Lancashire Children & Young People's Resilience, Emotional Wellbeing and Mental Health

Transformation Plan
2015 – 2020

Refresh 2016

Our Vision

We will work together with children and young people in Lancashire to support their mental health and wellbeing and give them the best start in life.

Contents

Introduction

The Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan for Lancashire (2015-2020) was published in January 2016. That document set out the first iteration of a five-year plan for Lancashire, to support local implementation of the national ambition and principles set out in Future in Mind – promoting, protecting and improving our children and young people's mental health and wellbeing.

The Plan aims to improve the resilience, emotional wellbeing and mental health of children and young people, making it easier for them and their families to access help and support when they need it and improving the standard of mental health services across Lancashire.

The plan was informed by consultation with children, young people and families and based on comprehensive identification of needs and evidence based practice as well as a clear understanding of the local context. This is set out in the Case for Change within the first iteration of the plan and should be read alongside this re-freshed plan, which aims to promote good emotional wellbeing and prevention of mental ill-health through early intervention, care and recovery.

Implementation of the plan is overseen by the Children and Young People's Emotional Wellbeing and Mental Health Transformation Board, which consists of key partners Pan Lancashire and is supported by a Clinical Reference Group.

The CYPEWMH Transformation Programme sits within the Mental Health work stream of the Healthier Lancashire and South Cumbria (HL&SC) Sustainability and Transformation Plan (STP) and as such reports into the HL&SC Programme Board. A copy of the STP Governance structure is included at appendix 6. However, it is recognised that within the STP, the CYPEWMH Programme interfaces with and contributes to delivery of STP priorities across a number of areas including Population Health & Prevention and Learning Disability, in particular.

The STP footprint includes Lancashire and South Cumbria. Lancashire North CCG is currently undergoing boundary changes to create a CCG covering the whole Morecambe Bay footprint. Up until now the South Cumbria area has been within Cumbria CCG and has been encompassed within the Cumbria Transformation Programme. In terms of Children and Young People's Mental Health, it is intended that, for the current time, the South Cumbria area of the new Morecambe Bay CCG will continue to be part of the Cumbria-wide Transformation Plan. This will be kept under review.

During the latter part of 2016/early 2017 we have worked closely with local stakeholders including service providers, clinicians and most importantly children, young people and families to review the plan. As part of this review we have:

- Identified and celebrated what we have achieved in the first year[1].
- Looked at new national requirements and imperatives to ensure our refreshed plan reflects these.
- Streamlined our objectives and deliverables.
- Engaged with children, young people, families and wider stakeholders to prioritise our objectives for the coming 4 years.
- Produced and published the outputs from this process within this, our re-freshed plan.
- Secured sign-off for our re-freshed plan across the health and social care system.

[1] Completed deliverables from year 1 of the plan are available on request.

Section 1 - Principles

Our plan is underpinned by some key principles that inform all our work. We will:

1. Work collaboratively with children, young people, families, carers, partners, providers and wider stakeholders to support them to:
    a. Shape, influence and drive forward delivery of our objectives.
    b. Engage in co-production of system solutions.
    c. Identify opportunities to improve efficiency, effectiveness and patient experience.

2. Draw on the learning from both local and national pilots and evidence based best practice.

3. Consider workforce roles, numbers, skill mix, recruitment and retention and develop plans to support implementation.

4. Undertake Equality Impact and Risk Assessments ensuring that we have due regard to the public sector equality duty (Equality Act, 2010)[2].

5. Draw on learning from the Joint Strategic Needs Assessment (JSNA) and other national and local data regarding needs and health inequalities.

6. Specify the anticipated benefits and impacts of our objectives and be clear about how these will be measured.

[2] A Public Sector Equality Duty Guidance document has been developed. This will be used alongside EIRA guidance and templates to support the programme in ensuring that all objectives are delivered with due regard to the requirements of the Equality Act (2010) including adherence to the 'Brown principles', reasonable adjustments, equality data collection and equality monitoring.

Section 2 – What have we achieved in year 1?

In 2016 we put all our foundational arrangements in place to support the work of the Transformation Programme (this included establishing our governance, initiating our work streams and developing our relationships). We also mobilised 13 key pieces of work that we believe will transform the system of service delivery for children and young people's emotional well-being and mental health. These are represented below.

Monitoring of investment, consistent performance and outcome measures

Lancashire Active Healthy Minds Programme targeting 40 schools a year

Pan Lancashire specialist peri natal community mental health team, delivering improved support for up to 500 women by 2019*

Developing Digital Thrive by 2019

Primary Mental Health Worker roles across Lancashire in 2017, to enable easier access to support and provision of a single point of contact for schools and primary care

Influencing NHS England for the provision of Tier 4 services

Improving access to psychological therapies by increasing the number of trained staff by up to 42 in 2017

Implementing a protocol and pathway across all acute providers and CAMHS services in 2017

Extending the upper age range for community CAMHS up to 19th birthday by 2017

Developing a dedicated place of safety for children and young people by 2019

Increasing access to CAMHS from 5 days to 7 days in 2017

Improving service arrangements for children with Learning Disabilities in 2017

Implementing a new Community Eating Disorder Service in 2017

Section 3 – What are our key priorities going forward?

We have reviewed our plan and identified the following **six** key priorities going forward, which we have clustered under main headings. We have then split these priorities into a series of objectives.

Promoting resilience, prevention and early intervention

Objectives:

1. By the 30th September 2017 we will have designed and commissioned a **"Mental Health Anti-Stigma Campaign"** building on the existing approach through "Life's ups and downs". By the 31st March 2018 we will have mobilised the campaign across Lancashire.

2. By the 31st March 2018 we will have developed, published and launched a Lancashire wide **"Resilience Framework"** which will include the following components:
    a. Set a common understanding of what is meant by 'Resilience' in the context of the Pan Lancashire area, in line with the CYP Emotional Wellbeing and Mental Health Transformation Programme.
    b. Provide a step by step guide considering, what, where, with whom and how resilience activities should be best delivered according to the evidence base.
    c. Provide information about sources of local good practice and opportunities for local networking and support.
    d. Provide a quality assurance checklist to ensure that activities are high quality, safe, and based upon best practice.

3. By the 31st March 2019 we will have designed and commissioned a **"Resilience training programme"** in line with the resilience framework for:
    a. Schools
    b. CYP
    c. Families
    d. Parent carers and young carers
    e. Other staff working with CYP and families in universal and community service

4. By March 2018 we will have defined a **"complementary offer"** of support to wrap around clinical services to help children; young people and families avoid escalation, recover earlier and maintain wellbeing. We will have mobilised by 2020/21.

5. By the 30th September 2017 we will have expanded the number of **"Primary Mental Health Workers"** (PMHW) or their equivalent and introduced

Psychological Wellbeing Practitioners (PWPs) to work within universal and targeted services to support and improve mental health and psychological wellbeing of children and young people.

6. By the 30th September 2017 we will have defined and designed a Lancashire wide approach to delivering a **"single point of contact"** which will include the following components:
    a. A definition of what we mean by single point of contact
    b. A description of the component parts of the single point of contact
    c. Guidance for commissioners on how to implement the approach locally
    d. Resources and tool for providers to use to develop local protocols

    By 31st March 2018 we will have implemented the **"single point of contact"** approach in each health economy.

Increasing Access to Specialist Perinatal and Infant Mental Health Support

Objectives:

7. By March 31st 2021 we will have delivered "**improvements in Universal Services"** including:
    a. Consistent Clinical Pathways
    b. Specialist posts and leadership roles on universal services

8. By March 31st 2021 we will have delivered **"improvements in services for infant mental health"** including:
    a. Infant Mental Health posts to be commissioned and emerging new pathways developed.
    b. Training of Adult Psychiatry and IAPT services.

9. By the 31st March 2021 we will have commissioned a **"specialist community perinatal mental health team**" allowing at least an additional 495 women each year to receive evidence based treatment closer to home when they need it.[3]

10. By the 31st March 2021 we will have a **"specialist inpatient mother and baby unit"** allowing at least an additional 21 women each year to receive evidence based treatment closer to home when they need it.[4]

[3] Subject to release of national resource
[4] Subject to release of national resource

Improving Access to Effective Support

Objectives:

11. By 31st March 2017 we will have developed a specification and commissioned a provider for an online one stop portal known locally as **"Digital THRIVE"** offering information, advice, self-help, care pathways and self-referral. By 31st March 2018 our online one stop portal known locally as **"Digital THRIVE"** will be operational across Lancashire.

12. By the 31st March 2017 we will have established a dedicated all age "**eating disorder"** service which fulfils the requirements of the Eating Disorders Commissioning Guide: Access and Waiting Time Standard (NHSE).

13. By 30th September 2017 we will have a **"0-19"** years (up to 19th birthday) CAMHS service model operational across Lancashire which will include arrangements for 7 day working and out of hours provision.

14. By 31st March 2018 we will have defined a local offer of service provision for CYP with emotional wellbeing and Mental Health needs aged **"0-25"** years. By the 31st March 2020 we will have developed and implemented our **"0-25"** years offer.

Ensuring appropriate support and intervention for CYP in Crisis

Objectives:

15. By 31st March 2017 we will have developed and implemented a **"pathway"** for CYP admitted to acute hospitals in crisis and a set of shared principles to be incorporated into local operational protocols. By 30th September 2017 all acute hospitals will have worked with local CAMHS providers and agreed local operational protocols.

16. By 31st March 2018 we will have developed and implemented as part of the all-age crisis care concordat:
    a. a **"consistent crisis response service"** for CYP within acute hospitals e.g. mental health triage/liaison services in A&E
    b. Provision of mental health support helplines for CYP, parents, carers, schools, the voluntary sector and other professionals.

17. By 31st March 2017 we will have **"7 day CAMHS crisis response service to CYP in acute hospitals"** in place across Lancashire.

18. By 31st March 2019 we will have **"Place of Safety (Section 135/6) and improved Crisis Assessment facilities"** in place across Lancashire CYP.

19. By 31st March 2017 we will have developed a **"Tier 4 collaborative commissioning plan"** for inpatient services for children and young people in Lancashire which supports our aspiration to work towards a balance between inpatient beds and intensive outreach support.

