	*32*
	No of Discharges	**299**	**75**	**51**	**38**	**47**	**36**	**53**
	Average Discharges	*240*	*73*	*32*	*37*	*42*	*28*	*32*
95% Target	**Tier 3 Assess (4 week)** (Breaches)	**60% (31)**	50% (14)	93% (1)	75% (2)	24% (13)	-* (0)	91% (1)
95% Target	**Tier 2 Assess (8 week)** (Breaches)	**82% (22)**	23% (24)	100% (0)	100% (0)	94% (1)	100% (0)	100% (0)
95% Target	**RTT (16 week)** (Breaches)	**78% (27)**	70% (9)	100% (0)	88% (2)	80% (4)	100% (0)	64% (12)
	First Appointment DNA	**10%**	10%	6%	14%	10%	8%	14%
	Follow-up Appointment DNA	**16%**	10%	11%	14%	18%	13%	20%

* There were no Tier 3 assessment undertaken in West Dorset in March

There is significant variance in performance across the six teams, with East Dorset and West Dorset appearing to perform the best in March against Bournemouth and Christchurch, which is significantly underperforming. This underperformance, coupled with the size of the Bournemouth and Christchurch team in comparison to the other CAMHS teams, shows that their results skew the overall CAMHS service results. Furthermore, team level data highlights that Poole is experiencing significant pressure providing timely Tier 3 assessments, which requires attention.

2.2.5 **Actions to Address Performance Undertaken To Date**

The following work has been undertaken to date to support improvement across the system:

2.2.6 **CAMHS Service Specific**

- Review of and production of local guidance regarding the use of patient choice and amendments to breach report.
- Review of patients booked into assessment appointments form July onwards who would breach waiting times and where possible earlier appointments to be offered.

- Ensure sufficient assessment appointments offered each month to manage referral rates.
- Treatment waiting lists amended to ensure clear distinction is made between those patients waiting from assessment and those already in receipt of support.
- Piloting new ways of managing referrals in such as the ART (Access to Resources) pilot in the Bournemouth Local Authority area to help inform future strategies.
- Identification of best practices in CAMHS Waiting List management by using the broader CAMHS network. Visit to Gloucester team completed 22nd March 2016 and ongoing visits/contact arranged with Northumberland and Sutton/Kingston Trusts
- On-going work to support improved pathways for Assessment to Treatment, including:
    - Implementation of an interim data recording solutions to gather intelligence that will inform the end strategy for treatment management.
    - Development of care pathways for specific diagnoses with a clear 'menu' of evidence base interventions to be used in line with the latest research base.

DHC have recently appointed a CAMHS Transformation Lead. This post has strategic responsibility for overseeing the CAMHS transformation agenda. The post holder works alongside the Lead Medical Consultant and two Clinical Leads to ensure a strong clinical underpinning to service developments.

An internal DHC CAMHS Transformation Group (CTG) has been established to provide strategic oversight and leadership for any transformative work undertaken and is chaired by the CAMHS Transformation Lead.

As part of a review of the functioning and effectiveness of the CTG six core working groups have been developed to sit under the CTG and drive key work streams associated with this agenda. The working groups include:

- Communication and engagement.
- Participation.
- Clinical processes and pathways.
- Data quality and performance.
- Workforce and training.
- Evidence based practice and routine outcome measures.

These key working groups will enable greater accountability and clarity over the different strands and ensure delivery of the overall transformation programme.

A Senior Manager within DHC will lead each work stream and it is intended that key stakeholders will be involved. Each work stream will have a clear purpose, tangible deliverables and an action plan to deliver these in a specific timeframe.

In 2015/16 the CCG agreed additional priority funding of £250K for CAMHS. DHC has also invested in capacity for new roles. This has enabled recruitment of the roles detailed in Appendix 1. The impact of these additional posts is being assessed as part of the Demand and Capacity review.

