Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Joint Committee of CCGs

Thursday 1st March 2018

13:00 – 15:00

Venue: Blackpool Central Library, Queen Street, Blackpool, FY1 1PX

Agenda

Agenda Item	Timings	Item	Owner	Action	Format
Standing Items					
1.	5 mins	Welcome and Introductions	Phil Watson	Information	Verbal
		Apologies	Phil Watson	Information	Verbal
		Declarations of Interest	Phil Watson	Information	Verbal
2.	5 mins	Minutes from the last meeting held on 11th January 2018	Phil Watson	Information	Paper
		Action Matrix Review	Phil Watson	Information	Paper
3.	5 mins	Any other business declared	Phil Watson	Information	Verbal
For Discussion/Recommendations					
4.	20 mins	SEND *Action Planning*	Hilary Fordham	For Approval	Paper
5a	20 mins	CAMHS *Options Paper*	Peter Tinson	For Approval	Paper
5b		Young Peoples Emotional Wellbeing and Mental Health: Transformation Plan Refresh 2017		For Approval	Paper
6.	20 mins	Perinatal Mental Health Community Service Bid	Debbie Nixon	For Approval	Paper
7.	20 mins	Planning/Finance Overview	Gary Raphael	Information	Paper to follow
8.	20 mins	Commissioning Policies 1. Policy for Dilatation and Curettage 2. Policy for Hysteroscopy 3. Policy for Hip Arthroscopy 4. Policy for Cosmetic Procedures	Rebecca Higgs/ Carl Ashworth	For Approval	Paper
9.	5 mins	Any Other Business	Phil Watson		Verbal
Formal meeting closed – continue with Questions from the Public					
10.	10 mins	Questions and Answers	All	Discussion	Verbal
For information only					
11.	The next JCCCG Meeting will be held on:-		Phil Watson	Information	Information

	Thursday 3rd May 2018			

Apologies should be sent to Susan Hesketh susan.hesketh1@nhs.net or dial 01253 951490

Details of Venue – Directions and parking attached

By Road

Blackpool Central Library
Queen Street
Blackpool
FY1 1PX

Telephone: 01253 478080

Parking

Queen Street Car Park – FY1 1PX (35 spaces – Pay and Display – coins only)

https://www.google.com/maps/dir/Queen+Street+Car+Park,+Queen+Street,+Blackpool/Blackpool+Central+Library,+Queen+St,+Blackpool+FY1+1PX/@53.8204832,-3.0548817,17z/data=!3m1!4b1!4m14!4m13!1m5!1m1!1s0x487b447bac23a72d:0x46dc4815f2ba7c9b!2m2!1d-3.052287!2d53.82063!1m5!1m1!1s0x487b447bca0f1d13:0x402314c6770e631c!2m2!1d-3.0531498!2d53.8205069!3e2

West Street Car-Park – FY1 1HA (177 spaces - Payment is by 5 pay and display machines, all accept credit cards, debit cards, and coins. 4 also offer contactless payment. If paying with coins please have the correct amount available - No change given. **Blue Badge holders – 3 hours free with valid clock display)**

https://www.google.com/maps/dir/West+Street+car+park,+West+Street,+Blackpool/Blackpool+Central+Library,+Queen+St,+Blackpool+FY1+1PX/@53.819268,-3.0560951,17z/data=!3m1!4b1!4m14!4m13!1m5!1m1!1s0x487b447a9a2c7eaf:0x43056c237e90c0f7!2m2!1d-3.0545203!2d53.8180292!1m5!1m1!1s0x487b447bca0f1d13:0x402314c6770e631c!2m2!1d-3.0531498!2d53.8205069!3e2

Talbot Road Car-Park - FY1 1AU (558 spaces - Payment is by 4 pay on foot machines which accept credit/debit cards and coins - Change given)

https://www.google.com/maps/dir/Talbot+Road+Car+Park,+Deansgate,+Blackpool/Blackpool+Central+Library,+Queen+St,+Blackpool+FY1+1PX/@53.8202462,-3.0531961,17z/data=!3m1!4b1!4m14!4m13!1m5!1m1!1s0x487b44798438cb25:0xe4ecf98ed54455b8!2m2!1d-3.049692!2d53.819966!1m5!1m1!1s0x487b447bca0f1d13:0x402314c6770e631c!2m2!1d-3.0531498!2d53.8205069!3e2

Lancashire & South Cumbria Change Programme Declaration of Interests – 1 April 2017 to 31 March 2018

Declaration of Interests form for Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members regarding financial and other interests.

This form is required to be completed in accordance The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations

Notes:

All members of Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members are required to register their financial and other interests on an annual basis on a Declaration of Interest form.

The form must be completed whether you have a declaration of interest to make or not, and should clearly state if there is no declaration of interest.

Any changes to interests declared, or new interests, must be registered within 28 days of the relevant event by completing and submitting a new Declaration of Interest form.

A signed, hard copy of the Declaration of Interest form should be delivered to the PA to Healthier Lancashire.

If in doubt as to whether a conflict or potential conflict of interest could arise, a declaration of the interest(s) should be made.

If any assistance is required in order to complete this form, then the member or employee should contact the Lancashire & South Cumbria Change Programme Director.

A Register of Interests will be made accessible to members of the public on request.

Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members completing this Declaration of Interest form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest that the person has and the circumstances in which a conflict of interest with the business or running of Healthier Lancashire might arise.

Interests that must be declared:

1. Roles and responsibilities held within member practices;
2. Directorships, including non-executive directorships, held in private companies or PLCs;
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with Lancashire & South Cumbria Change Programme;
4. Shareholdings (more than 5%) of companies in the field of health and social care;
5. Positions of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care;
6. Any connection with a voluntary or other organisation contracting for NHS services;
7. Research funding/grants that may be received by the individual or any organisation they have an interest or role in; and
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within Lancashire & South Cumbria Change Programme whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual.

Declaration of Interests – 1 April 2017 to 31 March 2018

Name:				
Position:	**Band 1-7**		**8 or Above**	
	Please tick appropriate Band (or Equivalent)			

Type of Interest	**Details: Self**	**Details: Family Member, Close Friend or Other Acquaintance**
1. Roles and responsibilities held within member practices		
2. Directorships, including non-executive directorships, held in private companies or PLCs		
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with Lancashire & South Cumbria Change Programme		
4. Shareholdings (more than 5%) of companies in the field of health and social care		
5. Positions of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care		
6. Any connection with a voluntary or other organisation contracting for NHS services		
7. Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within Lancashire & South Cumbria Change Programme		

Signatory to the Declaration of Interests

☐ **I have no interests to declare**

OR

☐ **I have interests to declare as above**

I have read and understood my obligations as outlined in the Standards of Business Conduct. I am signing to confirm that the information provided on this form is true and correct to the best of my knowledge.

I consent to the disclosure of this information to the Local Counter Fraud Specialist and/or NHS Protect for verification purposes and for the prevention or detection of crime.

I acknowledge that if any changes to the above declaration occur it is my responsibility to inform Lancashire & South Cumbria Change Programme at the earliest opportunity, and within 28 days of the relevant event.

Further to this; I will not engage (directly or indirectly via a third party) in any discussion or decision where my private or external interests may affect my ability to act in an open and transparent way; as required by the Standards of Business Conduct (both National and Local).

Signed: …….

Print Name: ……..……..…….

Date: ……..……..…….

Lancashire & South Cumbria Change Programme Response to Declaration of Interest

To be completed by the Programme Director

☐ **I accept the Declaration of Interest as per Section A below**

OR

☐ **I do not accept the Declaration of Interest and have provided reasons in Section B below**

I accept the Declaration of Interest:

A) Lancashire & South Cumbria Change Programme acknowledges the above declaration and confirms that it is appropriate and conforms with the Standards of Business Conduct Policy. This declaration will now be included in the Register of Interests. This declaration will remain on the Register of Interests until the signatory to the declaration informs Lancashire & South Cumbria Change Programme that this has changed. The signatory to the declaration will be excluded from any discussions or decision-making where it is perceived that the above declarations may adversely influence their ability to act in an open and transparent manner in line with the Standards of Business Conduct (National and Local).

I do not accept the Declaration of Interest:

B) Lancashire & South Cumbria Change Programme acknowledges the above declaration, however it is not considered appropriate in line with the Standards of Business Conduct Policy for the following reasons:

[Enter details here]

A record has been included in the Register of Interests, however this will be discussed at the next formally minuted Executive meeting to ensure that this perceived conflict is dealt with and managed in the most appropriate way. The signatory to the declaration will be excluded from any discussions or decision making where the above declaration is deemed to adversely influence their ability to act in an open and transparent manner in line with the Standards of Business Conduct (National and Local).

Authorised By: ……

Programme Director

Date: ……..

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

Notes of the Joint Committee of the Clinical Commissioning Groups
held on Thursday 11th January 2018, 13:00 -15:00
at Tanhouse Community Enterprise, Tanhouse, Ennerdale, Skelmersdale WN8 6NR

Chair	Phil Watson (PW)	Independent Chair	JCCCGs	Attended
Voting Members **(One vote per CCG)**	Alex Gaw	Chair	Lancashire North CCG	Apologies
	Andrew Bennett	Chief Officer	Morecambe Bay CCG	Attended
	Penny Morris	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
	Sumantra Mukerji	Chair	Greater Preston CCG	Attended
	Doug Soper	Lay Member	West Lancashire CCG	Attended
	Susan Fairhead	GP Member	Blackpool CCG	Apologies
	Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
	Gora Bangi	Chair	Chorley South Ribble CCG	Apologies
	Graham Burgess	Chair	Blackburn with Darwen CCG	Apologies
	Mark Youlton	Chief Officer	East Lancashire CCG	Attended
	Steve Gross	Lay Member (Primary Care)	West Lancashire CCG	Apologies
	Tony Naughton	Chief Clinical Officer	Fylde and Wyre CCG	Attended
	Mary Dowling	Chair	Fylde and Wyre CCG	Attended
	Paul Kingan	Chief Finance Officer	West Lancashire CCG	Attended
	Phil Huxley	Chair	East Lancashire CCG	Attended
	Debbie Corcoran	Lay Member for Patient & Public Involvement	Greater Preston CCG	Attended
	Roy Fisher	Chair	Blackpool CCG	Attended
	Denis Gizzi	Chief Officer	Chorley South Ribble & Greater Preston CCG	Apologies
In attendance	Amanda Doyle	STP Lead	Healthier Lancs & South Cumbria	Attended
	Andrew Bibby	Director for Specialised Services	NHS England	Apologies
	Andy Curran	Medical Director	Healthier Lancs & South Cumbria	Attended
	Carl Ashworth	Service Director	Healthier Lancs & South Cumbria	Attended
	Gary Hall	Chief Executive Officer	Chorley Council	Apologies
	Gary Raphael	Finance Director	Healthier Lancs & South Cumbria	Attended
	Jane Cass	Acting Director of Operations	NHS England	Attended
	Jo Turton		Lancashire County Council	Apologies
	Kim Webber	Chief Executive	West Lancashire Borough Council	Apologies
	Lawrence Conway	Chief Executive Officer	South Lakeland District Council	Apologies
	Louise Taylor	Director	Lancashire County Council	Apologies
	Sir Bill Taylor	Chair	Healthwatch	Attended
	Neil Greaves	Communications and Engagement Manager	Healthier Lancs & South Cumbria	Attended
	Paul Hinnigan	Lay Member	Blackburn with Darwen CCG	Attended
	Clive Unitt	Lay Member	Morecambe Bay CCG	Attended
	Dean Langton	Representative	Pendle Borough Council	Apologies
	Debbie Nixon	SRO Mental Health	Healthier Lancs & South Cumbria	Attended
	Neil Jack	Chief Executive	Blackpool Council	Apologies
	Rebecca Higgs	IFR Policy Development Manager	Midlands and Lancashire CSU	Attended
	Sakthi Karunanithi	Director of Public Health	Lancashire County Council	Attended
	Sue Hesketh	Office Co-Ordinator	Healthier Lancs & South Cumbria	Attended
	Katherine Fairclough	Chief Executive Officer	Cumbria County Council	Apologies
	Dawn Roberts	Representative	Cumbria County Council	Attended
	David Bonson	Chief Operating Officer	Blackpool CCG	Attended
	Harry Catherall	Chief Executive Officer	Blackburn with Darwen Council	Attended
	Steve Thompson	Director of Resources	Blackpool Council	Attended
	Becky Rossall	Comms & Engagement	Healthier Lancs & South Cumbria	Attended

	Charmaine McElroy	Business Manager to Amanda Doyle	Healthier Lancs & South Cumbria	Attended
	Lucy Atkinson	Comms & Engagement	Healthier Lancs & South Cumbria	Attended

		ACTION
1	**Welcome and Introductions** The Chair welcomed the members of the Committee to the formal meeting. He explained the status of the meeting and that the Committee had invited members of the public to a drop-in session prior to the meeting commencing, in order to give them the opportunity to ask questions in advance. He added that there would still be an option to ask questions after the meeting had finished.	**Information**
1.1	**Apologies and Quoracy** Apologies were received from: Alex Gaw, Denis Gizzi, Gora Bangi, Graham Burgess, Roger Parr, Katherine Fairclough, Louise Taylor, Neil Jack, Dean Langton, Gary Hall, Kim Webber, Laurence Conway and Susan Fairhead ***RESOLVED: The Chair noted the apologies and declared the meeting quorate***	**Information**
1.2	**Declarations of Interest** The Chair requested that the members declare any interests relating to items on the agenda. The Chair reminded those present that if, during the course of the discussion, a conflict of interest subsequently became apparent, it should be declared at that point. Sumantra Mukerji declared and interest to the Chair that was noted. ***RESOLVED: Sumantra Mukerji's declaration of interest was noted***	**Information**
2.	**Minutes from previous meetings for ratification** The minutes of the last meeting of the Joint Committee of CCGs held on the 2nd November 2017 were recorded as factually accurate ***RESOLVED: The minutes were ratified.***	**Agreement**
2.1	**Action Matrix Review** The Chair reviewed the action matrix and the following points were discussed: • **Mental Health Presentation** This is an agenda item at today's meeting and will be presented by Debbie Nixon. • **LMS Plan** Vanessa Wilson had agreed at the last meeting to provide members of the Committee with a condensed version of the full LMS Plan, so that members are sighted on key activities and timescales. This is to be checked with Vanessa Wilson that this has been done. • **Transforming Care** The amendments to the timeline within the Transforming Care paper were made and circulated to the Committee members. • **Mental Health – Prevention** Further updates will be made available to the Committee members around the mental health prevention work at an appropriate time in the future.	**Information**

	Mary Dowling queried that the commissioning of new pathology arrangements was not part of the action matrix. Gary Raphael explained that this had been referred to in the minutes of the last meeting and that the Project Leads will be picking this up. A formalised option appraisal is yet to come forward. This is mainly due to a timing issue, however providers are working collaboratively with commissioners and once an update has been received it will be brought to the Joint Committee for formal endorsement.	
3	**Any Other Business Declared:** The Chair asked the members of the Committee if they had any other business they wished to declare for discussion at the end of the meeting. Sumantra Mukerji asked if a discussion could take place with regards to non-availability of cheaper drugs. ***ACTION: This was agreed and to be noted for discussion at the end of the meeting*** The Chair added that there would also be an opportunity for the public to ask questions at the end of the formal meeting.	**Information**
4.1	**A New Commissioning Framework for Lancashire and South Cumbria** The Chair invited Andrew Bennett, Chief Officer at Morecambe Bay CCG, to commence this item. Andrew Bennett explained that he has been leading on a complex piece of work which may seem a bit abstract to the public, but is designed to achieve better outcomes for our patients. The summary paper for the Joint Committee explains the work carried out on the commissioning framework from August of last year. The document has an embedded slide deck and a glossary that will ensure that clarity is given on certain terms and expressions. This piece of work has a direct connection with the Mental Health policy that follows this item. The language that is used is crucial. He added that commissioning is about planning and buying functions and this piece of work commenced in August 2017 to ascertain how commissioning would function in the future. There is a need to ensure more value for the pound with better quality outcomes. Andrew Bennett thanked all those that were involved in the development and production of this paper. He explained that the framework outlines the commissioning model and decision making at different levels. He added that Mental Health services have been used as a test case with clear recommendations and next steps. Meetings have taken place with Mental Health leads to test the robustness of the model used. In Section 3.3 over 50 comments were received from different partners and individuals that have helped to shape a well-developed framework. This has helped to identify what people feel is important. Each comment has been classified, recorded and implemented. Andrew Bennett explained that commissioning should develop on three levels and should be a placed based approach such as at Lancashire and South Cumbria, local delivery partnership (LDP) and neighbourhood levels. Work also needs to be strengthened with Local Authority colleagues, working through any implications of commissioning. There has been benefit from clinicians in the room which has made a difference as to how to sustain this contribution. He added that in section 6, the next steps is to legitimise future work with partners including Local Authorities, HR, Finance, etc. for a grander ambition that can be explained more widely on the priorities that need further attention.	**Support**

By April, the ambitions are for Urgent and Emergency Care and Cancer to be using this type of approach to commissioning. With this in mind Andrew Bennett offered three recommendations to the Board:-

- The Joint Committee of CCGs is asked to endorse the framework for the development of the commissioning system in Lancashire and South Cumbria, recognising that this is a work in progress and subject to further development and comments.

- The Joint Committee of CCGs is asked to endorse the enabler workstreams and timetable in section 6 and agree that more detailed mobilisation plans are developed with JCCCG's being informed of the timetable for other services

- The Joint Committee of CCGs is asked to support further discussions with partners, especially Local Authorities in relation to the wider health and wellbeing agenda and specialised commissioning.

RESOLVED: All recommendations were agreed by the Board following Mary Dowling's alterations incorporated above.

Harry Catterall commented that this was an outstanding piece of work by Andrew Bennett. However he felt there was more work to be done with wider partners and Local Authorities. There needs to be acknowledgment from neighbourhoods to LDP and STP as there is a big difference between the three levels. As a unitary there is need to incorporate Adult and Social care as a statutory responsibility.