20. By 31st March 2021 we will have developed, agreed and implemented clear **"Tier 4 pathways"** for CYP entering and leaving Tier 4 services.

Improving Care for the Most Vulnerable

Objectives:

21. By 31st March 2021 we will have implemented a minimum service offer **"pathway for vulnerable groups"** which seeks to improve access to assessment, services and outcomes as follows:

    a. Children with attention deficit hyperactivity disorder (ADHD)
    b. Children with Autism spectrum disorder (ASD)
    c. Children looked after
    d. Children with Learning disabilities
    e. Children vulnerable to exploitation
    f. Children in contact with the youth justice system
    g. Children with adverse childhood experiences

Improving Service Quality

Objectives:

22. By 30th September 2017 we will have established and mobilised a CYP Lancashire wide **"provider network"** to facilitate joint working and collaboration, improve pathways and share good practice

23. By 31st December 2017 the network will have a defined **"provider network work programme"** focussing on the following key priorities:

    a. Early intervention in psychosis
    b. Self-harm
    c. Workforce retention, recruitment, training, continuing professional development (CPD) and supervision
    d. Carers and working carers assessments and feedback
    e. Policies, procedures and guidance
    f. Approach to risk support in line with Thrive
    g. Information sharing
    h. Using outcomes to inform practice and service planning

i. Prescribing protocols
j. Suicide strategy
k. Transitions policy
l. Out of hours psychiatry model
m. CYP Improving Access to Psychological Therapies (IAPT) programme
n. Parity of esteem with physical health

24. By 31st March 2017 we will have developed a **"performance dashboard"**.

25. By 31st March 2017 CAMHS service providers will routinely collect **"outcome measures"** which will be aggregated and reported through to the System Performance Group.

26. By 31st March 2018 NHS commissioned services will produce and publish **"annual quality improvement plans".**

Section 4 – How will we deliver?

The Transformation Board has become an effective body working with a range of entities and organisations including 3 CAMHS services, 8 Clinical Commissioning Groups (CCGs), 3 Local Authorities, 5 NHS Trusts, hundreds of schools, a wide ranging third sector, primary care, community services, various children and young people's support services and groups and children, young people and their families.

The role of the Board is to:

a. Lead in the design, delivery, implementation, review and evaluation of the 5 year Transformation Plan.
b. Oversee workstreams, implementation groups, task and finish groups etc. in line with the agreed governance structure.
c. Enable supporting communication and engagement activity.
d. Make recommendations for commissioning arrangements including investment priorities and the use of resources.
e. Make recommendations for service improvements and new delivery models.
f. Make decisions on behalf of organisations in line with delegated decision making authority.

The **Clinical Reference Group** is a sub-group of the Board and operates as support to the work of the Board by:

a. Providing a strong clinical voice.
b. Giving clinical opinion on matters relating to service development/service improvement.
c. Providing a place to test clinical feasibility.
d. Operating as a space from which to make shared clinical recommendations.
e. Being a place where the work of the Board can be aligned to existing and emerging evidence and best value practice (and vice versa).
f. Providing a mechanism for co-production and clinical consultation.
g. Being a capacity and capability support to work streams.
h. Operating as a transparent and professional forum that ensures a focus on clinical excellence.

Consensus for recommendations is made by consulting with the appropriate groups through several cycles for each project and at least one cycle involving young people, their carers and the public (Delphi methodology).

The overarching six clusters consist of a number of projects with principles and enablers translating the desired outcomes into practice. There are now three enablers in the programme:

a. Engagement with children, young people and their families or carers.
b. Communication.
c. Finance.

Engagement with children, young people and their carers has been used extensively to inform projects of the problems and difficulties they have faced whilst using a service, they have identified gaps or issues in the system for example in the eating disorder review young people were interviewed about their experiences. The interviews were subsequently made into short animated films and played back to commissioners and service providers contributing to the co-production of the services.

Our Communications and Engagement Team have held events and conducted interviews exploring the experiences of young people who have been in crisis which has meant that the development of a crisis pathway now includes education and training of staff in acute hospitals on using solution focused approaches as well as introducing consistent documentation and processes across the five acute trusts.

The large scale change that is being implemented with the transformation plan requires large scale **communication** between organisations, staff, the public, children, young people and their carers. There are systems in place to maintain the governance of the programme, which is communications between the organisations in the figure below, this takes the form of presentations to the relevant Boards and a monthly bulletin.

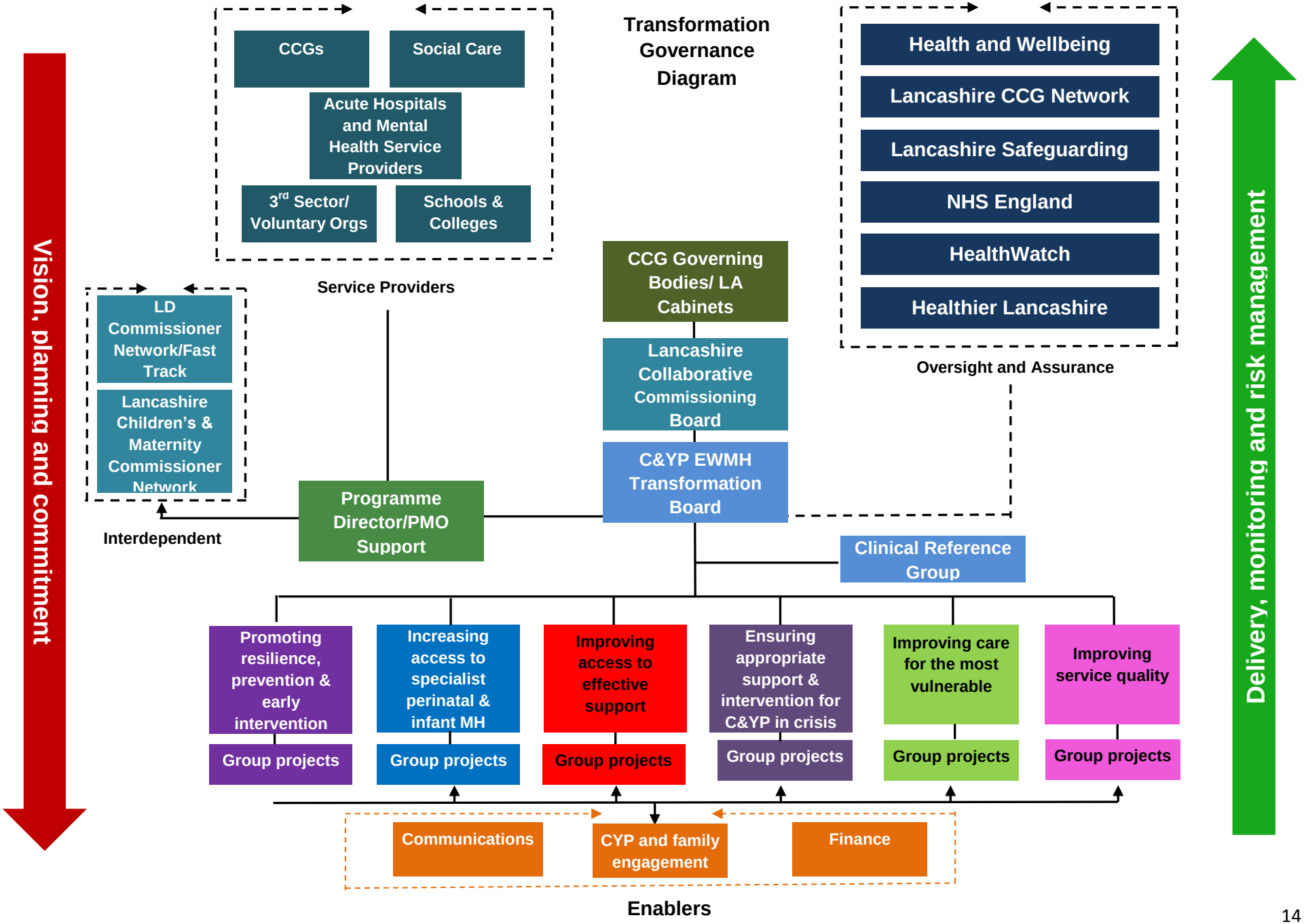
Work is under way in collaboration with children, young people and families to develop a unique visual identity for the Transformation Programme which will enable stakeholders across the system to identify any written, printed or digital material associated with the programme. This will be used to support the development of a social media and web presence to raise the profile of the programme and its work.

Finance is governed by the Commissioning and Finance Group who have put systems in place to make recommendations and monitor spend, it is led by a Chief Finance Officer from one of the member CCGs.

In co-commissioning services a consensus for recommendations is reached using the decision making principles of the programme and governance of the group. A template has been developed outlining the process for gaining agreement for business cases submitted to the group and approval by the Board.

The group also provide evidence of spend and delivery to the Board and in assurance to NHS England.

Below is a visual representation of our governance structure as well as supplementary information describing some of the work we did to refresh our plan and describe the year ahead, in more detail.