The CAMH service has been delivering Psychological Perspectives in Education and Primary Care (PPEP Care) workshops as part of a pilot with Reading University under the IAPT programme. These have been initially open to all education staff but would benefit a wider audience in the future. Session delivered:

- Anxiety Workshop: 40 attendees to date.
- Self-Harm Workshop: 36 attendees to date.
- Depression Workshop: 39 attendees to date.
- The Anxiety courses planned for April and May are fully booked and there are only 15 spaces left for the Adolescent workshops.

DHC has been part of the Wave 1 pilot of children and young people's IAPT (Improving Access to Psychological Therapies) within the Oxford and Reading collaborative. This has enabled staff to complete training in evidence based interventions and to develop process for the use of outcomes monitoring with patients as part of clinical practice. This work will now be expanded to support the improvements detailed in the next steps section of this report.

2.2.7 In 2015, the Dorset Young Inspectors undertook an inspection of local CAMH services. The team focused on understating the reasons why some children and young people do not attend their initial appointment with the service, or if they do, why they may not return for subsequent sessions. Following a process of desktop research, carrying out questionnaires and interviews and site visits, they made a series of recommendations. These recommendations have been reflected in the DHC service improvement plan.

2.2.8 The Joint Commissioning Operational Group and leads from within the Maternity and Family Health Team have been working closely with DHC management and clinical leaders to monitor the service and to highlight and understand the performance issues and drive work to support improvement. Areas with have been highlighted and are now being addressed are leadership arrangements within DHC, the use of data and intelligence by the service to understand the issues and to form the basis for improvement plans with clear actions against timescales to achieve specific outcomes.

2.3 Next Steps and Future Actions for Improvement

The following work has been planned to support work commenced with the overall aim of improving access and performance. Further detailed action plans for key work streams have and are being developed by DHC and are being shared with the CCG and commissioning partners.

2.3.1 Performance Trajectories

Monthly trajectories to address access issues have been requested and once agreed, will be reported and robustly monitored on a monthly basis via Contact Review Meetings (CRM). Contract mechanisms and levers will be applied if DHC fail to meet them.

DHC are developing these trajectories for performance improvement for referral to assessment times, at both service level and at team level. These will be based on current performance and a timeframe to achieve an improvement in performance at a defined percentage or number of weeks. DHC leadership are working with Team Leaders and Locality Managers to agree Action Plans for each team to come back into target.

Given the current methodology used to calculate the CAMHS scorecard and with teams having already booked assessments into May and June, it is proposed that trajectory targets are developed from July 2016 going forwards. In addition, given the significant variability seen amongst the teams, it is proposed that team level trajectories are developed that consider not just percentage breaches, but also prioritise reducing the longest breaches to ensure a more equitable service.

Proposed Trajectories:

Tier 2 Waiting Lists

- All localities (except Bournemouth and Christchurch) to maintain 95% compliance.
- Bournemouth and Christchurch Locality to achieve trajectory:

	Current	July	Aug	Sept	Oct	Nov	Dec
Percentage	23	40	50	60	70	80	95

Tier 3 Waiting Lists

- East Dorset, North Dorset, Weymouth and Portland to achieve 95% by August 2016.
- Remaining services to achieve following % trajectories:

	Current	July	Aug	Sept	Oct	Nov	Dec
Bournemouth	50	50	60	70	80	90	95
Poole	24	30	40	50	60	80	95
West Dorset	50	50	60	70	80	90	95

RTT Waiting Lists

- East Dorset, North Dorset, West Dorset to achieve 95% by August 2016.

- Remaining services to achieve the following % trajectories:

	Current	July	Aug	Sept	Oct	Nov	Dec
Bournemouth	70	70	75	80	85	90	95
Weymouth	64	70	75	80	85	90	95
Poole	80	80	85	85	90	95	95
North Dorset*	88	80	80	85	85	90	95

*Due to known staffing changes (turnover of four clinicians) in North Dorset that will affect capacity over the coming months a lower trajectory has been set.