Sakthi Karunanithi commented that we must not lose sight of the ability to identify how things could work at neighbourhood level and to also consider the resources required and the capability.

Geoffrey O'Donoghue acknowledged the sense of scale and pace and that what was happening was quite abstract. He feels that there is a need to gain greater engagement around this to ensure these changes are in the gift of the Local Authorities.

Sir Bill Taylor asked whether there are processes in place for managing this. There needs to be some creativity as to how we communicate this to the public.

Roy Fisher felt there is a need to understand the bed pressures. The pressure that is currently being seen in regards to social care issues can compound the issue. The hard work that has gone into this is very clear. He added that Blackpool CCG has not had an opportunity to discuss this paper; however they have a meeting next week. The question was asked as to whether Blackpool would be able to submit their comments at a later date.

Phil Watson highlighted that as part of the recommendations it was agreed that this was a document subject to further developments and comments.

Phil Huxley commended Andrew Bennett on the great work he had done with this document and added that this has been discussed at East Lancs CCG informally. He added that neighbourhoods are causing the most concern with regards to commissioning at that level and it was felt that there was need to have this clearly understood. Phil Huxley explained that East Lancs CCG may not feel able to endorse the framework in its current form.

Paul Kingan asked for clarity on the approach to commissioning above STP level.

Amanda Doyle advised that there have been initial conversations with Cheshire and Mersey STP and the ambulances 111. This document relates to how the commissioning function will be going forward and how it is implemented locally. Communication is really important. She added that there is a need to keep communicating with the public and try to avoid any confusion. The public are interested in access to services and how these

	services are delivered, but they are not interested in the how it is commissioned. It is key to ensure that the public are not overwhelmed with administrative decisions. This document does not make any changes to services. Andrew Bennett acknowledged that more work is needed on neighbourhoods and communication and engagement. A meeting has been arranged with specialised commissioning services to connect them into this process. Mary Dowling felt that this was a really good piece of work with a high level of demonstrable collaborative working and a good framework to take this forward. It was felt that with a few amendments to the recommendations that she would like to suggest, that in principle, this document should be endorsed by colleagues to be able to go back to CCGs to advise that this is a point in time. Sumantra Mukerji acknowledged that this was a good piece of work however referred to point 3.3.1 "Not material – noted but no change to the Commissioning Framework required (10 comments)" the question was asked whether these were comments or observations? Andrew advised that these can be shared. In the majority of contact it was face to face contact with not a lot of disagreement. ***ACTION: Comments to be shared with Sumantra Mukerji*** Harry Catterall feels that for the 8 CCGs this document would only be able to deliver services in 5. For completeness, place based commissioning for Health and Wellbeing has another tier in relation to Local Authority boundary. Steve Thompson welcomed this piece of work. With regulated care in Blackpool the level of collaboration is very good as, rather than focus on the differences they looked at the commonalities. ***RESOLVED: The Joint Committee agreed to endorse the framework.***	
4.2	**Mental Health Commissioning Development Mobilisation and Next Steps** The Chair invited Debbie Nixon to deliver this item. Debbie Nixon explained that she and Paul Hopley have been leading on this piece of work for Lancashire and South Cumbria and she thanked colleagues for their contributions to this. She added that the Five Year Forward View has a significant agenda with regards to improving mental health services and outcomes. As a result there is a need to be clear on how to communicate collectively with specialised commissioning, clinical commissioning and prevention and wellbeing. Debbie Nixon explained that commissioners came on board at an early stage and some were fairly enthusiastic and in agreement very early. She added that the main points are outlined on page 8 and within table 1. There is a need to have agreement to come together and that these are the areas we expect to commission services for going forward. Andrew Bennett commented that looking at the table there was a lot of commissioning at an STP level and questioned how this links with Local Authority. He added that by far, the greater number of people with mental health issues sits within an LDP level. Paul Kingan felt that this was a sensitive area for West Lancs who have done a lot of work on mental health locally. West Lancs confirmed that they support this document as they believe it will work in their area. However there is a need for assurance that this can work across boundaries i.e. Core 24. Debbie Nixon gave assurance that this is an ongoing developmental process.	**Support**

	Tony Naughton felt the need to express that his clinical leads feel that a number of items in table 1 need to be different. He commented on the level of clinical engagement across Fylde and Wyre CCG, in that he had concerns as to whether feedback from local clinicians had been incorporated. On this basis, he felt he would be unable to support this document in its current form. Debbie Nixon assured Tony Naughton that on the 14th December, the paper was circulated and two workshops were recently held to engage with a wide group of stakeholders. She explained that she had previously received confirmation from Fylde and Wyre CCG clinical leads endorsing this, as long as there was a caveat that this would be reviewed. Penny Morris felt that there was more clarity needed with regards to the language used and the use of acronyms i.e. ACS, ACP. Debbie Nixon referred to the latest version with regards to language. Mary Dowling felt that there was strength of feeling of some of the clinical members. She added that colleagues are happy to debate for all the right reasons. There is a strong desire to commission local and the language and heading on table 1 requires further refinements. Debbie Nixon added that this is still a work in progress. Amanda Doyle advised that if there is agreement from the Joint Committee that decisions are made collectively, this does not mean people do not have the right to comment going forward. She added that national commissioning policies and strategies are mandated. If there is an instruction to commission one way but can evidence that it can be done more cost effectively, there would have to be a robust argument as to why this has to be done separately. Phil Huxley questioned the reference to pooled budgets on page 10 paragraph 7.1. Debbie Nixon informed the Committee that they were not being asked to sign off a pooled budget. She added that the national direction of travel is to obtain specialised commissioning through a pooled budget. Three recommendations were made to the Board:- • The Joint Committee were asked to endorse the levels of Mental Health commissioning as per the Commissioning Development Framework recognising that it is work in progress and subject to further clarification on the categorisation of some services in Table 1. • The Joint Committee were asked to agree the mobilisation plan, including the requirement for more focussed engagement with the Local Authorities and Providers • The Joint Committee were asked to note the timescales of the mobilisation plan and enabling workstreams as set out in the paper **RESOLVED: All recommendations were agreed by the Board following Mary Dowling's alterations incorporated above.**	
5.	**Specialist Neuro Rehabilitation** *Implementing a New Model of Care* The Chair invited Carl Ashworth to commence this item. Carl Ashworth explained that Specialist Neuro Rehabilitation is currently under development and this was discussed at the Collaborative Commissioning Board (CCB) in December 2017. He added that the CCB supported the work and a new clinical model via new rehabilitation services in the community. The paper highlights the work undertaken and the challenges.	**Support**

	Carl Ashworth explained that key points have been recognised before finalising the model and there is a need to ensure existing resources are being used effectively on an official level. There a number of business cases in design which will need signing off. There is recognition of specialised commissioning in developing a new care model. The recommendations for the Joint Committee would be part of the developing modelling for these business cases going forward. Mary Dowling commented that this was an excellent paper and that the issues were articulated clearly. Phil Huxley stated that the principle point is the importance of engaging people and patients and that this needs to be recognised in the paper going forward. Geoffrey O'Donoghue queried whether the cover sheet was correct in relation to the Equality Impact Assessment. Amanda Doyle explained that this is correct as it is about how we commission the service, not specifically about the service. This was noted. **RESOLVED: The paper was agreed by the Committee.**	
6.	**Commissioning Policies** • Complementary and Alternative Therapies • Facial Nerve Rehab The Chair invited Carl Ashworth and Rebecca Higgs to commence this item. Carl Ashworth explained that work is ongoing on a suite of clinical commissioning policies for Lancashire and South Cumbria to reduce variance and remove system confusions and influence outcomes. The JCCCG previously agreed to the development of these policies and this is the first phase. He added that the briefing paper, processing document, public engagement and the two policies have been brought to the Committee to review and give assurance around the robustness of the process. Rebecca Higgs explained that the Complementary and Alternative Therapies policy has no financial impact. All CCGs have policies in place for the intervention of Complementary and Alternative Therapies. Some reviews have shown that this intervention has to be evidence based. Both policies have undergone clinical and public engagement and the Clinical Policy Development Implementation Group (CPDIG) would ask that the JCCCG endorse these policies. Doug Soper asked if it was expected to have a financial analysis to the paper, Rebecca Higgs advised that she would take this back to the CPDIG. Rebecca Higgs explained that Facial Nerve Rehab is a new criteria based policy which covers rehabilitation at an extra cost. There were some concerns expressed regarding financial impacts. Rebecca Higgs added that costs are associated with current poor provision as the existing pathway does not cover rehabilitation. She explained that there is an existing cost to patients that would benefit from the rehab. An improvement in function would support a reduction in these costs. Penny Morris advised that this came through to individual CCGs two weeks ago where the cost implications had been shared. The CCGs were asked to have sight of the paper prior to coming here. Penny felt that the CCGs did not get sense of what was at a local level and that currently, the pathway is around a conservative clinical assessment. Amanda Doyle advised that it is an ongoing cycle. The decision has been made that these policies come to the JCCCG and this is the first batch for a collective decision. Mary Dowling felt that there was good engagement and involvement around this process. However it was suggested that it would be helpful if at the start of the policy there could be	**Support**

	a policy statement upfront. **RESOLVED: Both policies were endorsed by the Committee**	
7. **7.1**	**Any Other Business** **Cheaper Drugs** A group discussion took place regarding this item. It was acknowledged that there is significant pressure on CCG prescribing costs. The reimbursement is set nationally for generic drugs. The setting is based on current market prices. Previously, concessions were made for the short term commissioning of pricing drugs due to short falls. The pharmacy would be reimbursed short term to take this into account. In April 2017 there were 27 price concessions, by October 2017 it had increased to 81 and there was a significant increase in drugs and their costs. If was felt that regulatory action against manufacturers and supply problems should be made. Suppliers are making more of their own decisions around pricing, which is out of our control along with wholesale pricing. The finance department in NHS England are looking at the increase in spend. Some CCGs are in more difficulty than others. It is understood that national teams are looking into these issues. Work is ongoing and guidance will be coming out in the next few weeks.	

The next JCCCG Meeting will be held on:
1st March 2018, 1.00pm – 3.00pm – Blackpool Central Library, Queens Street, Blackpool, FY1 1PX

The Chair thanked the Committee members and members of the public for their attendance and closed the meeting prior to taking questions from members of the public.

Topics discussed through the Public Questions:

Members of the Public
Crispin Atkinson – Voluntary Sector
Laura Anton – NHS Management Graduate
Eamonn McKiernan – GP Chorley South Ribble CCG
James Clayton – Protect Chorley Hospital
Susan Holdsworth – Protect Chorley Hospital
G. Jones

The public were reminded that there is a drop in session for an hour prior to the Joint Committee Meeting taking place. All the papers relating to the meeting are placed on the Healthier Lancashire website to give the public an opportunity to have more understanding of the meeting in order to be able to ask relevant questions.

Eamonn McKiernan – Retired Doctor – Item 4 –
Q. Can there be assurance that the providers of the services were given an opportunity to engage in discussions around commissioning?
A. Discussion with provider leaders have taken place as they are key partners and are kept fully appraised. This work is a development of our health care systems and as such the providers of services are fully engaged.

Sue Holdsworth – Protect Chorley Hospital
Q. Does this mean that by commissioning in this way more services will be provided by the private sector? Some services at CDH have moved to LTH and there is concern it will then be provided by the private sector.

A. Amanda Doyle advised there are 8 CCGs, Local Authority Councils and NHS England that commission services. The providers we work closely with and talk about are all the NHS Hospital Trusts and GP practices who technically are the independent sector there are also a range of not for profit providers that are also part of the system. There is a range of full profit providers working within the care service. Some elective services are referred by NHS England to private providers when there are capacity issues with providers.

Q, Sue Holdsworth asked if the NHS stopped referring to the private sector could this money not be fed back to the NHS.

A. Amanda Doyle advised that it is not just as simple as that. Patients are given a choice as to where they choose to have their procedure. Any provider that cannot delivery within timescales then makes the referral to the private sector

The public were reminded that questions should be in relation to topics discussed on the agenda at the meeting as there is a better context and better Q&A session.

Public engagement questions to be looked into further
The meeting was officially brought to a close at 15:15

Healthier Lancashire and South Cumbria Joint Committee of the Clinical Commissioning Groups Meeting Action Matrix

Ref	Subject	Owner	Update	Status	Complete
1	A New Commissioning Framework for Lancashire and South Cumbria	AB	Comments made from Partners and Individuals to be shared with Sumantra Mukerji		
2	Mental health - prevention	DN/SK	It was agreed that it would be beneficial for the Committee to receive an update on the work around mental health prevention at an appropriate time in the future.		

Joint Committee of Clinical Commissioning Group's

Title of Paper	Special Educational Needs and Disabilities – Post Inspection Update and Proposal for Next Steps		
Date of Meeting	1st March 2018	Agenda Item	4

Lead Author	Hilary Fordham	
Purpose of the Report	For Approval	X
Executive Summary	The purpose of this paper is to update the Joint Committee of CCGs on the outcome of the SEND Inspection which took place for Lancashire in November 2017. This was initially discussed with the Collaborative Commissioning Board (CCB) in January to agree the future support, delegated authority and reporting arrangements to take forward the considerable work that is now required.	
Recommendations	The Joint Committee of CCGs is asked to: • Receive the Inspection Report and note its implications for CCGs, Lancashire and the wider STP footprint. • Agree Option 1 for delegated authority related to SEND. • Agree Option A for a clear workstream for SEND together with formal accountability. • Agree that ASD pathway work is included under this workstream to fulfil the requirements of the WSOA. • Agree the resource of an 8c to lead the programme and the support requested of the CSU (final detailed to be agreed). • Support the Children's Commissioners to work through the Commissioning Framework with the aim of having a more long term and robust solution to commissioning consistently for children and young people.	

Equality Impact & Risk Assessment Completed	Not Applicable
Patient and Public Engagement Completed	Not Applicable
Financial Implications	Yes
Risk Identified	Not Applicable
If Yes : Risk	
Report Authorised by:	

Special Educational Needs and Disabilities – Post Inspection Update and Proposal for Next Steps

February 2018

Purpose

To update the Joint Committee of CCGs on the outcome of the SEND Inspection which took place for Lancashire in November 2017. This was initially discussed with the Collaborative Commissioning Board (CCB) in January to agree the future support, delegated authority and reporting arrangements to take forward the considerable work that is now required.

The Joint Committee of CCGs is asked to:

- Receive the Inspection Report and note its implications for CCGs, Lancashire and the wider STP footprint.
- Agree Option 1 for delegated authority related to SEND.
- Agree Option A for a clear workstream for SEND together with formal accountability.
- Agree that ASD pathway work is included under this workstream to fulfil the requirements of the WSOA.
- Agree the resource of an 8c to lead the programme and the support requested of the CSU (final detailed to be agreed).
- Support the Children's Commissioners to work through the Commissioning Framework with the aim of having a more long term and robust solution to commissioning consistently for children and young people.

Introduction

The Lancashire area was notified of its inspection on 6 November and the Inspection took place during week commencing 13 November. The Inspection takes the form of a whole system inspection with the Local Authority being the lead agency, but all CCGs as commissioners expected to take part and accept the findings and all providers being part of the process.

The Inspection took place as planned and all providers worked hard to ensure that the relevant visits took place as required.

Inspection Findings

It is fair to say that the Inspection findings are a difficult read and point to a number of failings and issues across the Lancashire area. The report states that:

'There are two fundamental failing in Lancashire local delivery. Children and young people and their families are not at the heart of delivery of the SEND reforms and leaders have failed to work together'

In essence the reforms have not had the attention that they needed at a senior level and whilst much work has been undertaken on process; be that of transferring children (over

6,000 in Lancashire) from Statements of Need to Education Health and Care Plans (EHCP) or ensuring that processes as described in NHS England audit tools are undertaken – the 'spirit of the code and reforms' has not been implemented and as result individual children have not always seen improvements.

These two areas underpin the full issues of the report and have to be addressed through:

- Partnership working supported by appropriate governance and reporting at the highest level across Lancashire to ensure those who are charged with undertaking this work are supported and constructively challenged.
- Ensuring that all organisations and their staff understand the wider vision for Lancashire with regard to implementation of the Reforms. SEND is not just about a small cohort of children with disabilities, it is a way of working across all children's and young people's services, ensuring they all get the support that they need whether or not they require an EHCP and up to the age of 25 to put them in a good place to achieve their potential in the rest of their lives.

The Letter sets out a number of main findings and areas for development and the full report can be found here https://reports.ofsted.gov.uk/local-authorities/lancashire

The area is now expected to submit a Written Statement of Action (WSOA) which explains how it will tackle the following weaknesses:

- Lack of strategic leadership and vision across the Partnership.
- Leader's inaccurate understanding of the local area.
- Weak joint commissioning arrangements that is not well developed or evaluated.
- Failure to engage effectively with parent and carers.
- Confusing, complicated and arbitrary systems and processes of identification.
- Endemic weaknesses in the quality of EHCPs.
- Absence of effective diagnostic pathway for ASD across the local area, and not diagnostic pathway in the north area.
- No effective strategy to improve the outcomes of children and young people who have SEND.
- Poor transition arrangements in health care services
- Disconcerting proportion of children and young people who have an EHCP who are permanently excluded.
- Inequalities in provision based on location.
- Lack of accessibility and quality on the local offer.

Process of development and monitoring of Written Statement of Action (WSOA).

A further letter from the DfE sets this out; it states that in partnership the area must write, agree and submit at WSOA to address the issues. The area has 70 days to do this from the date of issue of the letter, which means submission in April.

The Department of Education have allocated an advisor; Cath Hitchin to support and the NHS England have allocated Alison Cole to oversee the process from their perspective.

Once the WSOA has been agreed then Offsted and CQC will not be part of the process any longer, the DfE and NHS England will take responsibility for overseeing progress and

submitting a report at the 9 month period to the Secretary of State who, based on the report will after a year agree the next steps. Thus far only a very small number of areas that have been inspected have reached that point and all have needed to continue their journey of improvement.