Transformation Governance Diagram
CCGs
Social Care
Acute Hospitals and Mental Health Service Providers
3rd Sector/ Voluntary Orgs
Schools & Colleges
Service Providers
Health and Wellbeing
Lancashire CCG Network
Lancashire Safeguarding
NHS England
HealthWatch
Healthier Lancashire
Oversight and Assurance
CCG Governing Bodies/ LA Cabinets
Lancashire Collaborative Commissioning Board
C&YP EWMH Transformation Board
LD Commissioner Network/Fast Track
Lancashire Children's & Maternity Commissioner Network
Interdependent
Programme Director/PMO Support
Clinical Reference Group
Promoting resilience, prevention & early intervention
Increasing access to specialist perinatal & infant MH
Improving access to effective support
Ensuring appropriate support & intervention for C&YP in crisis
Improving care for the most vulnerable
Improving service quality
Group projects
Group projects
Group projects
Group projects
Group projects
Group projects
Communications
CYP and family engagement
Finance
Enablers
Vision, planning and commitment
Delivery, monitoring and risk management

Appendix 1 - Summary of new national must do's and imperatives

Implementing the five year view for mental health			
Ref:	**pg.**	**Narrative**	**Go Forward**
FV1	6	By2020/21, there will be a significant expansion in access to high-quality mental health care for children and young people. At least 70,000 additional children and young people each year will receive evidence based treatment representing an increase in access to NHS funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.	Therapist and supervisors/35%
FV2	6	CCGs should commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people.	All age crisis response
FV3	7	By 2020/21, evidence-based community eating disorder services for children and young people will be in place in all areas ensuring that 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases.	ED
FV4	7	By 2020/21, in patient stays for children and young people will only take place where clinically appropriate, will have minimum possible length of stay, and will be close to home as possible to avoid inappropriate out of area placements. All general in-patient units and young people will move to be commissioned on a 'place-basis' by localities so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds.	Tier 4 Pathways
FV5	7	Inappropriate use of beds in paediatric and adult wards to be eliminated.	Pathway and shared care protocol
FV6	8	By 2020/21, at least 1,700 more therapist and supervisors will need to be employed to meet the additional demand, in addition to actions to improve retention of existing staff, based on recommended caseloads. This will require new staff to be trained and supervised by experience staff, as well as return to practise schemes and local recruitment. Illustrative trajectory for necessary growth in therapists reflects the growth in additional funding in CCG baselines.	Therapist and supervisors/35%
FV7	8	CYP IAPT Programme to deliver post-graduate training in specific therapies, leading organisation change, supervision in existing therapeutic interventions and whole -team development. By 2018 all service should be working within CYPIAPT programme, leading to at least 3,400 staff being trained by 2020/21 in addition to the additional therapist above.	IAPT
FV 8	10	Developing special services for children with complex needs in the justice system.	Vulnerable pathways
FV9	12	By 2020/21, there will be increased access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment, closer to home, when they need it.	Perinatal

FV9	13	**Workforce requirements** Specialist multi-disciplinary community perinatal mental health teams with the right capacity and skill mix and able to offer psychological and therapeutic support	Perinatal

Other Guidance				
Ref:		**Narrative**	**Go Forward**	**Guidance**
A	4.14	**Mandate** 4.14 By April 2016, it is expected that more that 50% if people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services, working with local secondary mental health providers. A further £40 million is being made available 10 2015/16 through the tariff inflator to support the introduction of this standard.	Provider network work programme	The Forward View in Action 2014, NHSE et al
B	4.19	**Recommendation** 4.19 Ensure there is enough capacity to prevent CYP undergoing MH assessment in police cells (Crisis Concordat).	Crisis Provision	The Forward View in Action 2014, NHSE et al
C	2.15	**Recommendation** 2.15 Plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups.	Provider network work programme	The Forward View in Action 2014, NHSE et al
D	4.18	**Recommendation** 4.18 Investing in the effective community services will minimise the use of expensive and often out-of-area tier four services, and the incidence of young people being admitted to inappropriate settings.	Tier 4 Pathways	The Forward View in Action 2014, NHSE et al
E	12	**Recommendation** P.12 There should be close working links between targeted and specialist services (including education and local authority children's services, as well as voluntary sector services) to facilitate easy, smooth transfer between the different service tiers, as well as joint-working.	Provider network	Children and Adolescent Mental Health Services,2013 Joint Commissioning Panel for Mental Health (see pages 12 and 13)
F	100	**Intention** Improving support for children with additional needs p.100, We will focus on the outcomes and experiences of all children and YP with SEND. This includes vulnerable children such as CLA and ACE.	Vulnerable Pathways	Educational Excellence White Paper, 2016 DoE
G	97	**Intention** p.97 6.42 Good mental health and wellbeing are also important to success and while teachers are not mental health professionals, schools can play an important role in promoting wellbeing as well as helping to prevent and identify mental health issues.	Resilience Training	Educational Excellence White Paper, 2016 DoE

Other Guidance				
Ref:		**Narrative**	**Go Forward**	**Guidance**
H	11	**Intention** p.11, 3.4 Our strong expectation is that, over time, all schools should make counselling services available for their pupils.	Resilience Framework	Counselling Guide for Schools,2016,Dept Education
I	13	**Recommendation** p.13, 4.6 Promoting staff health and wellbeing should also be an integral part of the whole school approach the mental health and wellbeing. Head teachers have a contractual obligation to lead and manage staff with a proper regard for their wellbeing and healthy balance between work commitments.	Resilience Training	Counselling Guide for Schools,2016,Dept Education
J		HEE's priority is to ensure there is a stable and confident workforce, especially looking after children and young people. We need to ensure we have the right skill mix to deliver a safe and sustainable service for patients rather than relying on more doctors in training. Working closely with partners, we are looking at national and international models that provide the best outcomes for patients in order to learn from these.	Provider network work programme	HEE - Workforce initiative, accessed 21.11.16
K		**Mandate** Children and Young people - improving access to psychological therapies (IAPT) Expansion of the children and young people's IPAT transformation programme so that children and young people receive evidence based treatments by 2018.	IAPT	Health Education England - workforce initiative, accessed 21.11.16
L		**Intention** Therapist expansion To encourage expansion of the children and young people's mental health workforce through two training routes: Psychological Wellbeing Practitioners (PWP) Recruit to train(RtT)	IAPT	Health Education England - workforce initiative, accessed 21.11.16
M		**Intention** Community eating disorders Development of specialist community eating disorder teams for children and young people and to support the implementation of access and waiting time's standards by implementing 'whole team' training and supporting the development of training curricula and training in evidence based interventions.	ED	Health Education England - workforce initiative, accessed 21.11.16 5yr Forward View
N		**Intention** Improve the knowledge, attitudes & behaviour of young people and families around mental health.	Resilience Campaign	Time to change programme - anti-stigma for mental health
O		**Intention** Reduce the number of young people with mental health problems who experienced the negative impact of stigma and discrimination. Improve the confidence and ability of young people and families to speak openly about their mental health	Resilience Campaign	Time to change programme - anti-stigma for mental health

Other Guidance				
Ref:		**Narrative**	**Go Forward**	**Guidance**
		problems.		
P		**Intention** Improve the confidence and ability of all young people and families to tackle stigma and discrimination when they see it or experience it.	Resilience Campaign	Time to change programme - anti-stigma for mental health
Q		**Intention** Improve the social capital of young people with mental health problems by building young people's confidence and ability to get involved and engaged within their local communities and activities Time to Change - Resources available at http://www.time-to-change.org.uk/get-involved/resorces-youth-professionals	Resilience Training	Time to change programme - anti-stigma for mental health
R	3.3	**Mandate** p.3.3.Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI).	Resilience Campaign	CQUIN Guidance 2016 NHS England
S	3.5	**Mandate** p.3, 5.Transitions out of Children and Young People's Mental Health Services.	0-25	CQUIN Guidance 2016 NHS England
T	3.4	**Mandate** p.3, 4.Improving services for people with mental health needs who present to A&E	Crisis Response	CQUIN Guidance 2016 NHS England
		'The benefits of interventions during the early years of childhood (including before birth) are realised both in the short-term and over the entire life course of children'	Perinatal	NICE advice to local authorities (Fair society, healthy lives The Marmot Review 2010)
		https://www.nice.org.uk/guidance/qs133 is a quality standard on attachment includes the requirement for mental health staff to 'provide a comprehensive assessment prior to any intervention'	Perinatal	https://www.nice.org.uk/guidance/qs133
		https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0675 NG26 does have some guidance however it doesn't specifically state who does the assessment other than it has to be compliant with the manual below which I presume one would need to be a qualified mental health practitioner to conduct the assessment	Perinatal	https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0675 NG26
		Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5; reactive attachment disorder and disinhibited social engagement disorder) or the International classification of diseases and related health problems, 10th revision (ICD-10; reactive attachment disorder and disinhibited attachment disorder).	Perinatal	

Appendix 2 - Finance

Financial Baseline 2014/15 – 2016/17

	0-18 pop (10%)	14/15	15/16	15/16 Trans	16/17	16/17 Trans
Blackburn With Darwen CCG	4463	£1,286,230	£1,293,993	£332,082	£1,308,227	£470,796
Blackpool CCG	3413	£2,188,255	£2,206,150	£374,367	£2,206,150	£543,867
Chorley & South Ribble CCG	3851	£1,287,350	£1,277,535	£346,081	£1,290,868	£474,793
East Lancashire CCG	10755	£3,652,596	£3,726,241	£751,654	£3,764,260	£1,062,568
Fylde & Wyre CCG	2807	£987,070	£987,070	£314,890	£1,079,609	£433,889
Greater Preston CCG	4635	£1,206,841	£1,201,729	£396,506	£1,214,382	£563,187
Lancashire North CCG	3095	£662,366	£555,150	£297,838	£560,541	£420,021
West Lancashire CCG	2284	£862,548	£856,782	£220,236	£866,207	£300,869

		15/16		16/17	
	14/15 Baseline spend	Spend (inc Transformation	Spend per prevalent pop	Spend (inc Transformation	Spend per prevalent pop
Blackburn With Darwen CCG	£1,286,230	£1,626,075	£364.38	£1,779,023	£398.65
Blackpool CCG	£2,188,255	£2,580,517	£756.02	£2,750,017	£805.68
Chorley & South Ribble CCG	£1,332,159	£1,623,616	£421.57	£1,765,661	£458.45
East Lancashire CCG	£3,652,596	£4,477,895	£416.36	£4,826,828	£448.80
Fylde & Wyre CCG	£987,070	£1,301,960	£463.81	£1,513,498	£539.17
Greater Preston CCG	£1,155,417	£1,598,235	£344.85	£1,777,569	£383.54
Lancashire North CCG	£662,366	£852,988	£275.61	£980,562	£316.83
West Lancashire CCG	£862,548	£1,077,018	£471.61	£1,167,076	£511.05

2016/17 Breakdown of Allocations and Spend Per Theme

- **Allocations**

CCG Name	**Eating Disorder and planning in 2016/17**	**Transformation Plan allocation 16/17**	**Total**
Blackburn With Darwen CCG	£94,796	£376,000	£470,796
Blackpool CCG	£106,867	£437,000	£543,867
Chorley and South Ribble CCG	£98,793	£376,000	£474,793
East lancashire CCG	£214,568	£848,000	£1,062,568
Fylde and Wyre CCG	£89,889	£344,000	£433,889
Greater Preston CCG	£113,187	£450,000	£563,187
Lancashire North CCG	£85,021	£335,000	£420,021
West Lancashire CCG	£62,869	£238,000	£300,869
Totals	**£865,990**	**£3,404,000**	**£4,269,990**