Assumptions made when developing these trajectories:

- Teams need to estimate enough slots for assessments to cover both attended appointments and DNAs.
- A referral that is still open to the team within two weeks of being received is very likely to need booking for an assessment.
- Referrals discharged within two weeks of being received are unlikely to have any appointment booked for an assessment.
- Tier 4 referrals have not been included in this analysis.
- Period covered was referrals received, and assessments done, from April 2015 – January 2016.

2.3.2 **DHC Service Actions**

Action	Timescale 2016
Full Demand and Capacity review of the CAMHS service • Referral in to Assessment process • Assessment to Treatment process • Re-design of the referral in to assessment process and associated performance structure to ensure that the service is future ready for changes, such as adopting the Thrive model and Self Referrals.	Quarter 1 Quarter 2
Review of administration processes in each team to ensure that patients who are likely to breach are highlighted to Team Leads prior to appointments being agreed.	31st May
Implement Rio waiting lists for all teams to allow more efficient monitoring of waiting times and accurate reporting of patient choice. • Prioritising Screening and Assessment lists in Quarter 1	31st July
Develop a 'real time' suite of reports that teams can use to regularly review waiting lists.	TBC
Identify additional resource to support the Bournemouth and Christchurch team with assessments and treatments.	Ongoing
Carry out Waiting List Management workshops across all CAMHS teams	Quarter 1 and 2

Action	Timescale 2016
Development of Outcome Measures in RiO being worked on in partnership with the Gloucester CAMHS teams.	Roll out in Quarter 1/ early Quarter 2.
A refresh of the skills mix review. This will form part of a CAMHS workforce strategy that will commit to increasing the provision of high quality evidence based practice throughout the teams.	Quarter 1 2016/17
Development of technology and social media to: • support engagement of young people • make sure young people and their families have the right information about CAMHS before deciding if they need to access the service • develop innovative ways for young people to engage in treatment and support. This will include: • Self-help digital apps and websites • Review and redevelopment of DHC CAMHS Website (will need to include the capacity to manage self-referral) • Text Messaging appointment reminders • E-clinics via Skype (currently being piloted in Steps to Wellbeing and will be rolled out the CAMHS teams by June 2016) • Use of Twitter/Facebook • Development of Self-referral (the learning from the roll-out of this by the Steps to Well-being Service will be used to inform any developments in CAMHS). Online forums (capitalising on the learning and products from national projects).	During 2016/17

In addition to service specific development work, local partners, including both commissioners and providers are working together on the future strategic planning of local provision to improve the emotional well-being and mental health of children and young people across Dorset, Bournemouth and Poole.

2.3.3 **Pan Dorset Children & Young People's Emotional Well-being and Mental Health Strategy 2016-20**

The Strategy will aim to build a local vision and approach for a system of support for children and young people's emotional well-being and mental health, at all levels of need from building resilience to effective treatment. Utilising the nationally recognised THRIVE Model, it will bring together a wide range of partners and stakeholders to identify and support roles and responsibilities and embed them as part of everyday practice. Key aims will be to bring together the wide range of existing and new workstreams supporting this agenda to ensure a co-ordinated approach to transformation and provision; makes the best use of resources across the system, both new and existing; be based upon evidence of what works and focused on the needs of the local population.

The draft strategy will be open to public consultation until 6th May and it is anticipated that it will be approved for publication by the Pan Dorset Joint Commission Partnership for Children & Young People in May 2016. Following this, a comprehensive Implementation Plan will be developed and delivered by a wide range of stakeholders, both professionals and services and children, young people and families by September 2016.

2.3.4 **Dorset Local Transformation Plan and Funding**

This Plan was submitted and assured by NHS England in 2015 to support the national drive for transformation detailed through *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing* over the next four years.

Dorset's Local Plan will become an integral part of the Implementation Plan for the new local Strategy. The additional funding attached to it will support improvements to local support through an effective partnership approach. This is already being realised through improvement to the Children and Young People's Eating Disorder Service (YPEDS) commissioned from DHC.