We have been advised that the WSOA should be realistic. There is much to do and we should not aim to address all areas in the first year, it is important to make sure that we can achieve the actions and demonstrate progress on a number of areas, rather than trying to address all 12 areas in full.

It was stressed at the meeting by the Advisor that all the CCGs in the area need to agree formally how they will work together to ensure that having six CCGs to agree does not delay the process of improvement. The inspectors were all clear in their expectation that they wanted to see consistency of commissioning and provision across the patch. As reported at the December meeting this also raises issues of how this is managed across pan-Lancashire and even the STP footprint, given the flow of children across boundaries and the desire to work collaboratively across the STP.

Partnership Working and Governance

One of the areas of work that the report is particularly critical of is the apparent lack of partnership working and the associated governance to support this. It is critical to moving forward to agree the WSOA and to addressing the issues that this has been identified.

This work is taking place within a footprint that does not have co-terminous boundaries and also has emerging new structures which offer opportunity and challenge. There are also a number of agendas which health and localities work on together which overlap; learning disabilities, SEND and CAMHS.

Therefore the governance structure needs to ensure the following:

- Address the SEND issues for Lancashire.
- Bring together the learning disabilities, SEND and CAMHS agendas where appropriate to do so.
- Ensure that Lancashire can evidence coherent very senior level commitment to this agenda.
- Enable parties who are not affected by this report, but could learn from the work and have a vested interest in the wider agenda, to part of the same processes and learn from the experience.

The key action for CCGs is urgently agreeing how they will work together on this agenda so that they can then work collaboratively with Lancashire Local Authority and then with other partners to share learning. This could be undertaken via either:

1. A delegated arrangement to one person who works on behalf of all CCGs but reports back into the agreed governance arrangements.
2. All CCGs having representation on the steering group with LCC. The first task in this process will be to sign off the WSOA.

Option 1 has the benefit of a consistent approach, single point of contact for the Local Authority, clear lines of accountability. The second option is a continuation of the current

situation, it enables all CCGs to be engaged in the process, but does not provide for one voice for the Local Authority to work with and adds significantly to a workload which is already difficult for CCGs, as to date they have not all been fully engaged.

Previous papers have also set out the need to align the SEND programme with the Learning Disabilities Transforming Care Programme and the children's emotional health and well-being programme because of the significant cross over and the current duplication of work; for example the ASD pathways have been reviewed a number of times in various workstreams but no consistent conclusion has been reached. The options are:

A. Maintain a separate workstream for SEND, but with a much more formal accountability and reporting line to the JCCCG, as the other STP work streams have and ensure that those areas which have not yet had an inspection learn from the issues found in Lancashire.
B. Consider a joint workstream with Learning Disabilities and Autism TCP with strong links to the emotional health and well-being workstream. Consideration should also be given to inclusion of the Neuro-developmental pathway workstream which currently sits under the Children's section of the Acute and Specialist workstream and is including ASD in its remit.

Option A enables the agenda to be separately monitored and in the first instance maintains a focus on this area given the high profile, but does continue the separate themes which have emerged and tendency for duplication, whilst option B provides for a more joined up approach, but has the danger of not addressing the clear needs of the SEND agenda in the first instance. A middle way may be to start with a separate workstream and once it is established and progress monitoring is clear to re-consider bringing the areas together. However, it should be noted that whichever option is taken addressing the immediate issues with ASD should sit clearly with the SEND programme.

The preferred options at this stage are 1 and A with a clear agreement to ensure close links with the LD and CAMHS programmes and an agreement to re-visit the structure once the WSOA is agreed and good progress is being made.

Having set out clear options for how the work should be delivered it is also critical that the oversight governance structure is also clear. Attached at Appendix C is a proposed governance structure to ensure there are clear lines of accountability for those charged with undertaking this work. It would help to address the variable footprint issues to have the programme managed under the STP.

Immediate Support for the SEND Agenda

Addressing the issues and ensuring that the move forward to collaborative commissioning is going to be a large area of work. In order to support this agreement is sought for dedicated resource to support this agenda. In the first instance is full time Band 8c is sought to lead this programme of work in conjunction with the LAs. It is suggested that this post is offered as a secondment opportunity to ensure long term fit with the wider developments in the STP.

In addition continued and increased support from the CSU is requested to:

- Initially support the development of the WSOA.

- Support work on the initial areas of development which health are expected to do:
    - Standardisation of ASD Pathways
    - Implementation of the DCO function
    - Improvements in the EHC plan development process from a health perspective.
    - Standardise the work of the Children Looked After services.
- Commence addressing other areas as they are developed as part of the WSOA.

The equivalent of 1 WTE person is requested, although this will be a combination of grades to be agreed with the CSU. A Review will need to be undertaken of what support is required to deliver the overall programme once the WSOA is agreed and then the joint programme (SEND, LD and Neuro-development) if agreed at a later date.

Children's commissioning moving forward

Whichever options are chosen the Children and Young People's commissioners have indicated that in order to address some of the fragmented commissioning arrangements which currently exist across this agenda they wish to work through the commissioning framework to find a new way of commissioning across the STP. The development of joint post arrangements to oversee this work would provide a precursor to the outcome for Learning Disabilities and SEND. It is understood that LCC are also of a mind to do this; the other councils still need to consider this fully. This work has commenced on 30th January and will require support to reach a conclusion. However it must not become a distraction to addressing the issues raised in the SEND report.

Recommendations

The Joint Committee of CCGs is asked to:

- Receive the Inspection Report and note its implications for CCGs, Lancashire and the wider STP footprint.
- Agree Option 1 for delegated authority related to SEND.
- Agree Option A for a clear workstream for SEND together with formal accountability.
- Agree that ASD pathway work is included under this workstream to fulfil the requirements of the WSOA.
- Agree the resource of an 8c to lead the programme and the support requested of the CSU (final detailed to be agreed).
- Support the Children's Commissioners to work through the Commissioning Framework with the aim of having a more long term and robust solution to commissioning consistently for children and young people.

Hilary Fordham

Chief Operating Officer, MBCCG

February 2018

Joint Committee of Clinical Commissioning Group's

Title of Paper	Redesigning CAMHS in line with THRIVE in Lancashire and South Cumbria		
Date of Meeting	1st March 2018	Agenda Item	5a

Lead Author	Peter Tinson	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary		

The aim of the CAMHS Redesign project is to redesign NHS funded children and young people's emotional wellbeing and mental health (CYPEWMH) services across Lancashire and South Cumbria in line with THRIVE. Providers have been asked to collaborate with each other to clinically lead the co-production of a core service model in line with the agreed mandate. Chief Executives of the NHS providers have submitted a written commitment to proceed with the redesign working jointly to co-produce the new model.

On 13th December 2017, the Collaborative Commissioning Board (CCB) received a presentation regarding the proposed financial envelope for the CAMHS Redesign Project. The notes of that meeting confirm that "CCB agreed that the preferred option would be option 5 [pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG's will agree the investment plan]. This option was considered by members to be the best to address the wider needs, to allow for local flexibility around funding i.e. lottery bids etc., commitment, and services. It was agreed to recommend option 5 to the JCCCGs.

The purpose of this paper is to present option 5 alongside governance and decision making proposals for the redesign project, for agreement by the Joint Committee of Clinical Commissioning Groups (JCCCGs).

Recommendations	The JCCCGs is asked to: 1. Endorse the recommendation of CCB: Option 5 - pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG's will agree the investment plan 2. Agree the proposed governance/decision making arrangements for delivery of the project
Equality Impact & Risk Assessment Completed	Yes
Patient and Public Engagement Completed	Yes with further engagement planned as part of the redesign
Financial Implications	Yes, these are set out within the paper
Risk Identified	Yes
If Yes : Risk	These are set out within the paper
Report Authorised by:	

Healthy young minds

Lancashire & South Cumbria Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan

Redesigning CAMHS in line with THRIVE in Lancashire and South Cumbria

A collective and co-production commissioning approach
Report to the Joint Committee of CCG's
1 March 2018

Peter Tinson – Senior Responsible Officer for the Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme

Executive Summary

The aim of the CAMHS Redesign project is to redesign NHS funded children and young people's emotional wellbeing and mental health (CYPEWMH) services across Lancashire and South Cumbria in line with THRIVE. Providers have been asked to collaborate with each other to clinically lead the co-production of a core service model in line with the agreed mandate. Chief Executives of the NHS providers have submitted a written commitment to proceed with the redesign working jointly to co-produce the new model.

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The purpose of this paper is to present option 5 alongside governance and decision making proposals for the redesign project, for agreement by the Joint Committee of Clinical Commissioning Groups (JCCCGs).

Recommendation:

The JCCCGs is asked to:

1. Endorse the recommendation of CCB: Option 5 - pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG's will agree the investment plan
2. Agree the proposed governance/decision making arrangements for delivery of the project

1.0 Introduction

In February 2017, the Collaborative Commissioning Board (CCB) received the 17/18 business plan for the CYPEWMH Transformation Programme summarising the actions required in 17/18 to achieve the Transformation Plan objectives. It Identified the challenges ahead, including:

- the new access targets (estimated £5.5 million shortfall to meet the access targets by 2020/21)
- anticipated waiting times targets
- variations in service delivery
- variations in investment
- variation in the experiences of children, young people and families (CYP&F)

The plan recommended a more fundamental response in order to meet the transformation plan objectives.

The report recommended a process of whole system co-produced redesign of the children and young people's mental health system adopting a THRIVE model.[1] A redesign options appraisal paper was presented to CCB in June 2017, CCB endorsed the following options:

Scope: the scope of the project will include all NHS funded services (partially or fully) that could or should deliver activity towards the new national CAMHS access target

Securing the Provider: the new model of service will be commissioned via direct negotiation (contract variation) with existing providers (through a clear and rigorous road map)

A Project Initiation Document setting out the scope, aims and objectives of the project, approach, timeline and key stakeholders was agreed by the Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Transformation Programme Board in August 2017 and a Project Team was established to take the project forward.

Following engagement with stakeholders, a mandate for the redesigned service model has been developed and agreed (see Appendix A).

Providers have been asked to collaborate with each other to clinically lead the co-production of a core service model for NHS funded CYPEWMH Services across Lancashire and South Cumbria in line with the agreed mandate. Chief Executives of the NHS providers have submitted a written commitment to proceed with the redesign as planned working jointly with each other to co-produce the new model.

On 13th December 2017, CCB received a presentation regarding the proposed financial envelope for the CAMHS Redesign Project.

[1] The THRIVE model offers an opportunity to fundamentally change the way that services are conceptualised and delivered, moving away from the tiered approach to one that is integrated, person centred, goal focussed and evidence informed. THRIVE has been shown to reduce waiting times and improve service users' experience of care. https://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

The notes of that meeting confirm that "CCB agreed that the preferred option would be option 5 [pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG's will agree the investment plan]. This option was considered by members to be the best to address the wider needs, to allow for local flexibility around funding i.e. lottery bids etc., commitment, and services. It was agreed to recommend option 5 to the JCCCGs".

Appendix B includes a governance roadmap summarising the decisions and key milestones of the project to date.

2.0 National Context

CYPEWMH was one of the priority areas set out in the Five Year Forward View (FYFV) in October 2014. The Mental Health 5YFV set out a commitment to transform mental health services including a commitment that 70,000 more children per year nationally will access evidence based mental health care interventions.

Since the 5YFV was published there has been a raft of other publications demonstrating how we are failing our CYP in terms of their emotional wellbeing and mental health.

- On the heels of 5YFV the Department of Health and NHSE published a report in March 2015, Future in Mind. The report was the result of work by a joint taskforce and set out a national ambition and vision for promoting, protecting and improving our CYP mental health. This document formed the basis for CYPEWMH Transformation Plans across the UK.

- In 16/17 the Royal College of Psychiatrists produced a tool demonstrating the differential in CAMHS spend from £9.69 to £136.32 per head of population nationally.

- In October 2017 the Children's Commissioner published a report into the state of CYP mental health services. Most spend focusing on those with severe need, despite the existence of evidenced based interventions which prevent conditions escalating. An average of 6% of the mental health budget is spent on CYP but they make up 20% of population and most areas are failing to meet NHS benchmarks for improving services and providing crisis care.

- Also in October 2017 the Care Quality Commission published a review of CYPMH services. The key message was variation, in spend, availability and quality of services, commissioning and performance management. This results in CYP having a poor experience and some unable to access timely and appropriate care. There are examples of good and outstanding practice but there is variation which needs addressing.

- In December 2017 the Department of Health and the Department of Education published a green paper which sets out specific proposals that represent a fundamental shift in how we will support YP with their mental health.

Key issues:

- CYP with mental health problems face unequal chances and disruption to education, problems with employment and are more likely to engage in criminal activity.
- Adult mental health problems begin in childhood
- All above leads to wider societal costs
- Quality of service is variable and waits can be considerable

Specific proposals are:

- Designated lead in all schools for MH
- MH support teams – early intervention and ongoing help in schools and colleges
- New waiting time standard – 4 weeks

- Also 'Refreshing NHS Plans for 2018/19' re-emphasises the importance of CCGs achieving the Mental Health investment standard. Specifically 'this means a continued commitment to… achievement by each and every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce… consistent with the expectations already set out in the 2017-19 planning guidance'.

2.2 Local Context

The 2017/18 Business Plan for the CYPEWMH Transformation programme highlighted a range of variations across Lancashire and South Cumbria.

2.2.1 Variations in investment

The 2016/17 Royal College of Psychiatrists report, identified a differential in CAMHS spend across Lancashire and South Cumbria from £32.78 to £73.75 per child.

2.2.2 Variation in Service Delivery

We know that there are a number of areas of variation in service delivery across Lancashire and South Cumbria. Many of these have been highlighted by both the Lancashire Safeguarding Board and the Care Quality Commission:

- Age range – some providers are commissioned to accept referrals up to 16 only but do continue to work with young people to 19th birthday where others are commissioned to continue to work up to 19th birthday. This is set against a Transformation Plan commitment and national expectation that all CAMHS should accept referrals up to 18 and continue to work with young people up to 19th birthday.
- Children's Psychological Services are available in some area not others
- Counselling commissioned in Blackpool but not elsewhere
- Autistic Spectrum Disorder support offered by CAMHS in some areas but not others
- Learning Disability specific CAMHS in some areas but not others

- Out of hours – both 7 day and extended working day variable offer including provision of section 136.
- Attention Deficit Hyperactivity Disorder provision varies
- Criteria for access to CAMHS varies

2.2.3 Access Targets

In line with the Five Year Forward View for Mental Health and CCG Planning Guidance, the transformation of Children and Young People's Emotional Wellbeing and Mental Health must enable an increased number of children and young people to access treatment. Progress against this is measured via an Access Target which requires by 2021, 35% of the prevalent population (currently based on 10% of CYP) to be receiving treatment from an NHS funded mental health service. Where an area is already achieving an access rate above the required trajectory, then they should achieve a 7% per annum increase to ensure that they are continuing to increase access on the same gradient as the national trajectory.

It is estimated that over 4,000 additional children and young people across Lancashire and South Cumbria will require support to achieve the 2020/21 target. The current models of delivery and associated costs per child/young person would not be affordable in meeting these new targets, even allowing for the additional Transformation Funding. To maintain the existing levels of funding per child receiving treatment within the current service model, as the access targets rise, an investment of £5.5 million would be needed. There is £4 million of transformation funding available – a shortfall of £1.5m (27%). This supports the need for a re-design of services with a goal of implementing a more efficient service model.

2.2.4 Waiting List Numbers and Times

In addition to the access target we are also awaiting the introduction of national waiting list and waiting times targets for CAMHS which are expected to place increased pressure on existing services. We know that current waiting lists and times are lengthy. Quarter 1 data 2017/18 shows a total of 1,965 children on waiting lists for CAMHS with average waiting times of 73 days for CAMHS and 192 days for Children's Psychological Services.

2.2.5 Feedback from CYP

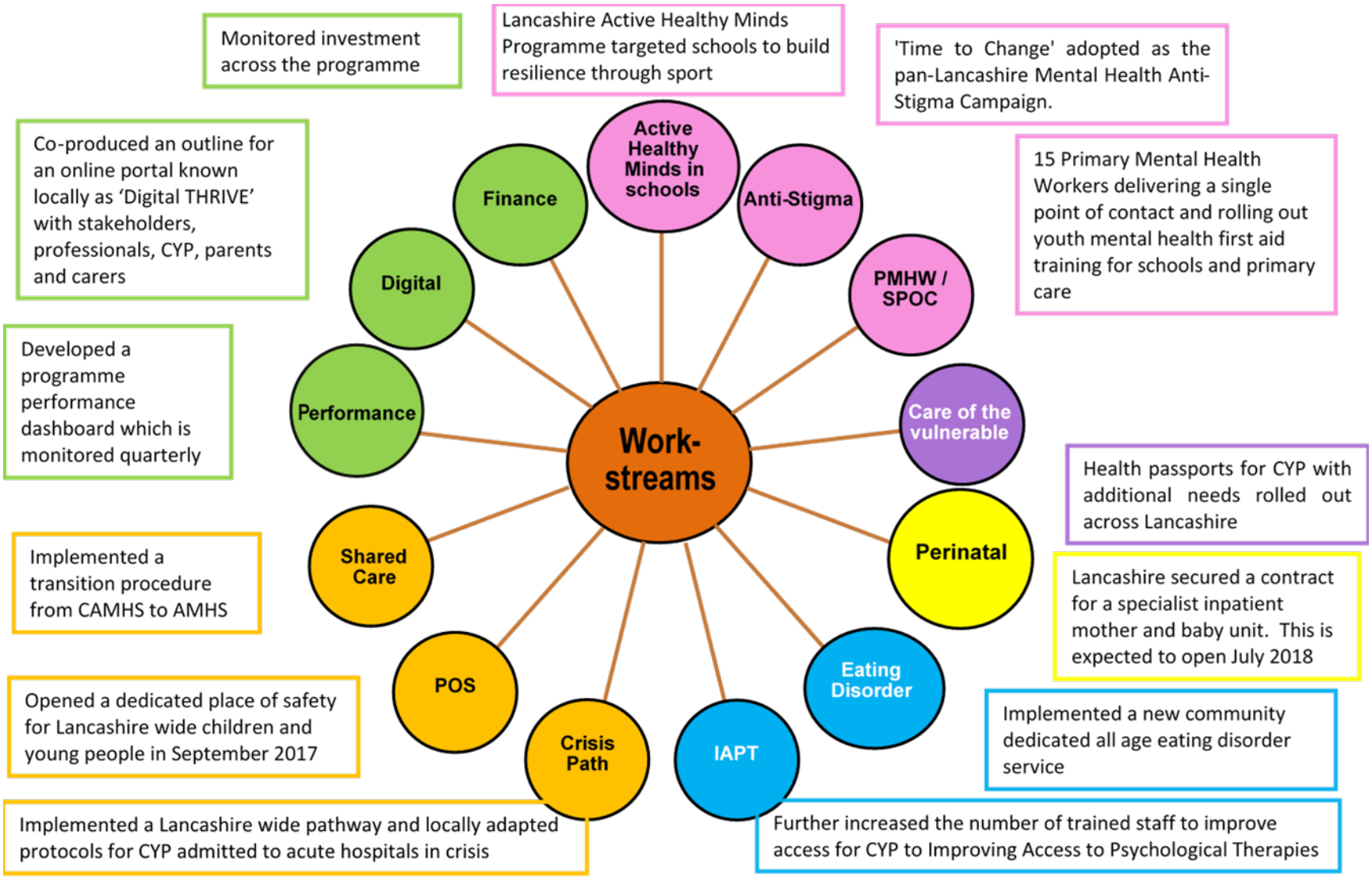
Children Young Peoples and Families Experiences report concerns regarding waiting times, duration and frequency of appointments, information provision, criteria to qualify for help and range of therapies/activities offered.
Other concerns raised by Children's Safeguarding Board Audit, and Lancashire Health and Wellbeing Board including a lack of transition planning, improving access for YP who want to self-refer, YP refused service provision due to chaotic lifestyle. Other concerns are the variability of and low investment when compared to national benchmarks.