2016/17 Commissioning Intentions/Spend

- **15% Top slice: £510,600**

Commissioning Intention	Workstream	Amount	Business Case Status
Resilience in schools Project	Resilience and early intervention	£72,00	Non rec business case agreed by Board- August
Backfill for IAPT Training	Access to services/ Workforce	£312,750	Business case agreed by Board- September
Provision of out of hours Psychosocial Assessments	Crisis	Approx. £96,350	Business case in development
Positive Behavioural support Training for Learning Disability Teams	Care of Vulnerable	£1,500	Draft Business case produced
Training Gap Analysis for those working with vulnerable groups	Care of Vulnerable	£28,000	Draft Business case produced
Total		**£510,600**	

- **85% Local Spend per Workstream Area**

Work stream	Allocation	%
Resilience and Prevention	£955,521	33
Access	£387,378	13
Care of Vulnerable	£637,341	22
Crisis	£359,999	12
Workforce	£50,000	2
Accountability and Transparency	£224,643	8
EL Still to allocate (Was Tier 4)	£161,602	6
BWD Still to allocate (Was Tier 4)	£78,402	3
WL Still to allocate	£38,664	1
Total	**£2,893,550**	**100**

2017/18 – 2021 Proposed Increased Investment in line with Five Year Forward View

- **Transformation Allocations**

CCG Name	Shares of weighted populations (National)	2016/17	2017/18	2018/19	2019/20	2020/21
NHS Blackburn with Darwen CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
NHS Blackpool CCG	0.37%	£437,920	£515,200	£625,600	£699,200	£787,520
NHS Chorley and South Ribble CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
NHS East Lancashire CCG	0.71%	£847,280	£996,800	£1,210,400	£1,352,800	£1,523,680
NHS Fylde and Wyre CCG	0.29%	£342,720	£403,200	£489,600	£547,200	£616,320
NHS Greater Preston CCG	0.38%	£447,440	£526,400	£639,200	£714,400	£804,640
NHS Lancashire North CCG	0.28%	£333,200	£392,000	£476,000	£532,000	£599,200
NHS West Lancashire CCG	0.20%	£238,000	£280,000	£340,000	£380,000	£428,000
National Resource		**£119,000,000**	**£140,000,000**	**£170,000,000**	**£190,000,000**	**£214,000,000**
Total Lancashire		**£3,398,640**	**£3,998,400**	**£4,855,200**	**£5,426,400**	**£6,111,840**

- **Eating Disorder Allocations**

CCG Name	Shares of weighted populations (National)	2017- 2021 (Per Year)
NHS Blackburn with Darwen CCG	0.32%	£94,796
NHS Blackpool CCG	0.36%	£106,867
NHS Chorley and South Ribble CCG	0.33%	£98,793
NHS East Lancashire CCG	0.72%	£214,568
NHS Fylde and Wyre CCG	0.30%	£89,889
NHS Greater Preston CCG	0.38%	£113,187
NHS Lancashire North CCG	0.28%	£85,021
NHS West Lancashire CCG	0.21%	£62,869
Lancashire Total		**£865,990**

Proposed Trajectories

Children and Young People (CYP) Access

*Estimated No of Children 0-18 with a MH Condition.	Est. 16/17 Baseline (Ref accepted)		Est. 16/17 Baseline (1st Treatment)		2017/18	2018/19	2019/20	2020/21
					30%	**32%**	**34%**	**35%**
4463	730	16%	420	9%	1339	1428	1517	1562
3413	1152	34%	584	17%	1024	1092	1161	1195
3851	542	14%	338	9%	1155	1232	1309	1348
10755	1600	15%	972	9%	3226	3442	3657	3764
2807	580	21%	306	11%	842	898	954	982
4635	712	15%	368	8%	1390	1483	1576	1622
3095	462	15%	290	9%	928	990	1052	1083
2284	344	15%	200	9%	685	731	776	799

Workforce Baseline

CCG	National Service Framework (2004)	RC Psychiatry 2006	15/16 Baseline	16/17	
Blackburn With Darwen CCG	30	35 including 10 PMHW	41.44	49.64	Including 4.9 PMHW Psychology
East Lancashire CCG	60	75 including 20 PMHW		10.5	
Blackpool CCG	30	35 including 10 PMHW		24.22	
Chorley & South Ribble CCG	30	40 including 10 PMHW	20.24	20.24	
Fylde & Wyre CCG	25	25 including 10 PMHW	12.8	16.8	Including 2 PMHW
Greater Preston CCG	35	45 including 15 PMHW	23.87	23.87	
Lancashire North CCG	25	35 including 10 PMHW	10.06	12.06	
West Lancashire CCG	20	25 including 10 PMHW	10.6	12.1	
Pan Lancashire	**255**		**119.01**	**169.43**	

CCG TRAJECTORIES FOR EATING DISORDER SERVICE

From Eating Disorders Workforce Toolkit: Males aged 10-19 31 per 100'000 pop

NEW CASES

	Total Eating Disorder New Cases - Age 10-19					
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Blackburn With Darwen CCG	17.0	17.2	17.3	17.6	17.6	17.8
Blackpool CCG	13.3	13.2	13.2	13.1	13.2	13.3
Chorley & South Ribble CCG	14.3	14.3	14.4	14.5	14.6	14.9
East Lancashire CCG	32.8	32.9	33.2	33.5	34.0	34.3
Fylde & Wyre CCG	11.3	11.1	11.0	10.9	10.9	10.9
Greater Preston CCG	17.7	17.8	18.0	18.2	18.6	18.9
Lancashire North CCG	13.3	13.0	12.9	12.7	12.7	12.8
West Lancashire CCG	9.5	9.5	9.4	9.4	9.4	9.4
TOTAL	**129.2**	**129.1**	**129.4**	**130.0**	**131.0**	**132.2**

ACCESSING SERVICE (Increasing from 70% to 95% over next 5 years)

	2016	**2017**	**2018**	**2019**	**2020**	**2021**
	70%	75%	80%	85%	90%	95%
Blackburn With Darwen CCG	11.9	12.9	13.9	14.9	15.9	16.9
Blackpool CCG	9.3	9.9	10.5	11.2	11.9	12.7
Chorley & South Ribble CCG	10.0	10.7	11.5	12.3	13.1	14.1
East Lancashire CCG	23.0	24.7	26.5	28.5	30.6	32.6
Fylde & Wyre CCG	7.9	8.3	8.8	9.3	9.8	10.3
Greater Preston CCG	12.4	13.4	14.4	15.5	16.8	17.9
Lancashire North CCG	9.3	9.8	10.3	10.8	11.5	12.2
West Lancashire CCG	6.7	7.1	7.5	8.0	8.5	8.9
TOTAL	**90.4**	**96.9**	**103.5**	**110.5**	**117.9**	**125.6**

URGENT CASES **Assumption: 35% Urgent and 65% Routine**

35%

	Total Eating Disorder New Cases - Age 10-19					
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Blackburn With Darwen CCG	4.2	4.5	4.9	5.2	5.6	5.9
Blackpool CCG	3.3	3.5	3.7	3.9	4.2	4.4
Chorley & South Ribble CCG	3.5	3.8	4.0	4.3	4.6	4.9
East Lancashire CCG	8.0	8.6	9.3	10.0	10.7	11.4
Fylde & Wyre CCG	2.8	2.9	3.1	3.3	3.4	3.6
Greater Preston CCG	4.3	4.7	5.0	5.4	5.9	6.3
Lancashire North CCG	3.3	3.4	3.6	3.8	4.0	4.3
West Lancashire CCG	2.3	2.5	2.6	2.8	3.0	3.1
TOTAL	**31.7**	**33.9**	**36.2**	**38.7**	**41.3**	**44.0**

ROUTINE CASES

65%

	Total Eating Disorder New Cases - Age 10-19					
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Blackburn With Darwen CCG	7.8	8.4	9.0	9.7	10.3	11.0
Blackpool CCG	6.1	6.4	6.8	7.3	7.7	8.2
Chorley & South Ribble CCG	6.5	7.0	7.5	8.0	8.5	9.2
East Lancashire CCG	14.9	16.1	17.3	18.5	19.9	21.2
Fylde & Wyre CCG	5.1	5.4	5.7	6.0	6.4	6.7
Greater Preston CCG	8.0	8.7	9.3	10.1	10.9	11.7
Lancashire North CCG	6.0	6.4	6.7	7.0	7.5	7.9
West Lancashire CCG	4.3	4.6	4.9	5.2	5.5	5.8
TOTAL	**58.8**	**63.0**	**67.3**	**71.8**	**76.6**	**81.6**

Assumption: In respect of both Urgent and Routine Performance (seen in 1 week and 4 weeks respectively) performance to increase from 20% to 95% over 5 years

No. Urgent Patients Seen	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
within 1 week	20%	35%	50%	65%	80%	95%
Blackburn With Darwen CCG	0.8	1.6	2.4	3.4	4.4	5.6
Blackpool CCG	0.7	1.2	1.8	2.5	3.3	4.2
Chorley & South Ribble CCG	0.7	1.3	2.0	2.8	3.7	4.7
East Lancashire CCG	1.6	3.0	4.6	6.5	8.6	10.8
Fylde & Wyre CCG	0.6	1.0	1.5	2.1	2.7	3.4
Greater Preston CCG	0.9	1.6	2.5	3.5	4.7	6.0
Lancashire North CCG	0.7	1.2	1.8	2.5	3.2	4.0
West Lancashire CCG	0.5	0.9	1.3	1.8	2.4	3.0
TOTAL	**6.3**	**11.9**	**18.1**	**25.1**	**33.0**	**41.8**

No. Routine Patients Seen	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
within 4 weeks	20%	35%	50%	65%	80%	95%
Blackburn With Darwen CCG	1.6	2.9	4.5	6.3	8.3	10.5
Blackpool CCG	1.2	2.3	3.4	4.7	6.2	7.8
Chorley & South Ribble CCG	1.3	2.4	3.7	5.2	6.8	8.7
East Lancashire CCG	3.0	5.6	8.6	12.0	15.9	20.1
Fylde & Wyre CCG	1.0	1.9	2.9	3.9	5.1	6.4
Greater Preston CCG	1.6	3.0	4.7	6.6	8.7	11.1
Lancashire North CCG	1.2	2.2	3.4	4.6	6.0	7.5
West Lancashire CCG	0.9	1.6	2.4	3.4	4.4	5.5
TOTAL	**11.8**	**22.0**	**33.6**	**46.7**	**61.3**	**77.6**

Appendix 3 - Feedback from Consultation

Consultation on the draft Re-freshed Transformation Plan took place from 13th December 2017 until 6th January 2017. The original transformation plan and draft re-freshed plan alongside easy-read versions of both were posted on the internet together with a link to a consultation survey. Over 300 stakeholders received an email with the link inviting them to read the re-freshed plan and respond to the consultation survey. They were also asked to forward on the email to others who may be interested.