The additional investment in the YPEDS will result in:

- Meeting the new national access and waiting time standard issued by NHS England (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)
- The aim is to meet new access standards for all referrals by July 2016 (50% from April 2016) based on ability to fully recruit new staff.
- Access will be available via a self-referral process
- 7 day working to support access requirements
- Treatment of co-morbidities experienced by patients within one service.
- Effective all age approach that does not require transition between services.
- Improved and effective liaison with hospital and CAMHS colleagues
- Development of better ways of joint working with and support to Primary Care for medical monitoring and physical health.
- A programme of effective carers training and support
- Embedding of IAPT approaches to ensure outcome focused working
- An improved focus on early intervention
- Improved communications including website and use of technology

2.3.5 **Specialist (Tier 4) Provision and Access**

Tier 4 in-patient provision for children and young people with mental health needs (including those with a Learning Disability, Autistic Spectrum Disorder (ASD) or an Eating Disorder) is commissioned by NHS England Specialist Commissioning Team. Their responsibility also includes different levels of secure provision.

Locally DHC provide a designated 10-bed adolescent in-patient unit located in Westbourne and commissioned by NHS England. This provision is accessible to any children or young person who requires this provision regardless of their registered location in the country. This means that the unit may treat non-Dorset patients and it may be the case that if the unit is full, Dorset patients may have to access treatment out of area while non-Dorset patients are seen in Dorset.

NHS England has provided the following data with further detail from local sources.

Position April 2016:

- 18 Dorset CCG patients are currently accessing a CAMHS ward, of whom 11 are located outside of Dorset. Of these, two are in medium secure accommodation, one is low secure and two are in PICU. All of these are for Tier 4 CAMHS.
- There is 1 individual with a primary diagnosis of Eating Disorder who is currently an in-patient outside of Dorset.

2015-16 Activity:

- There were 81 CAMHS admissions in 2015/16. The patient age on admission (during this 12-month period) ranged from 12 to 17. There was only one 12 year old and one 13 year old during this period.
- There were also 5 young people admitted to inpatient provision for the treatment of a primary diagnosis of an Eating Disorder.

Further work will need to be undertaken to understand the number of, financial cost and impact upon outcomes for Dorset children and young people who are required to travel out of area to access provision when local beds are being used by non-Dorset patients.

The national picture for the demand for Tier 4 provision is significant with demand higher that supply. The following actions and plans have been developed by NHS England to address the current issues faced:

- Nationally an additional 50 beds have been opened to improve access
- A new and improved system for the daily bed availability process has been implemented from 1/5/2016. All CAMHS Tier 4 providers input daily capacity updates into this database and web access to bed availability reports are available to CAMHS teams and case managers.
- There is a weekly case manager's national teleconference. A key focus is to discuss delayed discharges and over 18's in services in order to review barriers to 'move on'. Cases are escalated as required.
- The NHSE contracts for 2016-17 will include a South of England Length of Stay CQUIN (including CAMHS) which will help to highlight any barriers to

timely discharge and the wider support mechanisms needed across the system.

- Procurement is planned (proportionally) to procure services that need to change against a set of pre-determined conditions. The expectation is that all areas should be able to meet their own local needs with regard to general adolescent beds.

This work will be supported as part of the longer-term approach by the CCG and partners through the local transformation agenda to support timelier and earlier intervention, which in turn will help reduce the need for inpatient provision demand as well as the provision of improved step down support to assist with earlier discharge.

3. Conclusion

3.1 While it is recognised that there is still significant work to be undertaken I regard to CAMHS, actions to address the current issues have been undertaken and will continue to be closely directed and monitored with the ability to apply contractual levers and mechanisms if needed.

3.2 The Governing Body is requested to **note** the report and the developments undertaken to date and planned for the future.

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APPENDICES	
Appendix 1	**CAMHS Workforce Development**