3.0 Programme achievements to date

In January 2016, the CYPEWMH transformation plan for Lancashire (2015-2020) was published. It set out the first iteration of a five year plan for Lancashire to support the local implementation of the ambition and principles set out in Future in Mind referenced above.

In 2017 the plan was reviewed in light of new national requirements and a refreshed version was published. The implementation of the plan is overseen by the CYPEWMH Transformation Board which consists of key stakeholders and is supported by a Clinical Reference Group.

Key achievements to date are summarised below:


Monitored investment across the programme
Lancashire Active Healthy Minds Programme targeted schools to build resilience through sport
'Time to Change' adopted as the pan-Lancashire Mental Health Anti-Stigma Campaign.
Co-produced an outline for an online portal known locally as 'Digital THRIVE' with stakeholders, professionals, CYP, parents and carers
15 Primary Mental Health Workers delivering a single point of contact and rolling out youth mental health first aid training for schools and primary care
Developed a programme performance dashboard which is monitored quarterly
Health passports for CYP with additional needs rolled out across Lancashire
Implemented a transition procedure from CAMHS to AMHS
Lancashire secured a contract for a specialist inpatient mother and baby unit. This is expected to open July 2018
Opened a dedicated place of safety for Lancashire wide children and young people in September 2017
Implemented a new community dedicated all age eating disorder service
Implemented a Lancashire wide pathway and locally adapted protocols for CYP admitted to acute hospitals in crisis
Further increased the number of trained staff to improve access for CYP to Improving Access to Psychological Therapies
Work-streams
Active Healthy Minds in schools
Anti-Stigma
PMHW / SPOC
Care of the vulnerable
Perinatal
Eating Disorder
IAPT
Crisis Path
POS
Shared Care
Performance
Digital
Finance

Whilst a considerable amount has been achieved since the programme began, without working collaboratively across providers and commissioners to fundamentally redesign CAMHS we will not, as a system, be able to meet the access targets, anticipated waiting times targets or address the significant variations in spend, service delivery and outcomes. Collaborative working is essential to the success of the CAMHS Redesign.

4.0 Place Based and Collective Commissioning

The 5YFV has created a series of challenges to the ways in which commissioners currently work. The 5YFV set a strategic direction for population health improvement, service integration and improved finance and quality outcomes which challenges our current configuration of organisations and systems.

The 5YFV requires that we take much more decisive action on prevention and population health; we invest in new, more integrated, more efficient and more locally applicable models of care; we work much more closely with social care, primary care and specialist services, and over time we see a greater emphasis on efficiency coming from wider system improvements. Fundamentally, we also need a totally different relationship with our communities to enable them to shape our priorities and release the natural assets they have to contribute to their health and wellbeing.

We are responsible for making the best use of the resources we have in our system and more effective commissioning has a major part to play in this.

To achieve the changes required, all current commissioning and provider organisations in Lancashire and South Cumbria are seeking to find a new, locally relevant way, of organising our health and care system. We are committed to delivering health and care services that centre on "place", because we believe that we will achieve better outcomes if we collaborate with each other, our partners and our service providers to address challenges and improve the health of the defined populations that we serve.

We envisage an "integrated care system" in which health and local authority organisations work more closely with other system partners to share resources and decision-making around the most appropriate 'place'. Place based commissioning means commissioning the right care, in the right place, at the right time.

CCB has already agreed to deliver common standards and outcomes as part of the CAMHS redesign project through a collective commissioning approach across Lancashire and South Cumbria. Collective commissioning cannot succeed without agreeing an approach to differential spends and if providers are expected to work in a collaborative, open and transparent way there will be an expectation that commissioners adopt the same approach.

A number of financial options have therefore been considered.

5.0 Financial Arrangements

A range of options to determine the financial envelope for the redesign project were developed by the project team and CCG Lead Commissioners. These were presented to the Chief Finance Officers on 27 October 2017 and revised following their recommendations. The options were 'socialised' at the Collaborative Commissioning pre – meet on 14 November 2017 and also at CCG Executive Teams between 15 November and 5 December 2017.

Following feedback the options were further revised.

5 Options financial options were discussed at the Collaborative Commissioning Board on 12 December and option 5 was recommended.

5.1 Options

Option 1:
Delivery of minimum common standards and outcomes across Lancashire and South Cumbria based on current lowest spend. Some CCG's will spend more and patients receive better standards and outcomes.

Outcome of Option 1:
Acceptance of variation in spend and standards/outcomes regardless of prevalence or need.

Option 2:
Delivery of 'better than minimum' common standards/outcomes across Lancashire and South Cumbria based on the current spend plus the pooling of the transformation funding recurrently and allocation based on prevalence/need; some CCGs will continue to spend more and their patients will continue to receive better standards/outcomes

Outcome of Option 2:
Acceptance of variation in spend and standards/outcome regardless of prevalence or need.

Option 3:
2) above and a phased reduction of any transformation funding received above population shares over a three year period based on the understanding that matched local funding will be invested to sustain investment levels

Outcome of Option 3:
Assumes that when funding is returned CCGs commit to continue to spend equivalent on CYPEWMH. Risk to service model if local funding not invested when transformation funding returned. Too short term. CCG landscape likely to change in 3 years. May result if differential spends and service model at end of 3 years thus undermining attempts to address variations.

Option 4:

2) above for a three year period at the end of which funding is returned to subsidising CCGs and matched local funding will be invested to sustain investment levels.

Outcome of Option 4:
Same as option 3. Assumes that when funding is returned CCGs commit to continue to spend equivalent on CYPEWMH. Risk to service model if local funding not invested when transformation funding returned. Too short term. CCG landscape likely to change in 3 years. May result if differential spends and service model at end of 3 years thus undermining attempts to address variations.

Option 5:
Pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG will agree the investment plan.

Outcome of Option 5:
Common standards and outcomes with local delivery to reflect need, demography and complexity. Providers have maximum opportunity to redesign. Collective Commissioning based on place being STP. Model developed is based on need not historic funding.

The table below summarises the 5 options together with their associated advantages and disadvantages:

	Option 1: Delivery of minimum common standards and outcomes across Lancashire and South Cumbria based on current lowest spend. Some CCG's will spend more and patients receive better standards and outcomes	**Option 2:** Delivery of 'better than minimum' common standards/outcomes across Lancashire and South Cumbria based on the current spend plus the pooling of the transformation funding recurrently and allocation based on prevalence/need; some CCGs will continue to spend more and their patients will continue to receive better standards/outcomes	**Option 3:** 2) above and a phased reduction of any transformation funding received above population shares over a three year period based on the understanding that matched local funding will be invested to sustain investment levels	**Option 4:** 2) above for a three year period at the end of which funding is returned to subsidising CCGs and matched local funding will be invested to sustain investment levels.	**Option 5:** Pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG will agree the investment plan.
Offers a long term solution to variations in investment	✗	✗	✗	✗	✓
Does not require additional CCG investment	✓	✓	✗	✗	✓
Allows for local flexibility around non-NHS funding eg Local Authority, Lottery etc	✓	✓	✓	✓	✓
Places responsibility for delivery of the Mental Health Investment Standard the STP[2]	✗	✗	✗	✗	✓

[2] This requires CCGs to demonstrate an increase in funding levels in line with those set out in the Five Year Forward View

Allows CCGs to continue with existing contractual investment levels	✓	✗	✗	✗	? Depends on outcome of redesign
Supports ongoing delivery of common standards and outcomes	✓	✓	✓	✓	✓
Supports delivery of the access target across the STP footprint	✗	?	✓	✓	✓
Supports delivery of the access target on a CCG footprint	✓	✓	✓	✓	✗
Reflects local prevalence, need, demographics, complexity and geography	✓	✓	?	?	✓
Builds on and spreads local good practice across the footprint	✗	✓	✓	✓	✓
Allows CCGs an opportunity to test out and begin working collaboratively as an STP system	✗	✗	✗	✗	✓

Allows providers the freedom to develop a model outside of the constraints of existing financial and contracting arrangements					

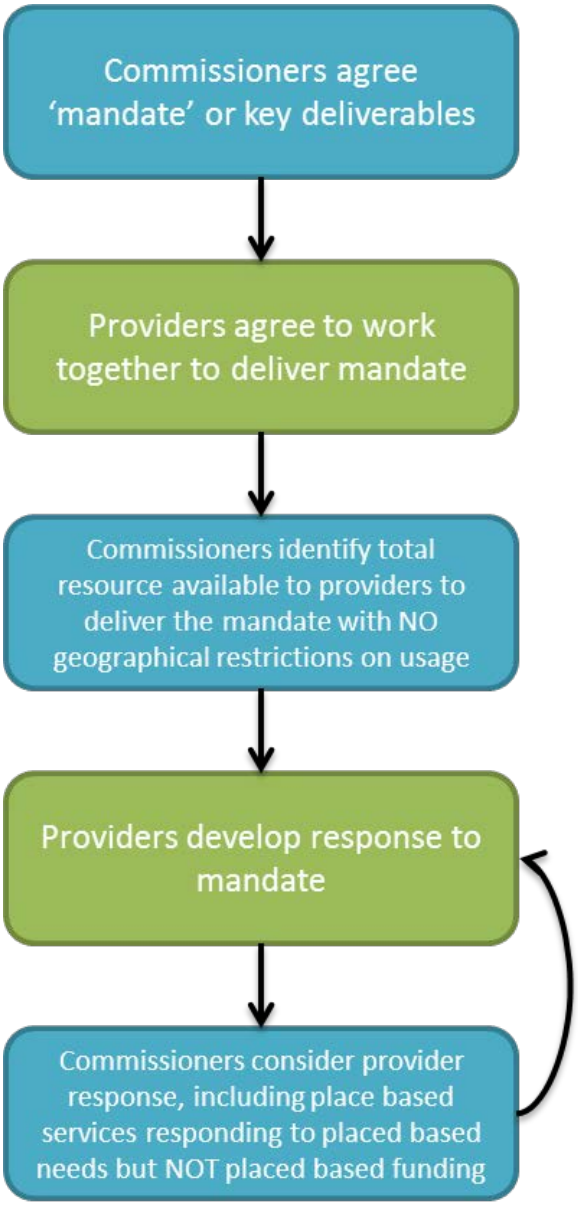
6.0 Mobilisation

Providers have been asked to collaborate to clinically lead the co-production of a core service model for NHS funded CYPEWMH Services across Lancashire and South Cumbria in line with the mandate.

Determining a financial model to fund the redesigned service model requires a number of factors to be taken into account. These include:

- Existing investment levels
- Prevalence
- Access targets and baseline performance against these
- Demographics
- Complexity
- Geography and its impact on physical access to services

It is therefore proposed that providers develop a consistent core service model with common standards and outcomes against the mandate that is funded through combining 100% of the existing CCG investment plus available transformation funding to deliver the service model consistently across the STP footprint whilst also reflecting local need, demography, geography and complexity. Proposals for the best use of resource would be developed by the providers based on the model developed and taking account of the factors listed above. Following evaluation, the final proposals would then be presented to the Joint Committee of CCGs for agreement. These would include investment in the voluntary, community and faith sector (VCFS) in addition to NHS providers. This is visually represented below:



Further work to develop, agree and establish mechanisms around any pooling arrangements will be co-ordinated through the CYPEWMH Programme Board in consultation with the CCG Chief Finance Officers.

7.0 Recommendation

On 13th December 2017, CCB agreed that the preferred option would be option 5. This option was considered by members to be the best to address the wider needs, to allow for local flexibility around funding i.e. lottery bids etc., commitment, and services. It was agreed to recommend option 5 to the JCCCGs.

JCCCGs are asked to:

Endorse the recommendation of CCB: Option 5 - pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG will agree the investment plan

8.0 Governance and Decision Making

A detailed project plan (see Appendix C) has been created for the redesign work. From this plan, the key points where a formal decision is required to progress the project have been highlighted. These key decisions have been mapped out using the Effective Decision-Making Toolkit (see Appendix D).

It is proposed that the following decisions within the CAMHS Redesign project will be made by CCGs:
1 Sign off of investment and governance
2. Sign off of payment model including any risk/gain sharing/performance payment
3. Sign off of final model including any pooling arrangements
Other decisions will be managed within the project under the jurisdiction of the CYPEWMH Transformation Board.

8.1 Recommendation

JCCCGs are asked to:

Agree the proposed governance/decision making arrangements for delivery of the project

9.0 Recommendations

JCCCGs are asked to:

1. Endorse the recommendation of CCB: Option 5 - pool all funding to deliver common standards/outcomes across Lancashire and South Cumbria and the JCCCG will agree the investment plan.
2. Agree the proposed governance/decision making arrangements for delivery of the project

APPENDIX A

Mandate on a Page: Redesigning CAMHS in Lancashire & South Cumbria in line with THRIVE

The Ask:

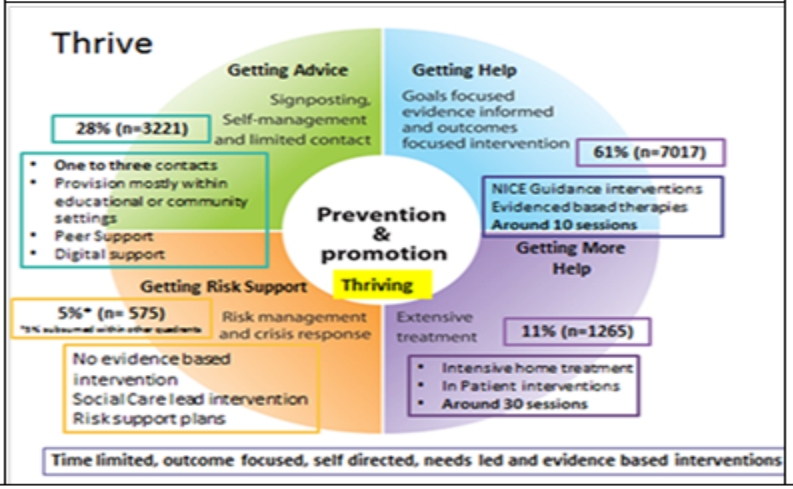
Providers are asked to collaborate with each other to clinically lead the co-production of a core service model for NHS funded Children and Young People's Emotional Wellbeing and Mental Health Services across Lancashire and South Cumbria in line with the following:

Must Do's:

a. Be co-produced with CYP, families, providers, commissioners and other stakeholders (see appendix A).
b. Reflect and respond to previous consultation (see EIRA) and incorporate ongoing engagement with CYP and families.
c. Offer quality services that result in positive patient experiences and deliver positive outcomes for children, young people and families in line with PREMS and PROMS.
d. Respond to the needs of our diverse communities and vulnerable groups (see EIRA).
e. Incorporate the use of digital therapies in line with evidence base and offering choice
f. Incorporate clinical support to online parenting groups and peer support based on recommendation in the ~~iTHRIVE~~ consultation e.g. closed Facebook groups with clinical input
g. Incorporate the full range of NHS funded interventions provided across sectors e.g. counselling (see appx D)
h. Reflect the THRIVE model: evidence based and outcomes lead; options and information for children and young people in need but not in treatment; interventions are focused and time limited; and a clear approach to risk support.
i. Support delivery of the national access target (see appendix B).
j. Take referrals from birth up to 18th birthday and continue to support up to 19th birthday, as needed
k. Offer a clear single point of contact for CYP, families, schools and primary care including providing consultation and advice.
l. Offer clear referral pathways including self-referral.
m. Incorporate a single point of access to all elements of the THRIVE model including a 'warm handover' to other services
n. Offer a direct route from adult IAPT for 16-18s with anxiety/depression as part of 'getting help'
o. Incorporate a range of roles including the new PMHWs and CWPs.