Stakeholders were asked to indicate the extent to which they agreed with the priorities set out in the plan and then to provide an explanation of their response. Respondents were also asked some questions about themselves to help us understand their comments and ensure representation.

There were 55 completed responses. Of the respondents no-one disagreed with the objectives and the majority (75%) agreed fully with them. All groups of respondent (i.e. service users, parents/carers, health professionals, members of the public and others) had some respondents who partly agreed with the refreshed objectives.

Most of the younger people who responded were fully supportive and most 26-35 year olds were also fully supportive of the proposals. The largest group of respondents were Health Professionals (33%), and nearly a quarter (24%) was parents/carers and over a 5th of respondents were from other groups such as voluntary sector, social work or children's advocate. A further 7% of respondents were young people who were not service users.

The vast majority of respondents were female (83%). Whilst there is no reason to think that males, whether service users or not, feel any differently about the objectives, as we only have a small level of male respondents we cannot say this conclusively. There is some representation from Asian/Asian British and Muslim communities (up to 14%) but there is under representation from certain other groups.

65% of respondents made a comment, replying to 'please tell us why'. The comments were largely positive but quite varied; although a number of common themes/points could be identified. However, the most common points made are as follows:

- Good to see families and young people at the heart of the objectives; looking at a client centred service is key with true children, young people and family involvement
- The objectives make sense and is a positive plan (as long as it can be implemented)
- Feel the plan will help support local families/children and particularly welcome perinatal mental health and eating disorder service plans
- Very supportive of early interventions and support beyond age 16

- Happy with a focus on vulnerable groups and concentrating on training for the workforce is excellent
- There is concern about the implementation; excellent ideas but needs to be seen in practice – without significant funding this could be a PR brochure – would be great if it can be made to happen but there have been too many false promises for young people
- Joined up working across the spectrum of mental health
- Excellent idea of a 'safe place'

A few suggestions made include:

- Roll-out of Primary Mental Health Workers should be done earlier
- 2018 is too long to wait
- More help should go into schools and more direct support for young people/children
- What about support for children under 5 years of age?
- More local inpatient support for when children/young people in crisis and parents cannot cope but need/want to maintain links and regular visits
- Would like to see the plan presented in a timeline
- More provision for families sooner
- More young people and families could have been consulted earlier in the process

The table below sets out each of the individual comments received together with a response indicated what actions have been taken as a result of the comment.

Comment from…	You said	We did
Voluntary sector worker	Early help makes sense at the individual and society level. Making support at this level easier to navigate will reduce stigma and increase up take in a cost effective manner. It is good to see the thoughts of families and young people are at the heart of this and the settings for this support are being considered. The plan supports cross sector working. I hope that this really does value the input of the voluntary/ third sector and the professionalism and expertise that they offer. Any contracting should be well publicised and be realistic in terms of payment mechanisms and the conflict this can cause if this is not carefully thought through (e.g the level of flexibility is reduced in PBR contracts and can cause massive issues for smaller organisations which are often closely linked to their communities and perform strongly on quality and VFM- it should be about more than cost alone)	Comment noted
Health professional	They make sense!	Comment noted
MLCSU	Being involved in the process and the work of the Transformation Board I feel that the priorities are right going forward	Comment noted
Health professional	I would like to see the roll out of Primary Mental Health Workers, to support stakeholders offer training and support young people earlier. I would like to see the CCGs getting the NHSE money for Tier4 services this would help with joint planning of urgent cases without several assessments taking place. Out of hours support in crisis and moving the age range upto 19 are excellent and I am really supportive of the development of specialist eating disorder services	Comment regarding Primary Mental Health Workers noted, this is reflected in Objective 5 of the plan. In relation to Tier 4, this is reflected in Objectives 19 and 20 of the plan. Other comments noted
Health professional	The principles are all sound and I like the focus on preventions and helping people maintain there mental health. I think that access to services, joined up working and accessing formal assessment where prevention is not enough needs more focus and this may come with further detail. Access to ADOS and ADHD assessments is very difficult in the county, such assessments should be multidisciplinary in nature but there is no formal multi disciplinary assessment available instead it falls to the parent or child to navigate	Comments noted We have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and

Comment from…	You said	We did
	the systems separate parts. Multi disciplinary Child Development Centre (CDC) models may function better however these require investment, the subsequent improvement in identifying need leads to further investment in then meeting that need. however the long term health and social benefits should be greater than the expenditure.	outcomes for children and young people from vulnerable groups.
Health professional	Looking at utilizing what is available and how best to meet needs, with existing resources, as cutting them is not a helpful option. Looking at a client centered service is key with true children, young people and family involvement.	Comment noted
Health professional	there are quite a lot of websites out there already. It seems to me that what is needed is "people" to support children and possible activities for them to do this via, eg scouts boys clubs activity clubs, discussion groups etc do we not already have groups to support health and well being in 18-25 yr olds and also eating disorder clinics / support takes quite a bit of time to read through to answer this question so not sure how rounded your responses are going to be !!	Comment noted Reflected in Objectives 4 and 11 of the plan.
Social Worker	The idea of a safe place is fantastic and much needed. It will allow them to be safe while help can be thought through. Also for stressed families to know their young person is safe will be very important. I just hope I'm still working in order to see this started. I work with looked after and adopted children and I wondered about your comment about half the children who are looked after having mental health difficulties. Although I agree with this I am not sure whether this is how CAMHS see the situation and wonder if more support is going to be available via their service or say for instance via the SCAYT team or are there going to be other services for this group ?	Comment noted We have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups. Also Appendix 4, highlights the national target reflected against Objective 11 of the plan that at least 35% if CYP with a diagnosable mental health condition will receive treatment from an NHS funded community mental health service.

Comment from…	You said	We did
Health professional	I work with families and children have a keen interest in infant mental health and perinatal mental health, and feel the plan will help support local children and families emotional well- being. I deliver infant mental health training within Blackpool (IHV champion trainer) mulit agency and feel this is needed to try and assist main carers to form a loving bond and support a secure attachment for the infant. the cost benefits of getting the support early is crutial	Comments noted
Young person/service user	By changing the way that CHAMS works and stop putting 16 years old on the adult services	Comments noted and reflected in Objective 11 of the plan
Member of the public	Lancashire are currently failing to safeguard children and failing to treat mental health problems in able and disabled children - I feel without significant funding your glossy brochure is a PR exercise. Perhaps you could include EMDR as a therapy in your bright, glossy brochure. I understand it is successful in treating both victims and perpetrators of chid sexual exploitation. Perhaps you could also be more vigilant when using leaving care companies, rather than choosing the cheapest and often least ethical provider.	Comments noted. Appendix 2 sets out a breakdown of transformation funding and commitments. We have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups. In relation to the comment regarding leaving care companies -there are a wide range of services and support available for care leavers in Lancashire. Some of these services are funded or provided directly by single agencies such as local authorities, and some are provided in partnership with other agencies.

Comment from…	You said	We did
		The services that Care Leavers need to access will depend on their own personal circumstances. The types of services offered to care leavers include an allocated personal advisor, accommodation, education, employment and training, higher education, financial support and support with health and well-being. Where third party providers are used, these are procured taking in account a range of factors, including the quality of the service. It is hoped that care leavers are satisfied with the services and support that they receive, but if there are specific concerns then care leavers should raise these with their allocated worker or their manager to resolve quickly. Services such as the Children's Rights Service are available to support care leavers who wish to complain, up to the age of 18. Your Local Authority will be able to provide further details of the help available to you to raise a concern or make a complaint.

Comment from…	You said	We did
Parent/carer	I haven't read them and you haven't shown me them!	A copy of the draft transformation plan refresh was included within the survey. The final agreed transformation plan will be shared on CCG and Local Authority websites
Parent/carer	All the priorities I agree with and would like to see services meeting the needs of all individual children. However, my child has a panic disorder that has developed since starting high school and worsened over time resulting in her leaving school into home education, as her parents who want the very best for our daughter we have struggled to get the relevant support needed and when we did receive support from CAHMS in preston, it was the worst experience of our lives. We have not been made aware of any support/resources available to support our daughter.	Comments noted and shared with CAMHS service management.
Parent/carer	Its good to be planning on help being available 24/7 but its too long to wait until 2018. Its really hard to get help even in 'office hours' as it is. More help should go into schools where young people are for most of their day and have open access to mental health trained professionals when they need it.	Comments noted, elements of the Crisis Pathway reflected within Objectives 16 and 17 will be in place prior to March 2018, in particular 7 days CAMHS crisis response service to C&YP in acute hospitals (Objective 17). Other elements will take longer. In relation to more help into schools, Objective 5 regarding Primary Mental Health Workers addresses this.
Work in a CCG	It provides a whole system approach, not just focusing on crisis but putting early intervention support in place through resilience work in schools and perinatal work. The focus on vulnerable groups and training for the workforce is an excellent step forward.	Comments noted

Comment from…	You said	We did
Community Development Worker	They make sense, as long as they are actually implemented	Comments noted
Member of the public	If you could make this happen, it would be great but there are too many false promises made to young people, there are services out there already but the children are being let down constantly by services due to demand.	Comments noted
Health professional	I work with pregnant teenagers and they have lots of mental health issues that we support them with, especially looking at early detection and prevention of mental health issues. my team would benefit from easy access to mental health support for our clients	Comments noted and this is reflected within Objective 9 of the transformation plan
Parent/carer	Its a very positive plan with the focus being on 'early intervention' rather than waiting till crisis point before services get involve. this can only be seen as a positive and will impact on so many young people to get the help they need much earlier.	Comments noted
Parent/carer	Early intervention work will help prevent more serious problems further down the line.	Comments noted
Parent/carer	Support is needed beyond 16 as is the case at present. A child in their final year at school cannot access Elcas if they are 16.	Comments noted and noted within Objective 13 of the transformation plan
School Governor	Seeks to provide good joined up working across the spectrum of mental health and well being issues and services.	Comments noted
Early Intervention Officer	To improve the mental health and well being of people in Lancashire	Comments noted
Health Professional	It is important to give timely, accessible support to children and young people to make sure that emotional difficulties do not lead to poor mental health, especially to those who fall into 'vulnerable' categories.	Comments noted, reflected in Objectives 1, 3, 5 and 6. Also we have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups.
Young person/not a service user	It is a necessity to provide improved services for young people	Comments noted

Comment from…	You said	We did
Parent/carer	I think more people need to understand about mental health and what it is	Comments noted and reflected in Objectives 1 and 3.
Health Visitor	I agree that you should be offering services to children age 0-19 as stated in the papers attached. However, presently, there does not appear to be any services for children under 5 years of age and this is much needed	Comments noted and reflected in Objective 13
Health Professional	There needs to be an emphasis regarding YP mental health and access to support via a number of means including low level; information and guidance and then via CAMHs and specialist services working together. There also needs to be more LOCAL inpatient support for when crisis level is reached and parents feel unable to support their child in their own home but want to be able to maintain links and visit regularly.	Comments noted, reflected in Objectives 1, 3, 4, 5, 6, 13, 19 and 20.
Health Professional	Children's emotional health needs to be addressed to improve their lifestyle outcomes, instilling coping mechanisms to deal with every day stresses. Working with children helps to build solid foundations to promote healthy lifestyles and positive decision making.	Comments noted and reflected in Objectives 1, 3, 4 and 5
Young person/not a service user	I believe it is good how the causes of mental health amongst the youth are being eradicated and it is a very good idea. However, the idea to get rid of mental health services is slightly concerning as mental health problems can be reduced but there will always be many people who suffer from mental health problems due to numerous problems and therefore will need the services.	Comments noted
Parent/carer	The mental health and well being of CYP is crucial to both their physical and mental well being. CYP cease to function on a daily basis without good mental health, the impact from poor mental health leads to poor physical health, isolation and failure to engage in education. Mental and emotional wellbeing is a high priority for CYP. The outcomes of improved mental health services lead CYP to engage fully in the community, education and socially.	Comments noted
Parent/carer	CYP emotional health and well being are paramount in them being able to build resilience for now and later in life challenges.	Comments noted
Young people's project worker for charity	More support for young people with mental health problems is greatly needed, they need support up to age of 25 and they need to be able to access emergency support 7 days a week without having to go to A & E.	Comments and reflected in Objectives 13,14 and 17

Comment from…	You said	We did
Health professional	They should all have a profoundly positive impact on people living in this area	Comments noted
Children's advocate	Excellent idea's of improving the service eg: working with pregnant mums, eating disorders, ADHD, YJS, Helpline. However when a professional recognises that a preventative service is required how do we know the referral will be acted on? Without this being put into practice is as difficult to tick 'fully' at this stage.	Comments noted and reflected in Objective 11. Also we have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups.
Experts by experience - we are a group of service users The Crew	Yes but it would be clearer if it was presented in a timeline. Plus more provision for families nearer to this date. Also we feel that more young people and families could have been consulted early in this process.	Comments noted, timeline added at Appendix 5. Consultation to develop the original transformation plan and subsequent consultation and engagement during delivery in Year 1 have been used to inform the refresh of the plan.
Children's advocate	Following our meeting, I would like to reiterate the need for specialist mental health services for children who have suffered adverse childhood experiences (ACE). I note your 'Care of the Most Vulnerable' workshop in September highlighted Children looked after and Care Leavers as vulnerable groups. This particular group quite often needs extensive mental health service input owing to the traumas they have suffered. It is very important mental health services are expanded to include therapies and intervention which address the needs of children and young people who have traumatic histories such as children looked after and care leavers. Being removed from your family of origin is always traumatic and regardless of the experiences in the family home, the child, now in care, is likely to suffer from some kind of trauma.	Comments noted and we have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups. Details have been shared with the Care of the Most Vulnerable Cluster lead.

Comment from…	You said	We did
	The main diagnoses for children or young people who have suffered from trauma or been looked after, can include: Post Traumatic Stress Disorder (PTSD) Dissociative Identity Disorder (DID) Personality Disorder (however this diagnosis is controversial and some professionals frown on this being given as a label to trauma survivors - especially children). Attachment Disorders. (as well as anxiety, depression, suicidal ideation and self injury, bipolar disorder etc) Unfortunately there has been limited research into the above disorders, with research into PTSD mainly involving Armed Forces Veterans, however PTSD is the injury experienced by children who have witnessed domestic violence, suffered child sexual abuse or been badly bullied etc. and there is little literature available as of yet (however this is increasing). There are however many interventions and therapies which have been shown to help heal trauma survivors including children who have been separated from their birth families and/or experienced any traumas mentioned above. This can often be a combination of talk therapy, CBT but also more complementary therapies such as physical therapy, acupuncture, EFT, ...the list is endless. Many adults have written about their experiences and the type of interventions which have helped them and I feel very strongly that with any commissioning arrangement , not only the voice of the child BUT also the voice of the ADULT care leaver should be heard as to what therapies have helped them. One thing is quite clear in that professionals have got it very badly wrong in the past and have even re-traumatised children and young people through their methods. We only have to look at the problems with CAMHS at the present time. Now is the time to really get a grip of this highly specialised area and I request that you	

Comment from…	You said	We did
	liaise closely with myself as Chair of the Corporate Parenting Board and the LINX group (Young people in care and care leaver representatives) when formulating commissioning plans for mental health services in Lancashire for our most vulnerable groups - especially children looked after and care leavers.	
Police	It is something and nothing really, but in view of all the multi agency work taking place with our Early Action teams around supporting young people, would it be better to have a photograph depicting the police talking with a young person rather than apprehending them?	Comments noted. We will amend the picture in the easy read version of the final agreed transformation plan.
Experts by experience	'I think there needs to be more mental health services because too many people suffer with these problems. I was diagnosed with moderate - severe depression, Reactive Attachment Disorder (RAD), Oppositional Defiant Disorder. When I was diagnosed, they wasn't explained to me in a way that I could understand so I researched them. When I've been referred for things I found out that there isn't enough long term treatments available, all the short term stuff aren't long enough for me as there isn't enough time for anything to work	Comments noted
Children's advocate	As can be seen below professionals seem very adept at labelling our most vulnerable young people as 'disordered' in some way when it is events that have happened to them through no fault of their own which have, more often than not, led to this labelling. 'I would like to see a complete end to the labelling of our most vulnerable young people with degrading and abusive psychiatric labels by all professionals involved in delivering mental health services across Lancashire. A trauma informed approach needs to be at the core of any transformation model, focussing on the actual problems and difficulties experienced by the child or young person whilst acknowledging influencing factors outside the child or young person and aiming to seek solutions to these.' 'Noone has ever recovered from abuse, whilst still being abused or living with the perpetrator. How can any professional ignore these facts and see the problem as residing as soley within the child?' 'It's time mental health services are completely transformed in	Comments noted and we have amended Objective 21 of the plan to reflect the need for pathways to improve access to assessment, services and outcomes for children and young people from vulnerable groups. Details have been shared with the Care of the Most Vulnerable Cluster lead.

Comment from…	You said	We did
	Lancashire, recognising the social construction of current mental illness models and opening their doors to and linking with a wider community involving family members and others eg DWP, employers, who may be contributing to a persons' ill health. I see too many care leavers who have depression, anxiety etc. owing to the sanctioning of their benefits by the DWP or threatened eviction from their properties by rogue private landlords etc. As a society we cannot ignore the contribution of others to a young persons' mental health problems any longer'.	
Parent/carer	Issues with link to survey. An observation. As the parent of a 23 year old who has complex and challenging needs I do not need to be told by EDT MH that there is no intervention available in evenings or a weekends apart from the police due to being open to LD team	Comments noted. Details have been shared with the Local Authority representatives on the Transformation Board.
Health commissioner	Mandate p.3.3.Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI). Resilience Campaign. CQUIN Guidance 2016 NHS England. For the mandate above, I don't know how a resilience campaign will address this and I feel that we should be looking after the physical health needs of all young people with a mental health condition (not just those with an SMI). For me, there needs to be a bit more about what we'll expect providers of services to do (like CAMHS) to ensure physical health needs are assessed and addressed, especially in relation to substance misuse, alcohol and tobacco use. Also, not much around the younger age group (post perinatal period but before school) – how do we support parents to promote their child's emotional health and wellbeing, how can they encourage their child to recognise and name their emotions etc.	Comments noted re physical health and reflected in objectives 1 and 3. Objective 23 amended to include parity of esteem with physical health. Comments noted and reflected in objectives 1 and 3.
Health Commissioner	Assurance of a highly skilled, competent workforce with the right capacity and skill mix across all levels of care including: Universal, Infant Mental Health, Community Specialist Teams and Inpatient Services. This will be in line with the future HEE Competency framework (to be published October 2017) describing the workforce needs at all levels including; generic knowledge, advanced knowledge and Specialist Services.	Comments noted, workforce is incorporated in the Principles section 3, Principle 3 and therefore forms part of the delivery of all objectives. New

Comment from…	You said	We did
	The new workforce will be delivered through a combination of upskill of existing practitioners and services and newly commissioned services set out below; 1)**Universal** - Consistent Clinical Pathways led by Strategic Clinical Network for Maternity and Health Visitor services Gap Analysis of Specialist Posts and leadership roles in Universal services Training of Adult Psychiatry and IAPT services. 2) **Infant Mental Health** - Infant Mental Health posts to be commissioned and emerging new pathways developed. 3) **Community Specialist Mental Health Teams** - A new specialist service will be commissioned allowing at least an additional 495 women each year to receive evidence based treatment closer to home when they need it. 4) **Inpatient Services** - a "specialist inpatient mother and baby unit" allowing at least an additional 21 women each year to receive evidence based treatment closer to home when they need it	objectives 7 & 8 have been added to the Peri-natal mental health section 3, page 8.