Pathways to be included:

Pathways to be developed as part of the redesign, reflecting the national access target definition, the ~~needs based~~ groupings set out in THRIVE elaborated (p14) and NICE guidance. Pathways to include those delivered directly and those delivered in partnership with other services



Must Do's continued:

p. Ensures workforce requirements are delivered in line with Stepping Forward to 2020/21.
q. Offer 7-day CAMHS crisis response with access to out of hours' on-call services and places of safety alongside Core 24
r. Offer access to the service in a range of CYP friendly settings.
s. Work in partnership with in-patient services to ensure CYP are supported in the least restrictive setting.
t. Allow for innovation and continuous improvement in response to national and local standards while enabling place based delivery and local variation, where appropriate. This should include the Green Paper (December 2017).
u. Support a collaborative system and a positive culture around children and young people's mental health by working in partnership with non-NHS funded services that form part of the complementary offer; to tackle stigma and raise awareness; and positioning the new service within the context of an overall offer for 0-25.
v. Work in partnership with AMH and physical health services to ensure CYP and families are supported holistically and that services recognise and respond to the impact that AMH may have on CYP
w. CYP are appropriately supported to transition in line with pan Lancashire Transitions procedure and NICE quality standards and learning from recent CQUIN.
x. Children and young people, who are vulnerable e.g. children looked after, young offenders, should have priority access to mental health assessments by specialist practitioners. Access to subsequent treatment should be based on clinical need.

Performance and outcome measures and targets

1. **Access Target**: Included in THRIVE diagram above and CCG breakdown appendix B (Attached)
2. **Waiting List Measures**: included as placeholders in FYFV MH dashboard and as part of national indicator set therefore may require further amendment once finalised nationally.
   a. Total number of CYP waiting for treatment by number of weeks waiting
   b. Average waiting time (days):
      i. from referral to treatment/intervention (National proposed 4 weeks – Green Paper Dec 2017)
      ii. from assessment to treatment/intervention
      iii. from referral to assessment
3. **Quality Measures**
   a. Transitions out of Children and Young People's Mental Health Services as per Commissioning for Quality & innovation (CQUIN) 2017/18 specification, with a goal to improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.
   b. Additional measures to be developed by providers
4. **Outcome measures:**
   a. No's of CYP with paired outcome measures
   b. % of CYP who show reliable improvement
   c. No's of CYP who have developed a goal based outcome
   d. % of those that show improvement on those goals
   e. No's of CYP who completed patient experience measure
   f. % of CYP reporting positive patient experience measure
5. **Mental Health Service Data Set (MHSDS):** Compliance to the minimum MHSDS submission of 100% completeness and full compliance against data quality as per the NHS Digital provider level data quality report, with ambition to be fully conformant to MHSDS by 1st June 2018 as per the Information Standard Notice.

APPENDIX B – Governance Summary

DATE	GROUP	DECISION
February 2017	CCB	CCB endorsed CYPEWMH Transformation Programme Business Plan recommendation: a process of whole system co-produced redesign of the children and young people's mental health system adopting a THRIVE model.
June 2017	CCB	CCB endorsed CAMHS Redesign scope and proposed approach
August 2017	CYPEWMH Transformation Programme Board	Agreed the Project Initiation Document
October 2017	Chief Finance Officers Group	Draft CAMHS Redesign Financial Envelope and Options shared and feedback received. Paper revised to reflect feedback
November 2017	CCB Pre-Meet	Draft (2) CAMHS Redesign Financial Envelope and Options socialised
November – December 2017	CCG Executives	Final CAMHS Redesign Financial Envelope and Options presented Responses collated
December 2017	CYPEWMH Transformation Board	Agreed CAMHS Redesign Mandate
December 2017	CCB	CAMHS Redesign Financial Envelope and Options Presentation reflecting feedback and responses from CCG Executives. Agreed that the preferred option would be option 5. It was agreed to recommend option 5 to the JCCCGs

APPENDIX C – Outline Project Timeline

Task Description	When By
Establish project governance	18.08.2017
PID signed off at Board	18.08.2017
Develop detailed project plan	18.08.2017
Initial dialogue with providers: PID, EIRA, draft mandate, draft co-production outline, timeline	27.10.2017
Providers submit agreement to SRO to collaborate and clinically lead development of co-produced model	10.11.2017
CHECK POINT 1: Formal agreement by providers to collaborate and clinically lead development of co-produced model - If CP 1 failed: report to CCB recommending proceed to plan competitive procurement - If CP1 passed continue with co-production and redesign	10.11.2017
Paper to CCGs: financial envelope	20.11.2017
Mandate sign off	04.12.2017
Paper to CCB financial envelope	12.12.2017
Dialogue with providers to confirm: PID, EIRA, mandate, £'l envelope, co-production expectations	18.12.2017
Submission of MOU/ Collaboration agreement by providers	29.01.2018
Submission of Co-production & engagement plan by providers	29.01.2018
C&F group evaluation of MOU/ Collaboration agreement and Co-production & engagement plan	05.02.2018
CHECK POINT 2: Acceptance of MOU/Collaboration agreement and Co-production & engagement plan - If CP 2 failed: report to CCB recommending proceed to plan competitive procurement - If CP 2 passed: continue with co-production and redesign	05.02.2018
T Board re: evaluation of MOU/ Collaboration agreement and Co-production & engagement plan	16.02.2018
CCG leads re draft payment model including any risk/gain sharing/performance %	16.02.2018
T Board sign off criteria for evaluation of proposal and panel	16.02.2018

process	
Providers commence co-production and engagement	28.02.2018
Dialogue with providers to test draft payment model including any risk/gain sharing/performance %	28.02.2018
CCGs to agree final payment model including any risk/gain sharing/performance %	10.05.2018
T Board to agree final payment model including any risk/gain sharing/performance %	18.05.2018
Official notice to providers re contract and commissioning intentions	25.05.2018
Submission of outline proposal by providers	25.05.2018
Evaluation of outline proposal by Evaluation panel with C&F group	04.06.2018
CHECK POINT 3: Acceptance of outline proposal - If CP 3 failed: report to CCB recommending proceed to plan competitive procurement - If CP 3 passed: continue with co-production and redesign	15.06.2018
T Board sign off of outline proposal	15.06.2018
Dialogue with providers with feedback. Plus discuss expectations re transition and implementation plan	22.06.2018
Providers to submit draft transition and implementation plan	20.07.2018
Providers end co-production and stakeholder engagement	30.08.2018
Dialogue with providers to feedback on draft transition and implementation plan	30.08.2018
Providers submit final proposal: service model; financial model; transition and implementation plan	08.10.2018
Evaluation of final proposal: service model; financial model; transition and implementation plan	02.11.2018
Report to T Board	16.11.2018
CHECK POINT 4: Acceptance of final proposal - If CP 4 failed: report to CCB recommending proceed to plan competitive procurement - If CP 4 passed: report to CCGs and CCB recommending variation of contracts	16.11.2018
Report to CCG governing bodies	21.12.2018
Report to CCB/JCCCGs	08.01.2019

Appendix D - The Effective Decision-Making toolkit and CAMHS Redesign

Paul Bauman – Director of Finance for NHS England is the executive sponsor of this toolkit. More information on the toolkit is available here:

http://www.futurefocusedfinance.nhs.uk/bpv-decision-framework

The toolkit operates assuming a participative style of decision making. Individuals or groups are assigned a role to play during each decision. There are 5 possible roles (RAPID):

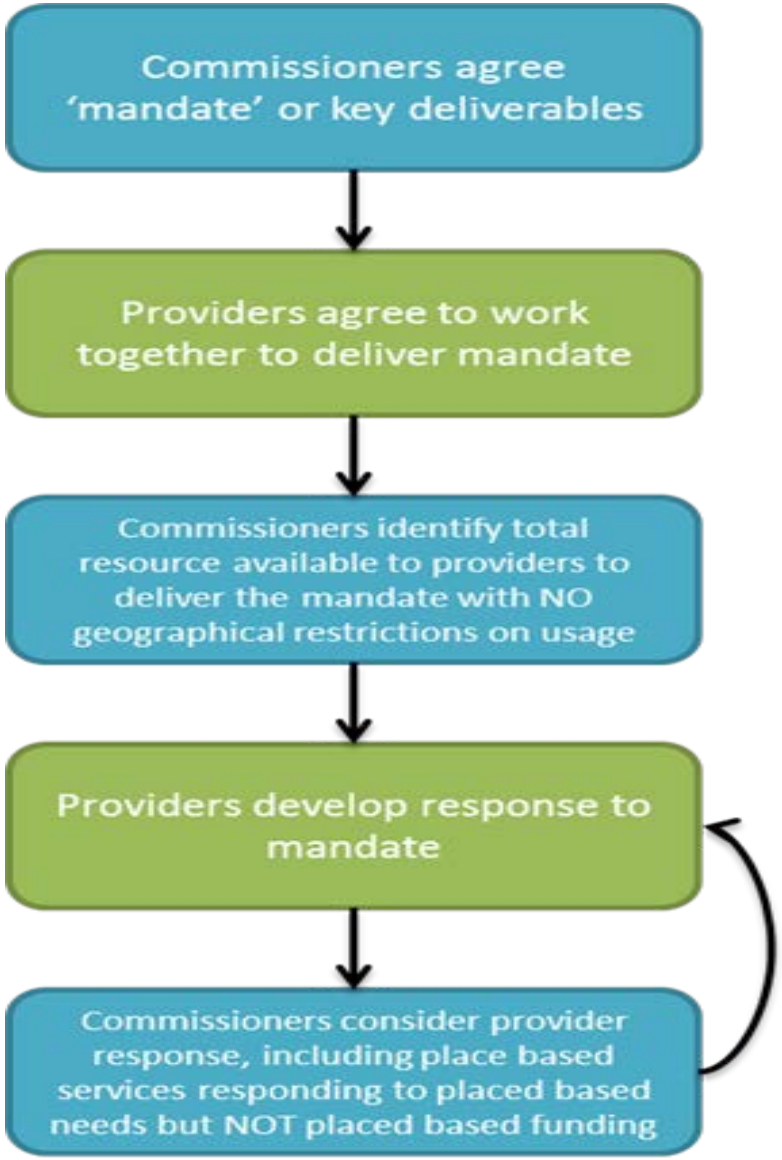
- Recommend – collects opinions and evidence to develop a recommendation for how to proceed. A recommendation is then put forward to the decision maker.
- Agree – a stakeholder whose opinion must be considered. While not holding power of veto, the decision maker must be made aware of any stakeholder concerns
- Perform – required to perform an action to support a decision
- Input – stakeholders who should be approached for their opinion or information to help inform a recommended way forward. The recommended way forward does not necessarily have to reflect a stakeholders view
- Decider – there is only ever one individual or group with the authority to execute a decision

The graphic below shows the differing roles that various stakeholders will play at each decision point within the CAMHS Redesign project:

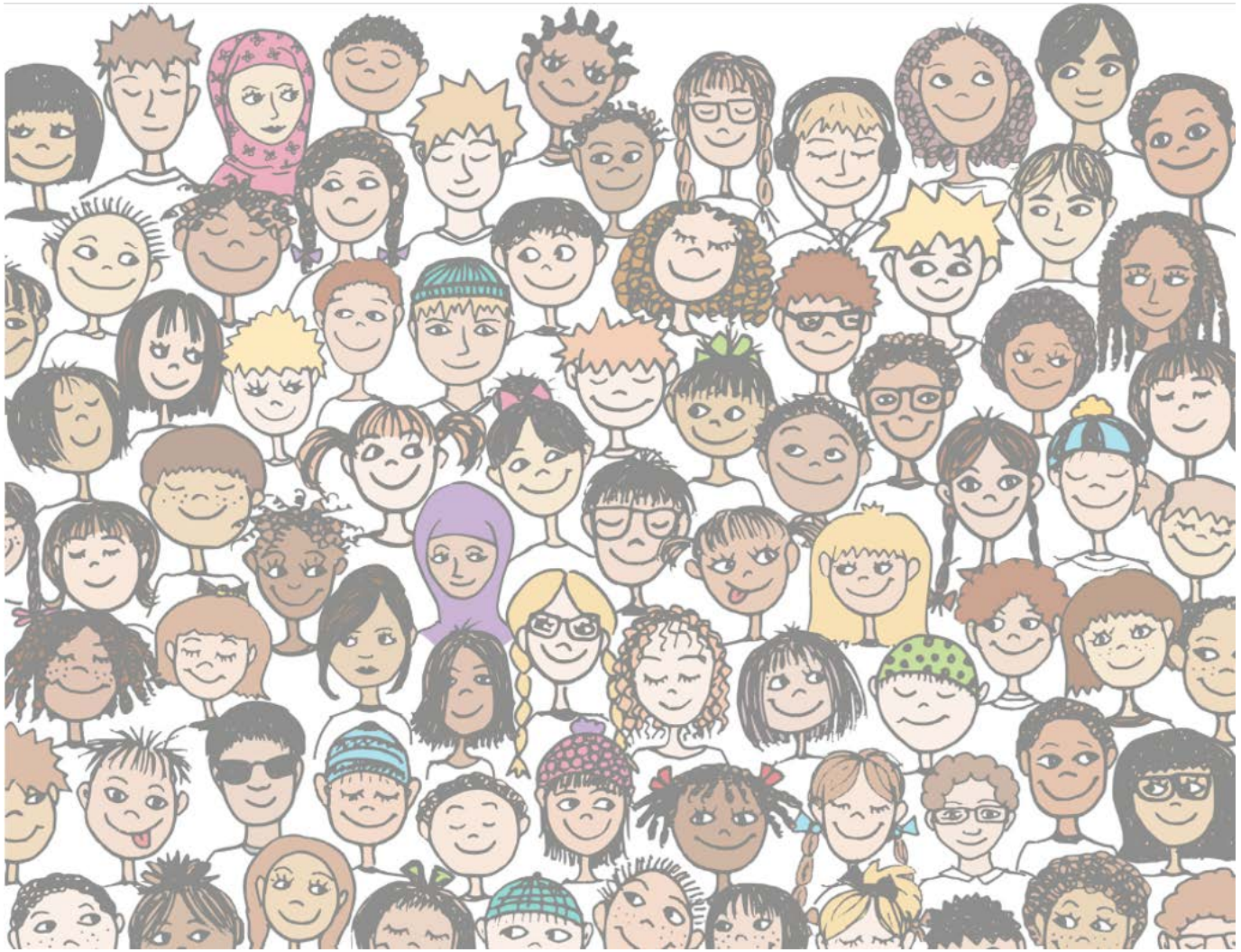
	Sub Decisions	Project Plan Ref	Stakeholders										
			Project Team	Commissioning & Finance Group	Lancashire CCG CFO Group	Programme SRO	CCG Governing Bodies	Collaborative Commissioning Board	Provider Collaborative	CCG MH Leads Group	MH Service Providers	CYP MH Transformation Board	Clinical Ref Group
1	What options will be presented to allow the financial envelope to be confirmed?	9	R	D		I							
2	Do we proceed with co-production approach to re-design?	13	R			D			A				
3	Is the proposed level of investment and governance supported?	21	I	R	A	I	A	D	I				
4	Is the mandate (detailed requirements for new service) agreed?	19		R		D			I	I			I
5	Confirm MOU for collaboration between providers	31	I	A					R			D	
6	Confirm Co production & Engagement Plan for project	31	I	A					R			D	
7	Decide Criteria and arrangements for Evaluation of Proposed New Service Model	33	I	R						I		D	I
8	Decide Payment model	40	I	R	A		A		A	I		D	
9	Does the final proposal meet the requirements?	56 + 60	I	I			A	D		I		R	I

The full Decision Handbook is presented below:

Redesigning CAMHS in LSC a collaborative approach

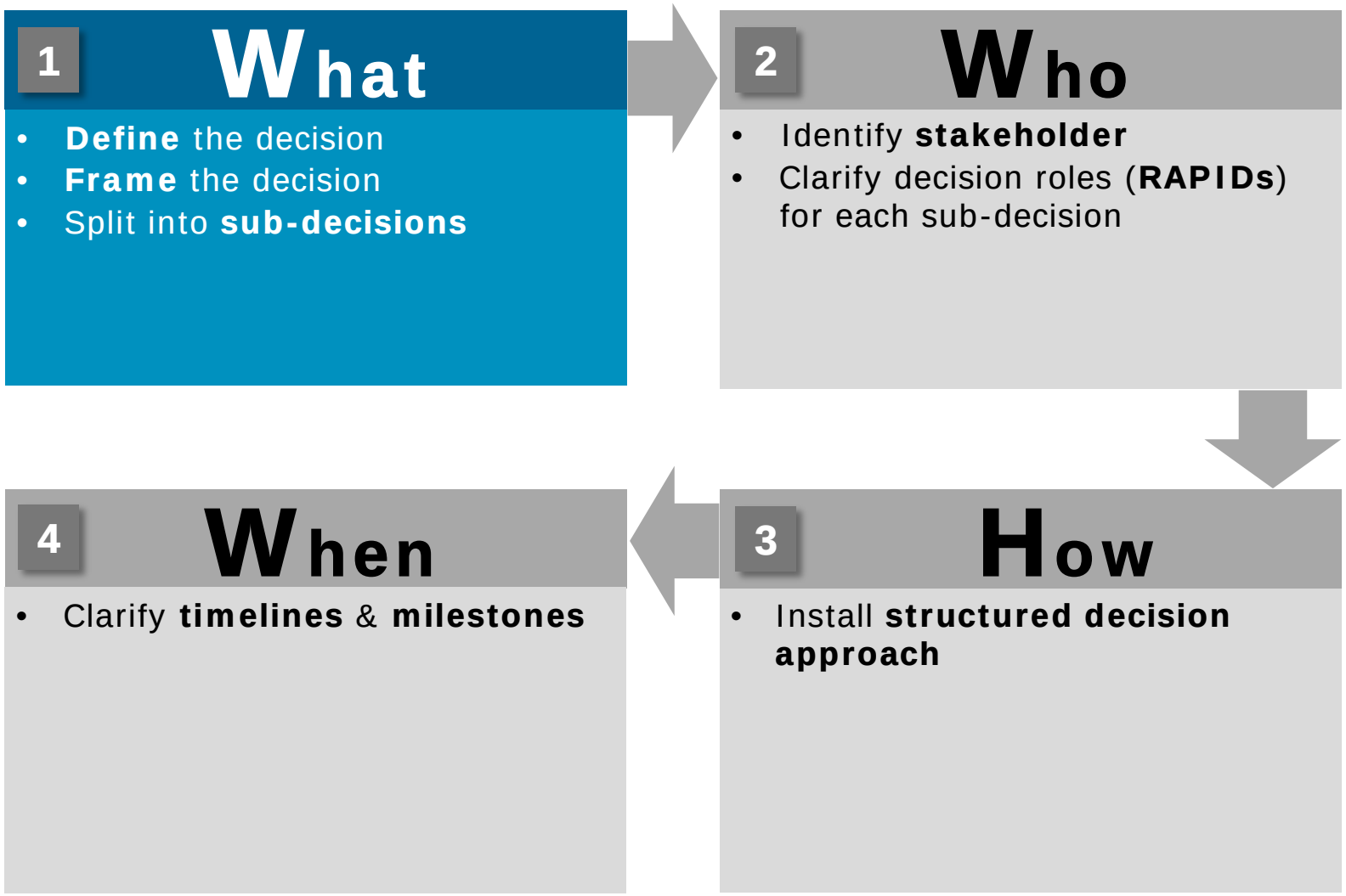


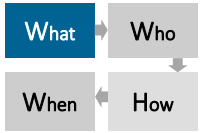
Decision Handbook:



Redesigning CAMHS in Lancashire and South Cumbria in line with THRIVE

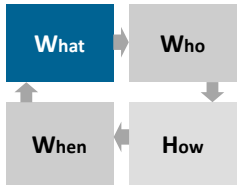
Decision roadmap: “What-Who-How-When”





Decision Charter: Lancashire & South Cumbria CYPEWMH

1 Situation	• Lancashire & South Cumbria CCGs have agreed to collaborate to redesign children's community mental health services • The new service will be provided in line with the THRIVE model of care • There are currently 4 providers of Children's mental Health Services in Lancashire & South Cumbria • It has been agreed that the new model of service will be commissioned via direct negotiation with existing providers • At least 35% of children and young people with a diagnosable mental health condition must receive NHS funded treatment by 2021 • Over 6,000 more children need to be treated across Lancashire & South Cumbria to achieve this target • £1.1 million has recently disinvested from Tier 3 CAMHS in Lancashire and reinvested in early help services • There is additional transformation funding available to support this project
2 Complication	• Redesign involves 8 CCGs, 4 Local Authorities, 4 NHS Service Providers and a multitude of other service providers. • Work is ongoing at STP footprint level to develop an approach to strategic commissioning which could conflict with the approach to redesigning Children's Mental Health Services • Elements of Crisis provision for children are in development as part of efforts to achieve 'Core 24' Mental Health Services which will need to interface with the redesign of Children's Mental Health Services • Existing levels of investment into NHS funded children's mental health services differ between CCG footprints • Local authority partners are under extreme financial pressure which could result in possible disinvestment from services
3 Decision	• **What will be the core model of CYPEWMH provision within THRIVE across Lancashire & South Cumbria?**
4 Constraints	• Solution can not exceed existing levels of funding + transformation funding • Solution must allow all NHS Commissioners to achieve the 35% access target • Solution must provide a core service model which is suitable, deliverable and affordable for all commissioners
5 Outcomes	• Achieve National CYP Access Targets • Consistent level of core service provision across Lancashire & South Cumbria • Reduced level of inpatient admissions for Children's Mental Health



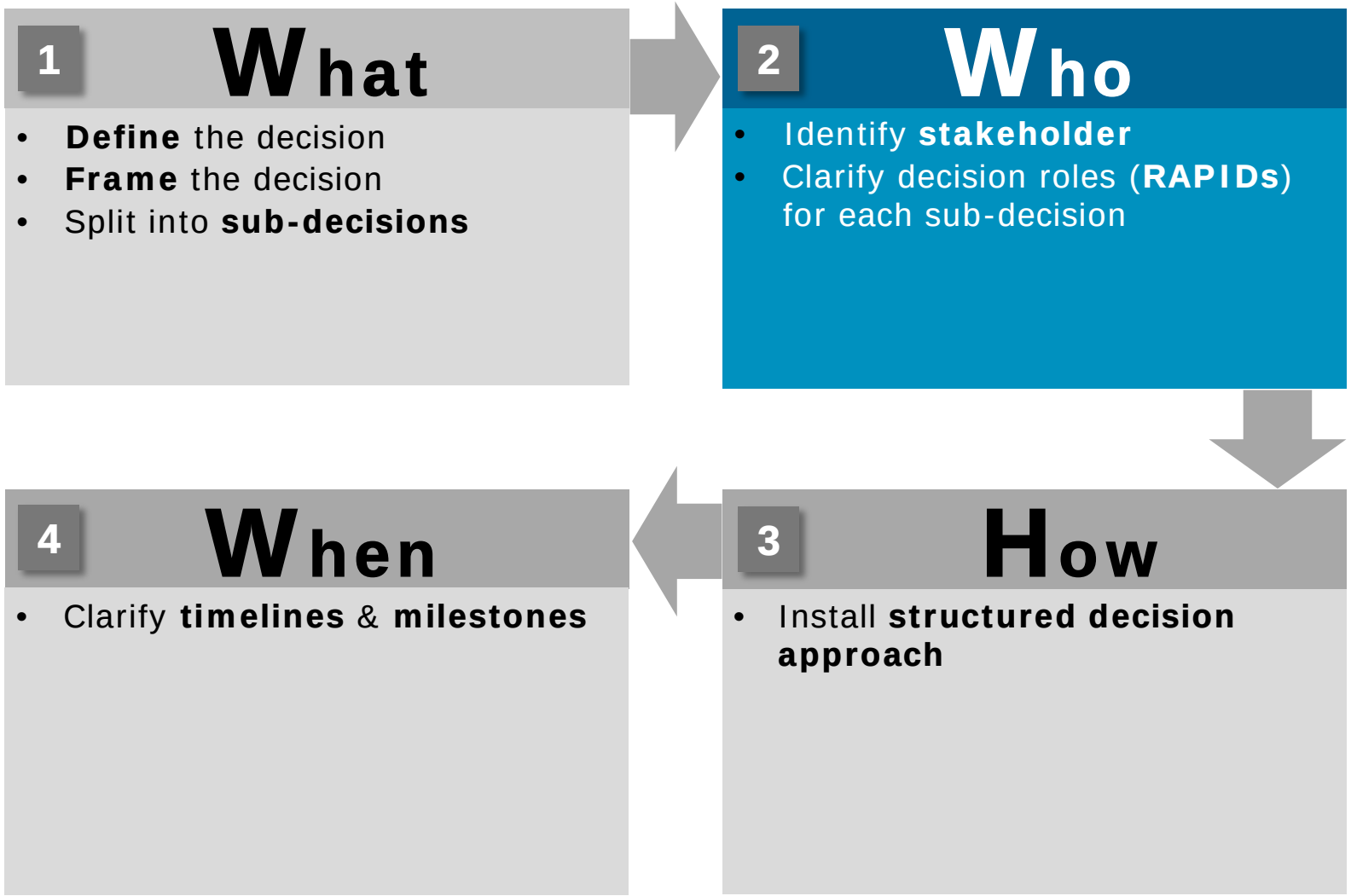
Decision architecture: Lancashire & South Cumbria CYPEWMH

Main decision:

What will be the core model of CYPEWMH provision within THRIVE across Lancashire & South Cumbria?

	Key sub-decisions
1	What is the proposed level of investment that will support the project?
2	Do we proceed with co-production approach to re-design?
3	Is the proposed level of investment and governance supported?
4	Is the mandate (detailed requirements for new service) agreed?
5	Confirm MOU for collaboration between providers
6	Confirm Co production & Engagement Plan for project
7	Decide Criteria and arrangements for Evaluation of Proposed New Service Model
8	Decide Payment model
9	Does the final proposal meet the requirements?

Decision roadmap: “What-Who-How-When”



Rules for allocating decision roles

RAPID should reflect what will work in 90% of situations – design for the rule, not the exception

- Only one D for each decision
- Locate the D at the right level in the organisation
  - Primary value lies in the business
  - Appropriate information lies
  - Reaction time is appropriate
  - Best capability to integrate information, make trade-offs
- If D belongs to a group, clarify how it gets exercised

Recommend

- Only one R – individual who does 80% of the work to develop the recommendation
- R has broad visibility and access to information for relevant inputs
- R has credibility with both Is and D

Input

- Can be multiple Is
- Assigned only to those with valuable, relevant information which could potentially change the decision
- Avoid I proliferation

Decide

Agree

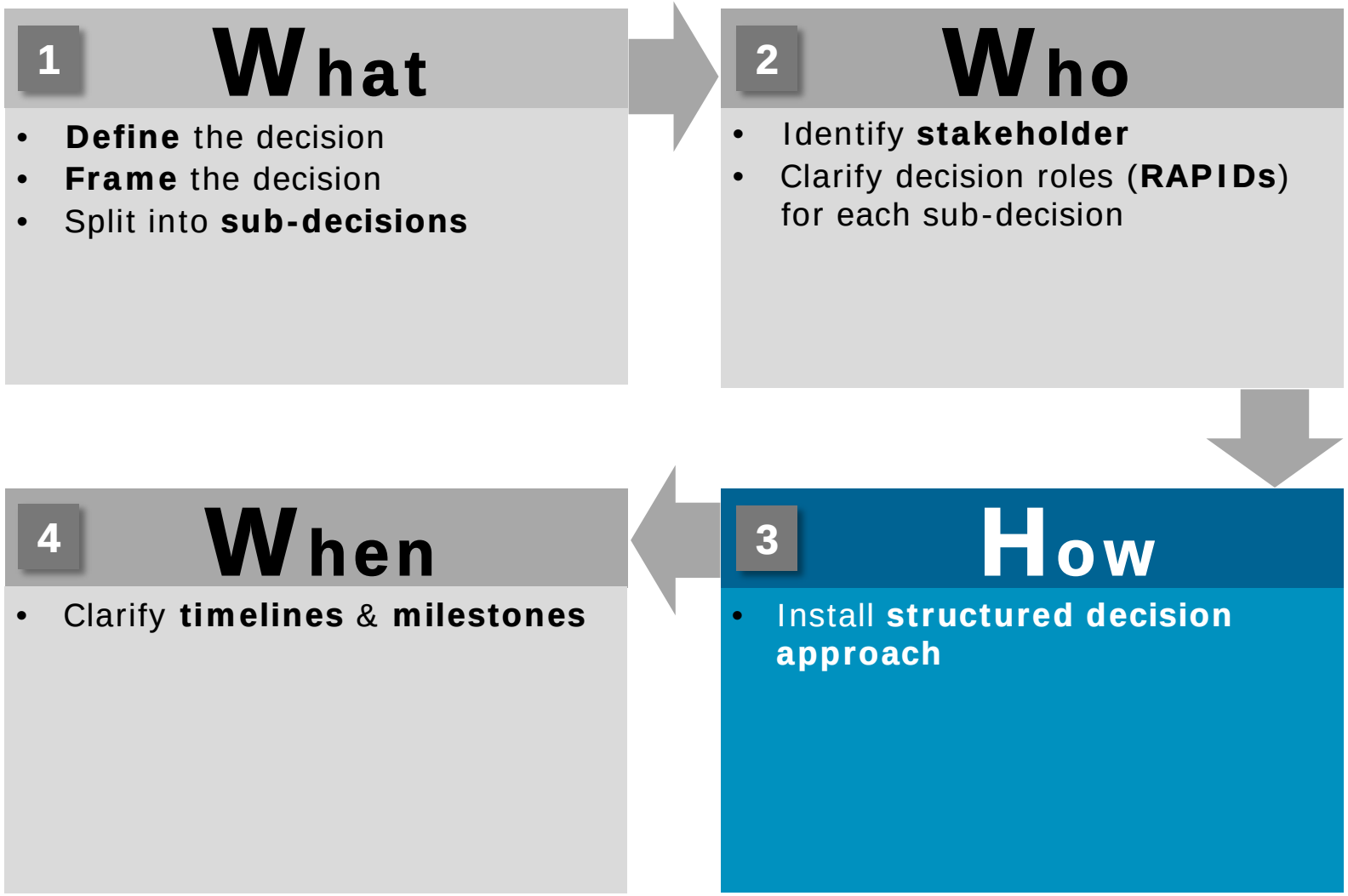
- A's should be assigned sparingly
- Usually for extraordinary circumstances (e.g. regulatory or legal)
- A is on the R – D makes a final decision

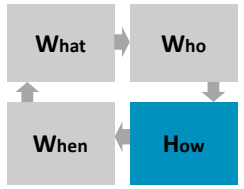
Perform

- May be multiple Ps
- May involve P as an I to help upfront planning

Sub Decisions		Project Plan Ref	Stakeholders										
			Project Team	Commissioning & Finance Group	Lancashire CCG CFO Group	Programme SRO	CCG Governing Bodies	Collaborative Commissioning Board	Provider Collaborative	CCG MH Leads Group	MH Service Providers	CYP MH Transformation Board	Clinical Ref Group
1	What options will be presented to allow the financial envelope to be confirmed?	9	R	D		I							
2	Do we proceed with co-production approach to re-design?	13	R			D			A				
3	Is the proposed level of investment and governance supported?	21	I	R	A	I	A	D	I				
4	Is the mandate (detailed requirements for new service) agreed?	19		R		D			I	I			I
5	Confirm MOU for collaboration between providers	31	I	A					R			D	
6	Confirm Co production & Engagement Plan for project	31	I	A					R			D	
7	Decide Criteria and arrangements for Evaluation of Proposed New Service Model	33	I	R						I		D	I
8	Decide Payment model	40	I	R	A		A		A	I		D	
9	Does the final proposal meet the requirements?	56 + 60	I	I			A	D		I		R	I

Decision roadmap: “What-Who-How-When”



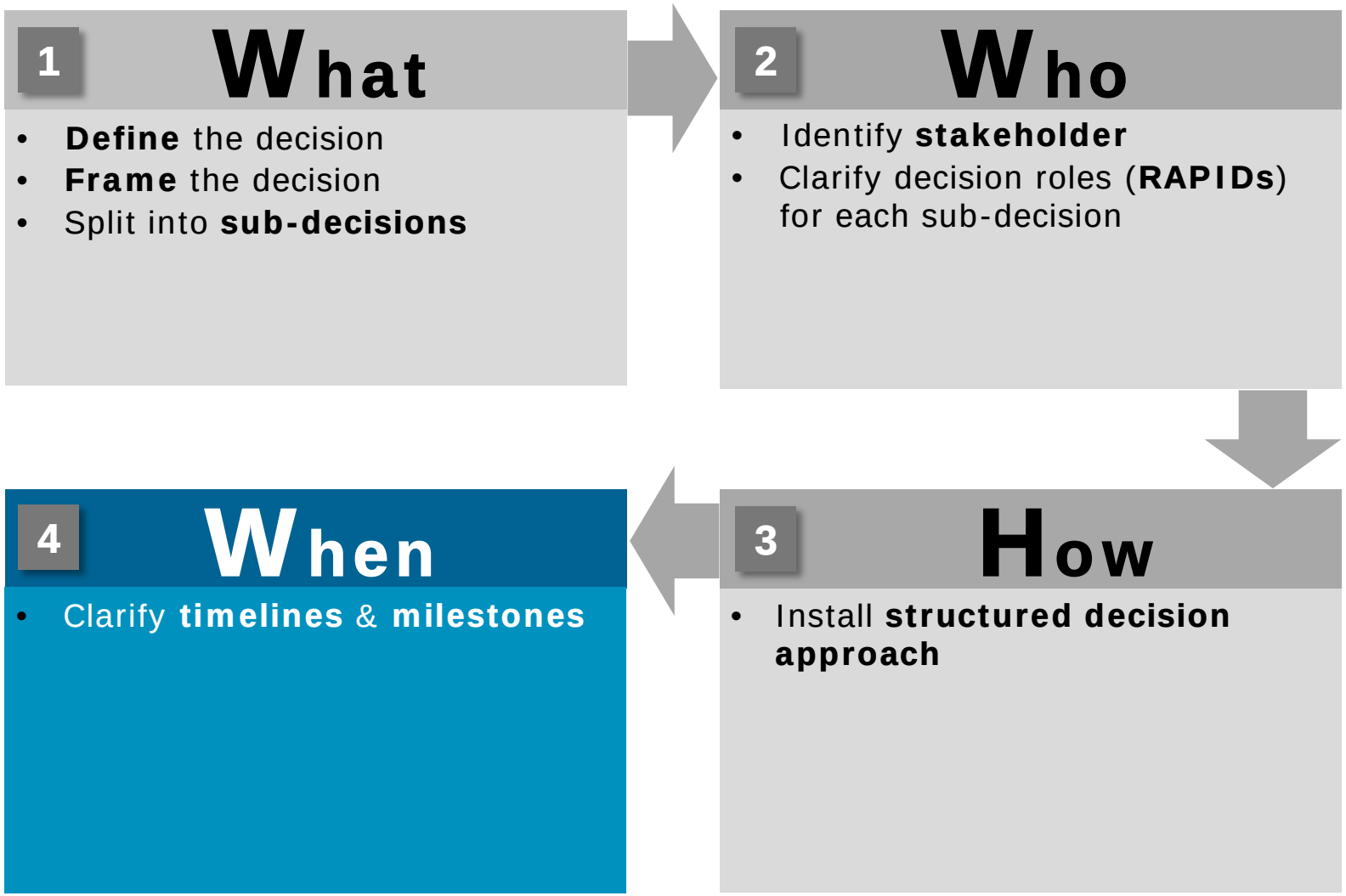


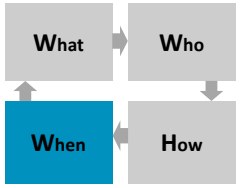
Critical Steps: Lancashire & South Cumbria CAMHS

What will be the core model of CYPEWMH provision within THRIVE across Lancashire & South Cumbria?