Appendix 4 – Objectives, Impact and Measures

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
Promoting resilience, prevention and early intervention			
1. By the 30th September 2017 we will have designed and commissioned a **"Mental Health Anti-Stigma Campaign"** building on the existing approach through "Life's ups and downs". By the 31st March 2018 we will have mobilised the campaign across Lancashire.	30.9.17 31.03.18	**Health & Wellbeing:** The campaign will give children, young people and their families, practical advice and support to help them look after their own emotional health and wellbeing, creating resilience. **Care & Quality:** The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Number of people visiting the 'Coping with life's ups and downs' website. Life in Lancashire survey – 2-3 questions.
2. By the 31st March 2018 we will have developed, published and launched a Lancashire wide **"Resilience Framework"** which will includes the following components: • Set a common understanding of what is meant by 'Resilience' in the context of the Pan Lancashire area, in line with the CYP EWMH	31.3.18	**Health & Wellbeing:** The framework will help to ensure that any resilience programmes and work that are commissioned and delivered are in line with best practice thus maximising children and young people's resilience, including their ability to manage and recover from mental health issues. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Stakeholder feedback. Life in Lancashire survey – 2-3 questions. Take up of toolkit.

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
Transformation Programme. • Provide a step by step guide considering, what, where, with whom and how resilience activities should be best delivered according to the evidence base. • Provide information about sources of local good practice and opportunities for local networking and support. • Provide a quality assurance checklist to ensure that activities are high quality, safe, and based upon best practice.			
3. By the 31st March 2019 we will have designed and commissioned a **"Resilience training programme"** in line with the resilience framework for: a. Schools b. CYP c. Families d. Parent carers and young carers e. Other staff working with CYP and families in universal and community service	31.3.19	**Health & Wellbeing:** The programme will give children, young people and their families access to practical advice, support, tools and techniques to help them look after their own emotional health and wellbeing. Maximising children and young people's resilience, including their ability to manage and recover from mental health issues. **Care & Quality:** The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time.	**Local measures:** Uptake of training programmes Participant feedback Life in Lancashire Survey – 2-3 questions

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
		Finance & Efficiency: Greater resilience will enable us to more effectively respond to predicted increasing demand.	
4. By 31st March 2018 we will have defined a **"complementary offer"** of support to wrap around clinical services to help children; young people and families avoid escalation, recover earlier and maintain wellbeing. We will have mobilised by 2020/21.	31.3.18 31.3.21	**Health & Wellbeing:** By nurturing the development of a range of asset based supports such as peer support, buddying, online communities, community events and mutual aid we will enable and empower children, young people and families to support themselves and each other. **Finance & Efficiency:** Nurturing resilience and the development of community assets will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Life in Lancashire Survey – 2-3 questions
5. By the 30th September 2017 we will have expanded the number of **"Primary Mental Health Workers"** (PMHW) or their equivalent and introduced **"Psychological Wellbeing Practitioners"** (PWPs) to work within universal and targeted services to support and improve mental health and psychological wellbeing of children and young people.	30.9.17	**Health & Wellbeing:** By providing the link between specialist CAMHS and primary and community services the workers will help to: • Build capacity and capability within community services in relation to prevention, early identification and intervention. • Help promote awareness and importance of emotional health and wellbeing, improving perceptions and attitudes. **Care & Quality:** Support access to appropriate services. Offer effective assessments and evidence based therapeutic interventions. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Service user views Number of assessments Number of evidence based therapeutic interventions Outcome measures to be agreed PMHW and PWPs in post

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
6. By the 30th September 2017 we will have defined and designed a Lancashire wide approach to delivering a **"single point of contact"** which will include the following components: • A definition of what we mean by single point of contact • A description of the component parts of the single point of contact • Guidance for commissioners on how to implement the approach locally • Resources and tool for providers to use to develop local protocols By 31st March 2018 we will have implemented the **"single point of contact"** approach in each health economy.	30.9.17 31.3.18	**Care & Quality:** By establishing a consistent approach to single point of contact across Lancashire we will ensure that speed and ease of access to a seamless service is improved, reducing delays and ensuring that children and young people receive the support they need. **Finance & Efficiency:** By improving timely access to support and treatment, escalation will be reduced and as such the number of contacts and the need for more intensive services will decrease. We will also reduce the number of inappropriate referrals by providing support earlier in the pathway.	**National measures:** Referral to treatment times for IAPT and ED. **Local measures:** Referrals to CAMHS Inappropriate referrals to CAMHS Admissions to tier 4 Patient experience measures
Increasing Access to Specialist Perinatal and Infant Mental Health Support			
7. By March 31st 2021 we will have delivered "**improvements in Universal Services"** including: • Consistent Clinical Pathways • specialist post and leadership roles on universal services	31.3.21	**Health & Wellbeing:** • The development of resilient children supported by positive parent and child attachment achieved via multidisciplinary family centred approaches. • Early recovery and maintenance of mental well-being that enables women with serious or complex mental illness and their families to function effectively in day	**National Measure:** NICE Quality Standards QS133 National Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
		to day life i.e. childcare activities, employment, social activities etc. **Care & Quality:** • The ability for women to make informed choices through the provision of pre conception counselling. • A reduction in the risk of avoidable harm to women and infants due to mental health needs in the perinatal period. • A reduction in the severity, duration, and the negative impact of mental illness in the perinatal period. **Finance & Efficiency:** • Access to specialist care close to home reducing the need for inpatient admission and eliminating the need for travel to access specialist care out of area.	assessment before intervention programme for attachment difficulties
8. By March 31st 2021 we will have delivered **"improvements in services for infant mental health"** including: • Infant Mental Health posts to be commissioned and emerging new pathways developed. • Training of Adult Psychiatry and IAPT services.	31.3.21		**National Measure:** NICE Quality Standards QS133 National Data set IAPT Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive assessment before intervention programme for attachment difficulties
9. By the 31st March 2021 we will have commissioned a **"specialist"** community perinatal mental health team allowing at least an additional 495 women each year to receive evidence based treatment closer to home when they need it. *subject to release of national resource	31.3.21		**National measure:** Number of women receiving specialist peri-natal care in a community team. **Local measures:** 21 women per year accessing specialist inpatient mother and baby units. Patient reported outcome measures.
10. By the 31st March 2021 we will have a **"specialist"** inpatient mother and baby unit allowing at least an additional 21 women each year to receive evidence based treatment closer to home when they need it.	31.3.21		
Improving Access to Effective Support			

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
11. By 31st March 2017 we will have developed a specification and commissioned a provider for an online one stop portal known locally as **"Digital THRIVE"** offering information, advice, self-help, care pathways and self-referral. By 31st March 2018 our online one stop portal known locally as **"Digital THRIVE"** will be operational across Lancashire	31.3.17	**Health & Wellbeing:** The portal is expected to improve the health and wellbeing of CYP and families by improving access to information, self-help materials and support: • Enabling people to access support earlier • Reducing reliance on T3 and T4 CAMHS • Supporting appropriate use of CAMHS	**Local measures:** Reduction in % inappropriate referrals to CAMHS. Increase in the number of CYP with a diagnosed mental health condition enabled to access help. Number of hits on the Digital Thrive portal.
12. By the 31st March 2017 we will have established a dedicated all age **"eating disorder"** service which fulfils the requirements of the Eating Disorders Commissioning Guide: Access and Waiting Time Standards (NHSE).	31.3.17	**Health & Wellbeing:** The service is expected to improve outcomes for CYP with ED by: • Offering a dedicated specialist service offering NICE guideline compliant treatments. • Improving access to information, advice and self-help through the development of an upstream offer. **Care & Quality:** The service is expected to improve access to ED support that is compliant with national commissioning guidance. **Finance & Efficiency:** The service is expected to lead to reduced admissions to tier 4 CAMHS ED beds.	**National measures:** By 2020/21, 95% of CYP (up to age 19) referred for assessment or treatment for an ED should receive NICE-approved treatment within 1 week for urgent cases and 4 weeks for every other case. **Local measures:** Admissions of CYP with ED to Tier 4 CAMHS ED beds. Patient reported outcome measures.
13. By 30th September 2017 we will have a **"0-19"** years (up to 19th birthday) CAMHS service model operational across Lancashire which will include arrangements	30.9.17	**Care & Quality:** The new 0-19 arrangements will offer a consistent level of service across Lancashire, supporting greater numbers of children and young people to access the support they need. The new arrangements will also improve outcomes	**National measures:** By 2020/21, at least 35% of CYP with a diagnosable mental health condition will receive treatment from an NHS funded community

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
for 7 day working and out of hours provision.		by delaying transitions until after adolescence, enabling continuity of care throughout this challenging period for CYP and families. The 0-25 offer will ensure a comprehensive and consistent set of services and supports across Lancashire. **Finance & Efficiency:** Increased access and continuity of care will lead to better outcomes for CYP and will enable us to more effectively respond to predicted increasing demand. In the longer term it will lead to reduced demand for adult mental health services.	mental health service. By 2021, increased numbers of therapists and supervisors will have been employed to meet the additional demand. **Local measures:** Admissions to CAMHS tier 4 inpatient beds. Patient reported outcome measures.
14. By 31st March 2018 we will have defined a local offer of service provision for CYP with EWMH needs aged **"0-25"** years. By the 31st March 2020 we will have developed and implemented our **"0-25"** years offer.	31.3.18 31.3.20		
Ensuring appropriate support and intervention for C&YP in Crisis			
15. By 31st March 2017 we will have developed and implemented a **"pathway"** for CYP admitted to acute hospitals in crisis and a set of shared principles to be incorporated into local operational protocols. By 30th September 2017 all acute hospitals will have worked with local CAMHS providers and agreed local operational protocols.	31.3.17 30.09.17	**Care & Quality:** The pathway and protocol will lead to a consistent multi-agency response to CYP who are admitted to paediatric wards, ensuring their needs are assessed in a timely and holistic way, reducing lengths of stay and reducing delayed discharges. **Finance & Efficiency:** The pathway and protocol will lead to reduced lengths of hospital stay and reduced incidences of delayed discharge.	**Local measures:** Time from triage to admission and assessment (if appropriate). Length of stay. Delayed discharges.
16. By 31st March 2018 we will have developed and implemented as part of the all-age crisis care concordat • a **"consistent crisis**	31.3.18	**Care & Quality:** Children and young people across Lancashire will receive a consistent response when they are in crisis.	**Local measures:** Number of staff trained to treat young people with empathy and supportive methods. Admissions to acute and specialist