	SUB-DECISION	CRITICAL STEPS					
1	What is the proposed level of investment that will support the project?	Submit Ad-hoc request to providers regarding financial baseline	Analyse all finance information	Produce paper outlining proposed baseline	Paper presented to Commissioning & Finance Group	Paper accepted by Commissioning & Finance Group	
2	Do we proceed with co-production approach to re-design?	Provider Collocative established	Initial dialogue with providers	Providers submit agreement to SRO	SRO accepts Provider Agreement		
3	Is the proposed level of investment and governance supported?	Proposed baseline paper shared with CFO Group	All CCG Governing Bodies indicate support for proposed baseline paper	Formal sign off of paper from CCB			
4	Is the mandate (detailed requirements for new service) agreed?	Draft Mandate produced	Draft refined with input form CCG leads and CRG	Draft refined with input from providers	Mandate presented to Commissioning & Finance Group	Mandate accepted by commissioning and finance group	
5	Confirm MOU for collaboration between providers	Providers discuss how they will work together	MOU produced	MOU reviewed by Commissioning & Finance Group	MOU signed off by CYP MH Board		
6	Confirm Co production & Engagement Plan for project	Providers discuss approach to engagement and co-production	Engagement and Co Production plan produced by providers	Reviewed by commissioning & finance group	Signed off by CPY MH Board		
7	Decide Criteria and arrangements for Evaluation of Proposed New Service Model	Draft produced	Draft refined with input form CCG leads and CRG	Reviewed by commissioning & finance group	Signed off by CPY MH Board		
8	Decide Payment model	Develop draft payment model	Draft payment model refined with input from providers and CCG leads	Share draft payment model with Lancashire CFO Group	Reviewed by commissioning & finance group	Signed off by CPY MH Board	
9	Does the final proposal meet the requirements?	Draft proposal submitted by providers	Providers submit draft transition and implementation plan	Drafts evaluated and feedback provided	Final versions submitted	Final versions accepted by CPY MH Board	Formal sign off from CCB

Decision roadmap: “What-Who-How-When”





When: Lancashire & South Cumbria CAMHS

What will be the core model of CYPEWMH provision within THRIVE across Lancashire & South Cumbria?

Sub Decisions		Project Plan Ref	2017/18								2018/19									
			August	September	October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	January
1	What is the proposed level of investment that will support the project?	9																		
2	Do we proceed with co-production approach to re-design?	13																		
3	Is the proposed level of investment and governance supported?	21																		
4	Is the mandate (detailed requirements for new service) agreed?	19																		
5	Confirm MOU for collaboration between providers	31																		
6	Confirm Co production & Engagement Plan for project	31																		
7	Decide Criteria and arrangements for Evaluation of Proposed New Service Model	33																		
8	Decide Payment model	40																		
9	Does the final proposal meet the requirements?	56 + 60																		

Joint Committee of Clinical Commissioning Group's

Title of Paper	Lancashire and South Cumbria Children and Young People's Emotional Wellbeing and Mental Health: Transformation Plan Refresh 2017		
Date of Meeting	1st March 2018	Agenda Item	5b

Lead Author	Peter Tinson	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	This paper presents the Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan Re-Fresh 2017 and Year 3 Priorities.	
Recommendations	The Joint Committee of Clinical Commissioning Groups is asked to approve the Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan Re-Fresh 2017 and Year 3 Priorities.	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	Yes	
Financial Implications	Yes – these will be set out in a separate Business Plan for the Programme to be presented at a future meeting.	
Risk Identified	Yes	
If Yes : Risk	The programme has a comprehensive risk register and issues log which is reviewed monthly and reported to the CYPEWMH Transformation Board.	
Report Authorised by:		

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

Transformation Plan
2015 – 2020

Refresh 2017

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 (CYPEWMH) 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.[1]

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.

In 2016 and in 2017, we reviewed and refreshed the plan. On both occasions we 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 to date.
- Looked at new national requirements and imperatives that have been published since the 2017/18 plan was refreshed, to ensure that this plan reflects these.
- Updated our objectives and deliverables.
- Incorporated our performance dashboard into the plan. This shows how well we are doing in improving experiences and services for children, young people and families.
- Engaged with children, young people, families and wider stakeholders to prioritise our objectives for the coming 3 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] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

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. During 2017 Lancashire North CCG underwent a boundary change to create Morecambe Bay CCG, covering the previous Lancashire North area as well as the South Cumbria area. Up until then 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 continue to be kept under review. The Cumbria Plan is being refreshed and will follow the same structure as the Lancashire Plan. This will mean that the two plans can be read alongside each other in order to provide an STP-wide picture.

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.
    d. To understand how their feedback has informed service development and redesign.

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

3. Ensure that we recognise and respond to the needs of children, young people and families who have protected characteristics which include: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief and sex. This will include undertaking Equality Impact and Risk Assessments and ensuring that we have due regard to the public sector equality duty (Equality Act, 2010)[2].

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

5. Continually strive to improve services and outcomes for children, young people and families by sharing our performance against national targets through publication of our performance dashboard within the refreshed Transformation Plan and its monitoring through the Transformation Board

6. Ensure that parity of esteem forms a fundamental foundation for delivery of our plan

7. Seek to achieve a balance between ensuring positive outcomes for children, young people and families whilst at the same time developing services that are both sustainable and affordable.

[2] A Public Sector Equality Duty Guidance document has been developed. This is 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?

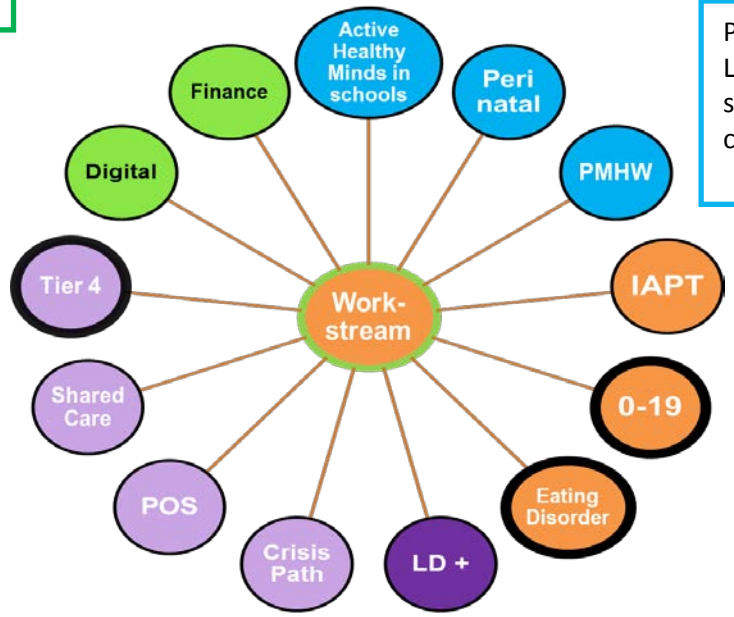
In 2016 we put all our foundational arrangements in place to support the work of the Transformation Programme (this included establishing our governance, initiating our work streams and developing our relationships). We also mobilised 13 key pieces of work that we believe will transform the system of 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 have we achieved in year 2?

Our systems and relationships have matured in year two with a number of our objectives having been achieved. Children, young people and their families are benefitting from enhanced emotional wellbeing and mental health services and greater access to support.

Monitored investment across the programme

Lancashire Active Healthy Minds Programme targeted schools to build resilience through sport

'Time to Change' adopted as the pan-Lancashire Mental Health Anti-Stigma Campaign.

Co-produced an outline for an online portal known locally as 'Digital THRIVE' with stakeholders, professionals, CYP, parents and carers

15 Primary Mental Health Workers delivering a single point of contact and rolling out youth mental health first aid training for schools and primary care

Developed a programme performance dashboard which is monitored quarterly

Completed training needs analysis for those working with vulnerable groups

Health passports for CYP with additional needs rolled out across Lancashire

Implemented a transition procedure from CAMHS to AMHS

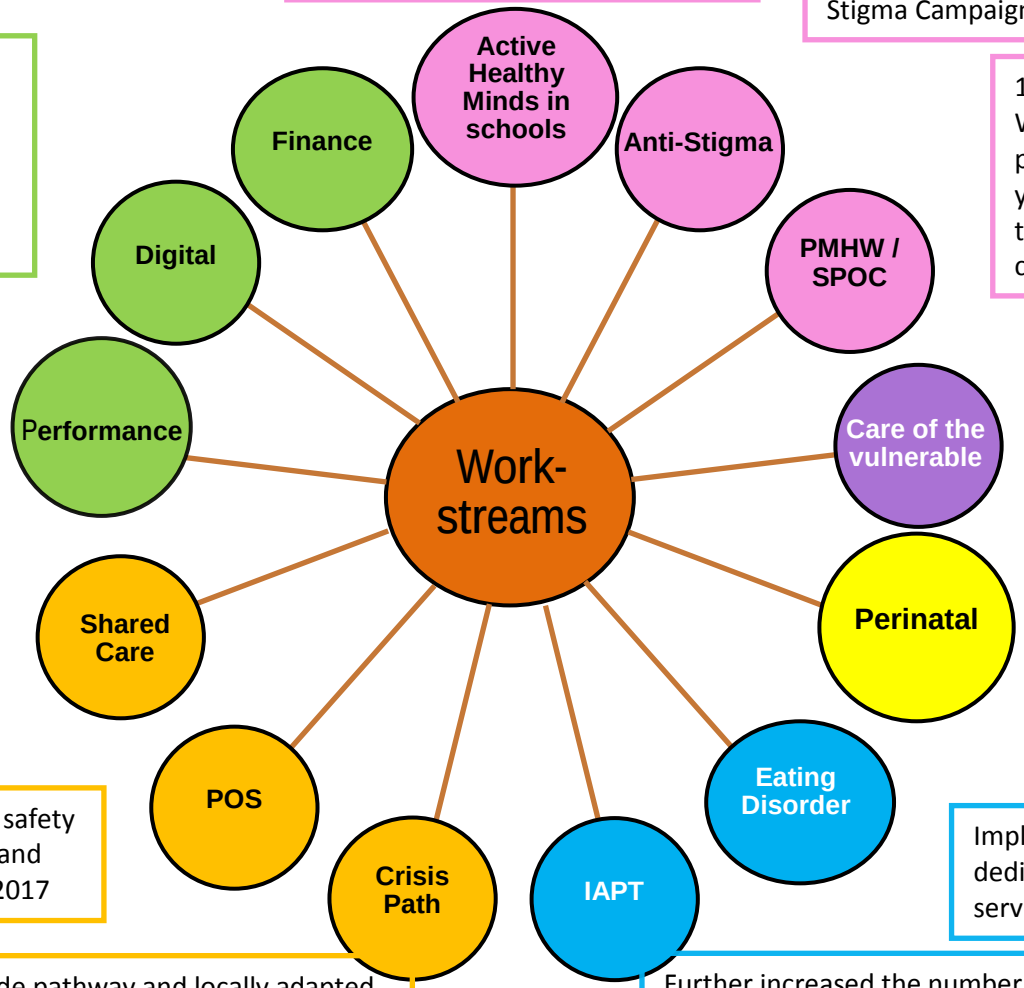
Lancashire secured a contract for a specialist inpatient mother and baby unit. This is expected to open July 2018

Opened a dedicated place of safety for Lancashire wide children and young people in September 2017

Implemented a new community dedicated all age eating disorder service

Implemented a Lancashire wide pathway and locally adapted protocols for CYP admitted to acute hospitals in crisis

Further increased the number of trained staff to improve access for CYP to Improving Access to Psychological Therapies



Section 4 – What are our objectives 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 31st March 2018 we will have mobilised our "**Mental Health Anti-Stigma Campaign"** the campaign across Lancashire.

2. By the 30th September 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 31st March 2019 each team of Primary Mental Health workers will have delivered four **"mental health first aid courses"** to a maximum of 16 participants per course.

5. By 31st March 2019 all Primary Mental Health workers will be trained to deliver **"schools mental health first aid"** one day course.

6. By 30th June 2018 we will have defined a **"complementary offer"** of support for vulnerable people who do not access mainstream services 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.

7. By 31st March 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.

Increasing Access to Specialist Perinatal Health Support

Objectives:

8. By 31st March 2021 we will have delivered "**improvements in Universal/Mainstream Services"** including:
    a. Consistent Clinical Pathways
    b. Specialist posts and leadership roles on universal services
    c. 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 December 2018 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]

Improving Access to Effective Support

Objectives:

11. By 31st March 2018 our online portal known locally as **"Digital THRIVE"** will be operational across Lancashire.

12. By 31st March 2018 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.

13. By 31st January 2019 we will **"redesign CAMHS"** in Lancashire and South Cumbria in line with THRIVE.

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

14. By 31st March 2019 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.

15. By 31st December 2018 we will have reviewed our dedicated all age community **"eating disorder"** service and will make recommendations to the Programme Board for future delivery.

Ensuring appropriate support and intervention for CYP in Crisis

Objectives:

16. By 31st March 2018 we will have developed as part of the all-age crisis care concordat:

a. **An agreed model for "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 2018 we will have extended the existing Safe Place in Blackburn with Darwen to provide a **"two-bedded step-up/down facility"** for children with complex needs, available for young people from across the STP footprint.

18. By 31st March 2019 we will have developed and agreed a **"risk support approach"** in line with THRIVE and drawing on the findings from the AMBIT pilot in Blackburn.

19. By 31st March 2018 we will have co-produced and implemented a **"crisis training package"**

a. to support families, carers and residential settings who are caring for young people in crisis
b. for mental health professionals to improve their confidence in supporting young people in crisis and to avoid admissions or facilitate discharge

20. By 31st March 2021 we will have worked collaboratively with partners in specialised commissioning to redesign and re-procure **"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.

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

Improving Care for the Most Vulnerable

Objectives:

22. 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

23. By 30th September 2018 we will have secured interim community services to support **"children with behaviours that challenge"**, pending the CAMHS redesign.

24. By 31st March 2018 we will have shared opportunities to **"upskill staff working with vulnerable groups"** across pan-Lancashire, in line with the recommendations from the training gap analysis. This will be through Mind-ed and Safeguarding briefings.

Improving Service Quality

Objectives:

25. By 31st March 2021 we will have worked with the **"provider network"** through the clinical reference group to oversee and support delivery of the following sub objectives:

a. By 31st March 2018 we will have provided assurance to the board that CYP have access to evidence based **"early intervention in psychosis"** services in line with the access and waiting time standards for people experiencing a first episode of psychosis.

b. By 31st March 2021 we will have developed a pan–Lancashire community wide consensus definition of **"self-harm"** and a pathway for use by the wider community, schools, all health professionals and other key professionals.

c. By 31st March 2021 we will have scoped mechanisms to ensure that services consistently identify **"carers and working carers"**, support carers to receive carers assessments and to access support as appropriate.

d. By 30th September 2018 we will have defined a core set of **"policies, procedures and guidance"** that are required across sectors and services. We will then:
   I. support providers across sectors to self-audit against the required list.
   II. develop a work plan to support providers to identify and address gaps from audits.

e. By 31st March 2021 we will collaborate with Lancashire and South Cumbria STP Digital Programme to ensure that **"information sharing"** protocols are in place and are operating effectively.

f. By 30th September 2018 we will have worked with AQUA to develop an **"outcomes framework"** to support and underpin delivery of the Programme.

g. By 31st March 2021 we will collaborate with the Lancashire and South Cumbria STP Medicines Management Programme to ensure the inclusion of appropriate **"prescribing protocols"** and practices as part of pathways for children and young people.

h. By 31st March 2021 we will work collaboratively with the Lancashire and South Cumbria STP **"Suicide Prevention"** oversight group to develop and deliver plans to reduce the incidence of suicide in children and young people.

26. By 31st March 2021 we will have worked collaboratively with Health Education England, NHS Improvement, NHS England and the Lancashire and South Cumbria STP to develop a **"workforce strategy"** in response to *Stepping Forward to 2021: Mental health workforce plan for England.*[5]Specifically, we will have grown the CYPEWMH workforce in line with IAPT targets.

[5] https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan

27. By 30th September 2018 we will have incorporated reporting against the national **"transition"** CQUIN[6] into the CYPEWMH Programme Performance Dashboard.

28. By 31st March 2018 CAMHS service providers will routinely collect **"outcome measures"** which will be aggregated and reported through to the System Performance Group.

[6] https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

Section 5 – 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, 7 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 continued in order to obtain insight and intelligence to inform projects of the problems and difficulties they have faced whilst using a service.

We have effectively engaged with children, young people and our stakeholders to inform our decision making. Alongside children and young people we have co-designed a visual identity (branding) for the transformation programme. During the co-design we worked closely with children and young people in order to capture their thoughts and feelings to inform the creative brief. We utilised a number of creative methods during co-design for example; creative workshops with young people and also primary school activities to uncover pupils' perceptions and understanding of emotions, particularly around being healthy and happy. Following this we created three design concepts for testing and approval with stakeholders, children and young people. After collating the feedback option two was selected and further developed to reflect the feedback. The selected design has been adopted by the programme and is illustrated throughout this plan.

We have hosted numerous surveys via a range of methods paper, electronic and social media. We also placed survey podiums within locations of CAMHS services in order to obtain real time patient and carer experience. Using this information we have been able to understand patient, carer experience and inform decision making.

We have held a number of large scale events in order to actively engage with stakeholders and communicate key messages.

Examples of such events are:

- Singing the (Better Local Emotional Wellbeing and Support Services) BLEWWS II event on 24th April 2017
- Education Event on 23rd February 2017
- Transformation Board Hijack 14th June 2017

During the board hijack, the board invited children and young people from across Pan Lancashire to be part of the Lancashire Children's Services Investigation (CSI) team's hijack of the monthly board meeting. Typically board meetings are

held within office hours however in order to accommodate children and young people's education/work commitments the board meeting was held in the evening. During the hijack Lancashire CSI team shared their thoughts and opinions about how the board and the programme have engaged with young people. Following a number of active exercises and problem solving tasks set by Lancashire's CSI team the Lancashire's CSI team compiled a report which highlighted the positive engagement that has already taken place however they reminded the board that continual involvement and engagement with CYP is required at every stage of the transformation process.