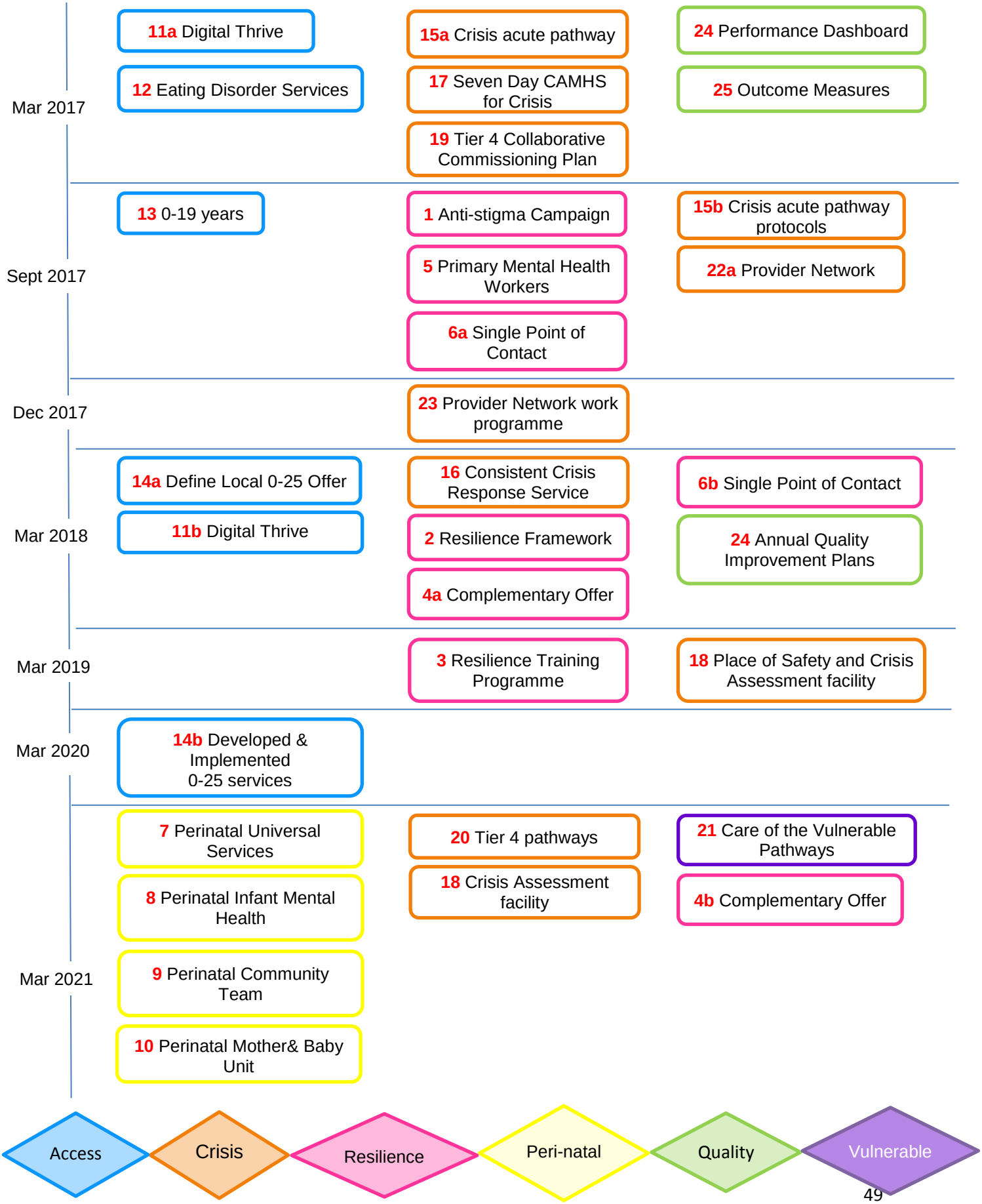
OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
response service "for C&YP within acute hospitals e.g. mental health triage/liaison services in A&E • Provision of mental health support helplines for CYP, parents, carers, schools, the voluntary sector and other professionals.			services.
17. By 31st March 2017 we will have "**7 day CAMHS crisis response service to CYP in acute hospitals"** in place across Lancashire.	31.3.17	**Care & Quality:** Children and young people across Lancashire will receive a timely response from local CAMHS services 7 days per week. **Health & Wellbeing:** By providing a 7 day service children and young people will be supported to avoid escalation and maintain their wellbeing.	**Local measures:** Time to triage and assessment. Length of stay. Number of acute admissions.
18. By 31st March 2019 we will have **"Place of Safety (Section 135/6) and improved Crisis Assessment facilities"** in place across Lancashire CYP.	31.3.19	**Care & Quality:** Dedicated and tailored facilities will offer children and young people a more appropriate environment for assessment at times of crisis. **Health & Wellbeing:** Children and young people will be supported to avoid escalation and maintain their wellbeing.	**Local measures:** Number of acute admissions.
19. By 31st March 2017 we will have developed a **"Tier 4 collaborative commissioning plan"** for inpatient services for	31.3.17	**Care & Quality:** The work will improve access to Tier 4 CAMHS services for CYP by ensuring that the level of provision locally reflects demand. It will also improve the quality of	**National measures:** Total bed days in CAMHS tier 4 per CYP population.

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
children and young people in Lancashire which supports our aspiration to work towards a balance between inpatient beds and intensive outreach support.		patient experience by developing a seamless pathway. **Finance & Efficiency:** Reducing admission to Tier 4 will free up investment that can be re-invested in community based services.	**Local measures:** Tier 4 out of area placements. Tier 4 admissions. Tier 4 delayed admissions. Tier 4 delayed discharges.
20. By 31st March 2021 we will have developed, agreed and implemented clear **"Tier 4 pathways"** for CYP entering and leaving Tier 4 services.	31.3.21		
Improving Care for the Most Vulnerable			
21. By 31st March 2021 we will have implemented a minimum service offer **"pathway for vulnerable groups" which seeks to improve access to assessment ,services and outcomes** as follows: h. Children with ADHD i. Children with ASD j. Children looked after k. Children with Learning disabilities l. Children vulnerable to exploitation m. Children in contact with the youth justice system n. Children with adverse childhood experiences	31.3.21	**Care & Quality:** • Thresholds for CAMHS and the CAMHS offer for vulnerable groups will take cognisance of complexity and the specific needs of the vulnerable groups. • There will be a standardised approach to diagnosis through tools and MDT • Support for families on waiting list for diagnosis or where children have a diagnosis of Autism or ADHD. • Improved pathway for vulnerable children and within THRIVE model 'getting support'. Families are able to accept diagnosis and are supported to make a management plan. • Alignment of outcomes with Transforming Care Programme for CYP with LD who are over-represented in CAMHS Services. • Implementation of Routine Enquiry for Adverse Childhood Experiences.	**Local measures:** Gold Standard pathway in place for Autism based on NICE guidance and ratified by Strategic Clinical Network (SCN). Waiting times Families feel supported/ prevention family breakdown/improved emotional wellbeing of CYP. Pathways and reduced admissions through proactive Care and Treatment Reviews Vulnerable young people feel able to understand reasons for behaviour earlier and be supported Following ACE Training, Staff in universal services understand the impact of adversity on behaviours

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
		• Training programme for staffing and building Routine Enquiry as a commissioning requirement within Service Specifications • CAMHS, Paediatrics, LD and school nursing (including Sp school nursing) have up to date training to support children with Autism, ADHD, Learning Disabilities, children known to CSE and YOT	
Improving Service Quality			
22. By 30th September 2017 we will have established and mobilised a CYP Lancashire wide **"provider network"** to facilitate joint working and collaboration, improve pathways and share good practice.	30.9.17	**Care & Quality:** Improved joint working and collaboration, partners sharing learning and working jointly on relevant standards, targets and pathways. This will lead to improved coordination of services between providers and seamless pathways for children young people and families. Documentation and procedures will be consistent.	**Local measures:** Work programme delivers agreements on shared approaches.
23. By 31st December 2017 the network will have a defined **"provider network work programme"** focussing on the following key priorities: a. Early intervention in psychosis b. Self-harm c. Workforce retention, recruitment, training, CPD and supervision d. Carers and working carers assessments and feedback e. Policies, procedures and	31.12.17		

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?
guidance f. Approach to risk support in line with Thrive g. Information sharing h. Using outcomes to inform practice and service planning i. Prescribing protocols j. Suicide strategy k. Transitions policy l. Out of hours psychiatry model m. CYP IAPT programme n. Parity of esteem with physical health			
24. By 31st March 2017 we will have developed a **"performance dashboard"**.	31.3.17	**Care & Quality:** Gaps and issues will be more readily identified and addressed.	**Local measures:** Time from issue or breach to actions to address them.
25. By 31st March 2017 CAMHS service providers will routinely collect **"outcome measures"** which will be aggregated and reported through to the System Performance Group.	31.3.17	**Care & Quality:** Consistent comparisons between providers will enable gaps in provision to be addressed as a whole system. **Finance and Efficiency:** Members of the system will hold each other to account.	**Local measures:** Dataset available and reported routinely.
26. By 31st March 2018 NHS commissioned services will produce and publish produce and publish **"annual quality improvement plans".**	31.3.18	**Care & Quality:** Drawing on the work of the provider network, performance dashboard and outcome measures service providers will be able to readily identify areas for improvement, develop plans to address these and work collaboratively to implement.	**Local measures:** Plans published annually and actions implemented.

Appendix 5 - Children and Young People's Resilience, Emotional Wellbeing and Mental Health Transformation Plan Timeline



Appendix 6 - Healthier Lancashire & South Cumbria Governance Structure from the STP