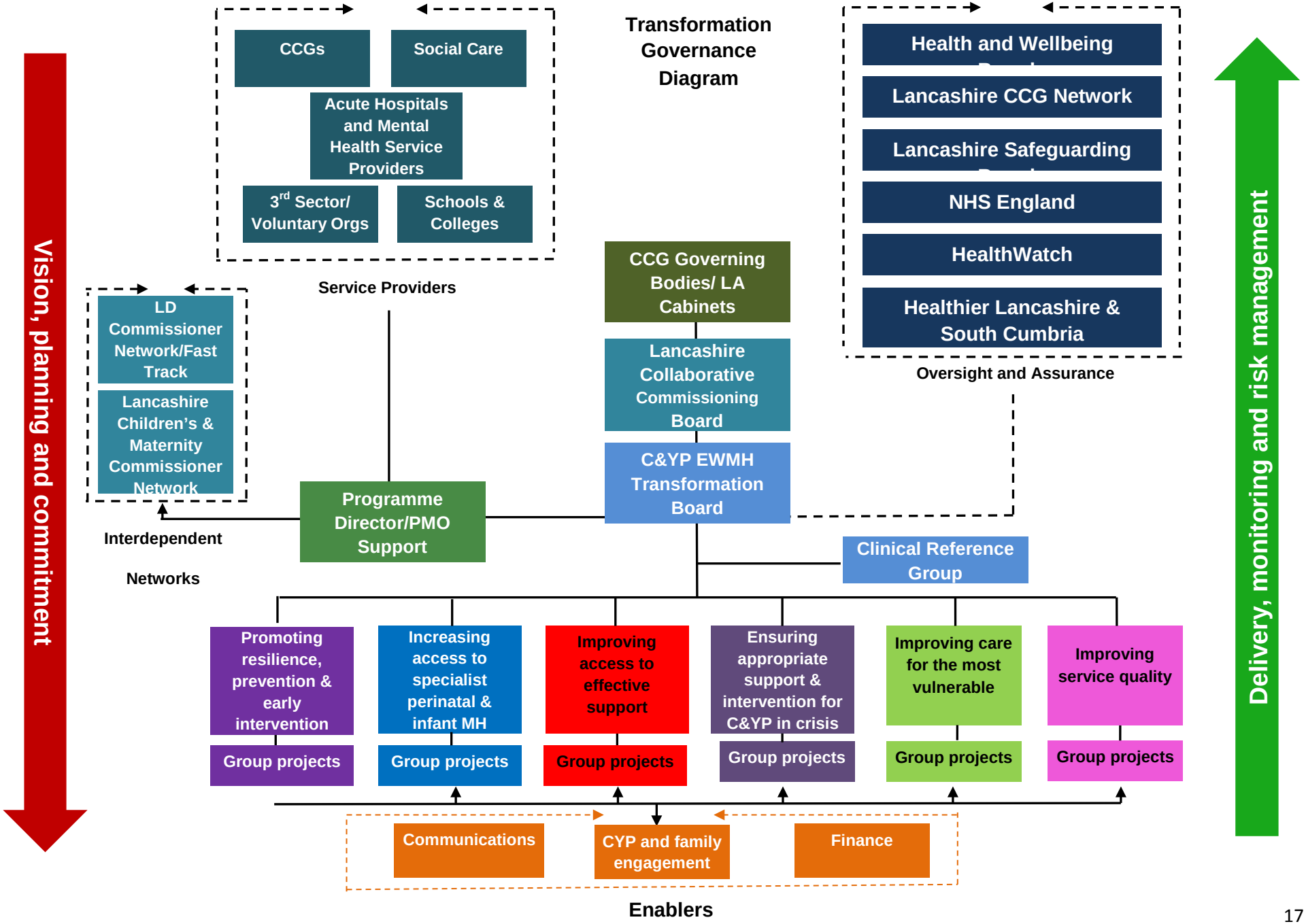
Stakeholder engagement, we continue to work with and strengthen stakeholder partnerships, working with stakeholders to inform decisions and shape change as we move forward. Examples of this are, inviting stakeholders to be part of various work streams within the programme in order to contribute valuable expertise and insight.

We have undertaken a large scale engagement activity in order to co-design and produce a website for the programme, working with (but not exclusively) children, young people, families, carers, professionals, providers in order to design a website that is accessible, engaging and ultimately will be of benefit to children and young people.

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. Continual work is being carried out to grow and strengthen communication channels and networks. We have established a social media presence via twitter and we continue to grow our presence, following and engagement via social media.

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.

Transformation Governance Diagram



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

ID	Narrative	Reference	Plan Objective	Plan ID:
01	**Intention** 14. Robust local workforce plans to grow and transform the Mental Health workforce, aligned with finance and service plans p.28 https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan	Stepping Forward to 2020/21: Mental Health Workforce Plan for England	Workforce	Section 4 Objective 25 *Develop a workforce strategy*
02	**Recommendation** Learning disabilities: identifying and managing mental health problems (2017) https://www.nice.org.uk/guidance/qs142	NICE Quality Standards (QS142)	Care for the most vulnerable	Section 4 Objective 21d *Learning disabilities pathway*
03	**Intention** 8. A structured approach to referrals from education providers to CAMHS must be developed across the country. We have seen cases of strong partnerships between mental health services and education providers, but such links do not exist in many local areas. (p.17, Paragraph 32) https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/849/849.pdf	CYP's Mental Health – the Role of Education, 2016-17, (2017)	Promoting resilience, prevention and early intervention	Sections 2 & 3, *Primary Mental Health Workers/ Single point of contact*
04	**Forthcoming** New support for schools with every secondary school in the country to be offered mental health first aid training and new trials to look at how to strengthen the links between schools and local NHS mental health staff https://mhfaengland.org/mhfa-centre/news/2017-01-09-government-	Government announce-ment (Jan 17)	Promoting resilience, prevention and early intervention	Section 3, *Primary Mental Health Workers and Mental Health first aid training*

ID	Narrative	Reference	Plan Objective	Plan ID:
	announces-plans-for-youth-mental-health/			
05	**Mandate** Sentencing Children and Young People Overarching Principles and Offence Specific Guidelines for Sexual Offences and Robbery Definitive Guideline https://www.sentencingcouncil.org.uk/wp-content/uploads/Sentencing-Children-and-young-people-Definitive-Guide_FINAL_WEB.pdf	Sentencing Council June 2017	Care of the most vulnerable	Section 4 Objective 21f *Children in contact with the youth justice system pathway*
06	This survey indicates that there is some interest in peer support particularly in schools provided there are certain safeguards in place. Approx 50% young people would be interested in becoming or receiving mentor/peer support. The lit review concurred. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/603742/Peer_support_analysis_of_call_for_evidence_report.pdf https://www.gov.uk/government/news/15-million-to-help-young-people-spot-signs-of-mental-illness	Peer support and children and young people's mental health (2017) DoE	Promoting resilience, prevention and early intervention	Section 4 Objective 2 *Resilience framework and Resilience Training Programme*
07	Lenehan Review https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585376/Lenehan_Review_Report.pdf	These are our children: A review by Dame Christine Lenehan Director, Council for Disabled Children	Care of the vulnerable	Section 4 Objective 21 *Pathways for vulnerable groups*

ID	Narrative	Reference	Plan Objective	Plan ID:
08	Care Education and Treatment Reviews NHS England https://www.england.nhs.uk/learning-disabilities/ctr/care-education-and-treatment-reviews/	Care, Education and Treatment Reviews for children and young people Code and Toolkit	Care of the vulnerable	Section 4 Objective 21 *Pathways for vulnerable groups*
9	**Intention** 14. Robust local workforce plans to grow and transform the Mental Health workforce, aligned with finance and service plans https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan	Stepping Forward to 2020/21: Mental Health Workforce Plan for England	Workforce	Section 4 Objective 25 *Develop a workforce strategy*
10	**Mandate** A mental health mother and baby unit in the North West. New or expanded specialist perinatal mental health team. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf	Next Steps on the NHS Five Year Forward View	Increasing Access to Specialist Perinatal Health Support	Section 4 Objective 10 *Specialist inpatient mother & baby unit*
11	**Mandate** Improved care for children and young people. An extra 35,000 children and young people being treated through NHS-commissioned community services next year compared to 2014/15, growing to an extra 49,000 children and young people getting the care they need in two years' time. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf	Next Steps on the NHS Five Year Forward View	Improving Access to Effective Support	Section 4 Objective 13 *CAMHS redesign in line with THRIVE*

ID	Narrative	Reference	Plan Objective	Plan ID:
12	Care closer to home, NHS will fund more Tier 4 specialist inpatient beds to reduce travel for treatment. Local CAMHS to reduce inpatient use. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf	Next Steps on the NHS Five Year Forward View	Redesign & re-procure inpatient beds & intensive outreach	Section 2 *Influence NHS England on Tier 4 beds*
13	Specialist mental health care in A&Es. Core 24 standard in place https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf	Next Steps on the NHS Five Year Forward View		Section 4 Objective 16a *Consistent crisis response for CYP*
14	Approval of courses for approved mental health professionals http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted	Children & Social Work Act (2017)	Workforce	Section 4 Objective 25 *Develop a workforce strategy*

Appendix 2 - Finance

The eight CCGs across Lancashire have committed to invest the Transformation Monies received, as detailed in the Five Year Forward View, to improve access for children and young people into evidenced based provision. These investment levels are detailed in the table below:

Transformation Funding	Blackpool CCG	Blackburn with Darwen CCG	Chorley & South Ribble CCG	East Lancashire CCG	Fylde & Wyre CCG	Greater Preston CCG	West Lancashire CCG	Morecambe Bay CCG Lancashire North element	Total
2016/17	£437,000	£376,000	£376,000	£848,000	£344,000	£450,000	£238,000	£335,000	£3,404,000
2017/18	£514,118	£442,353	£442,353	£997,647	£404,706	£529,412	£280,000	£394,118	£4,004,707
2018/19	£624,286	£537,143	£537,143	£1,211,429	£491,429	£642,857	£340,000	£478,571	£4,862,858
2019/20	£697,731	£600,336	£600,336	£1,353,950	£549,244	£718,487	£380,000	£534,874	£5,434,958
2020/21	£785,866	£676,168	£676,168	£1,524,975	£618,622	£809,244	£428,000	£602,437	£6,121,480
Total	£3,059,000	£2,632,000	£2,632,000	£5,936,000	£2,408,000	£3,150,000	£1,666,000	£2,345,000	£23,828,000

Increased Investment from 2014/15 – 2017/18

The following table shows the investment by CCG for 2017/18 compared to the baseline position in 2014/15.

	0-18 pop (10%)	14/15 Baseline	£ per prevalent child	17/18	£ per prevalent child
Blackburn With Darwen CCG	4463	£1,286,230	£288.20	£1,750,870	£392.31
Blackpool CCG	3413	£2,188,255	£641.15	£2,436,275	£713.82
Chorley & South Ribble CCG	3851	£1,287,350	£334.29	£1,743,772	£452.81
East Lancashire CCG	10755	£3,652,596	£339.62	£4,561,883	£424.16
Fylde & Wyre CCG	2807	£987,070	£351.65	£1,482,871	£528.28
Greater Preston CCG	4635	£1,206,841	£260.38	£1,692,370	£365.13
Lancashire North CCG	3095	£662,366	£214.01	£960,151	£310.23
West Lancashire CCG	2284	£862,548	£377.65	£1,146,207	£501.84
Lancashire Total	35303	£12,133,256	£343.69	£15,774,399	£446.83

Specific Investment for children and young people with an Eating Disorder requiring a Community Intervention

In line with the Five Year Forward View for Mental Health the eight CCGs have, in addition to the above investment, commissioned a pan Lancashire Community Eating Disorder service. The contributions to this are detailed in the table below:

CCG Name	2017/18
Blackburn With Darwen CCG	£94,796
Blackpool CCG	£106,867
Chorley and South Ribble CCG	£98,793
East Lancashire CCG	£214,568
Fylde and Wyre CCG	£89,889
Greater Preston CCG	£113,187
Lancashire North CCG	£85,021
West Lancashire CCG	£62,869
Total	**£865,990**

2017/18 Commissioning Intentions/Spend

For 2017/18 the Programme Board agreed to align 85% of the Transformation Funds to a number of key objectives within the plan. The remaining 15% would stay in the CCGs to fund local coordination and innovation. This is detailed in the table below

	Blackburn with Darwen CCG	Blackpool CCG	Chorley and South Ribble CCG	East Lancashire CCG	Fylde and Wyre CCG	Greater Preston CCG	Morecambe Bay CCG*	West Lancashire CCG	Total
85% Aligned Spend: • Transformation Programme Delivery • Active schools programme • Complimentary Offer of support • Primary Mental Health Workers/ PWP • Perinatal Pathway • 7 day CAMHS • IAPT (Increased capacity of workforce) • Increased Access • Care of vulnerable	£376,040	£437,920	£376,040	£847,280	£342,720	£447,440	£333,200	£238,000	£3,398,640
15% Local Spend: • Local Innovation • Local Coordination	£66,360	£77,280	£66,360	£149,520	£60,480	£78,960	£58,800	£42,000	£599,760

Appendix 3 Performance

This appendix presents key performance information for the programme. This includes:

- The number of children and young people with a diagnosable mental health condition accessing NHS funded community services.
- The numbers of children and young people accessing community eating disorder services within one week for urgent referrals and four weeks for non-urgent referrals.
- Information regarding the children and young people's emotional wellbeing and mental health workforce.

CYP Access Targets

The Programme is currently monitoring performance against the CYP access target in three ways;

1) Targets based on the **original baseline** which was submitted for the **NHSE plan in 2017** and is based on a definition which predates that which has now been set nationally. This was used to provide the programme with an early indication of performance in the context of a lack of clarity and information regarding the national definition.

2) **Local Position** which is calculated using data that is collected locally, based on the national definition and monitored locally to understand the current position.

3) **National Mental Health Data Set (MHSDS) position** which is based on the data that is submitted to the MHSDS and is expected to be used for monitoring the indicator nationally by NHSE. Currently only a limited amount of local data is flowing to the MHSDS.

NHSE have advised to continue to monitor against all 3 of the above until a decision has been made nationally as to whether the plan should be re-submitted based on new local position (2 above) and whether the MHSDS will be used to monitor the indicator for 17/18 period.

1. Access Targets as per the NHSE submitted plans

CCG	Total no. of CYP aged 0-18 with a diagnosable mental health condition.	16/17 Baseline (Ref accepted)		16/17 Baseline (1st Treatment)		2017/ 18	2018/ 19	2019/ 20	2020/ 21
						30%	**32%**	**34%**	**35%**
Blackburn with Darwen	3871	**762**	20%	**463**	12%	**1161**	**1239**	**1316**	**1355**
Blackpool	2952	**1298**	44%	**767**	26%	**886**	**945**	**1004**	**1033**
Chorley South Ribble	3227	**700**	22%	**349**	11%	**968**	**1033**	**1097**	**1129**
East Lancashire	8115	**1747**	22%	**1058**	13%	**2435**	**2597**	**2759**	**2840**
Fylde and Wyre	2293	**548**	24%	**260**	11%	**688**	**734**	**780**	**803**
Greater Preston	3975	**736**	19%	**378**	10%	**1193**	**1272**	**1352**	**1391**
Morecambe Bay	6398	**NA**	NA	**NA**	NA	**1919**	**2047**	**2175**	**2239**
-Lancashire North	3059	**468**	15%	**304**	10%	**918**	**979**	**1040**	**1071**
-South Cumbria	3339	**NA**	NA	**NA**	NA	**1001**	**1068**	**1135**	**1169**
West Lancashire	2040	**397**	19%	**237**	12%	**612**	**653**	**694**	**714**
Lancashire	32,871					**9861**	**10519**	**11176**	**11505**

2. Access Targets as per the Local calculated position

		Part 1a: The number of children and young people with a new referral from 1st January 2016, receiving at least two contacts (including indirect contacts) within a six week period where their first contact occurs before their 18th birthday		Part 2a: The number of children and young people, regardless of when their referral started, receiving at least two contacts (including indirect contacts) and where their first contact occurs before their 18th birthday					
CCG	Total no. of CYP aged 0-18 with a diagnosable	16/17 Baseline Actuals (CYP New Referrals receiving at least 2 contacts within 6 weeks period)		16/17 Baseline Actuals (All CYP) versus 28% Target		2017/18 @ 30% Target	2018/19 @ 32% Target	2019/20 @ 34% Target	2020/21 @ 35% Target
Blackburn with Darwen	3871	**291**	8%	**767**	**20%**	1161	1239	1316	1355
Blackpool *	2952	**624**	21%	**1154**	**39%**	1235	1321	1414	1513
Chorley South Ribble *	3227	**461**	14%	**987**	**31%**	1056	1130	1209	1294
East Lancashire	8115	**799**	10%	**1769**	**22%**	2435	2597	2759	2840
Fylde and Wyre *	2293	**418**	18%	**818**	**36%**	875	937	1002	1072
Greater Preston	3975	**417**	10%	**905**	**23%**	1193	1272	1352	1391
Morecambe Bay	6398	**323**	5%	**548**	**NA**	1919	2047	2175	2239
-Lancashire North	3059	**323**	11%	**548**	**18%**	**918**	**979**	**1040**	**1071**
-South Cumbria	3339	**NA**	**NA**	**NA**	**NA**	**1002**	**1068**	**1135**	**1169**
West Lancashire *	2040	**295**	14%	**574**	**28%**	614	657	703	752
Lancashire & SC CCGs Total	**32,871**	**3,628**	11%	**7,522**	**23%**	**10,488**	**11,200**	**11,930**	**12,457**

* CCGs with asterisk have achieved the access targets (see table below for details) during 2016/17 period therefore furture years target has been based on 7% increase on activity. Please note that the 2019/20 and 2020/21 trajectories may be amended dependant on actual performance and new guidance during the re-submission of the CCG plan.

Please note that the local position is based on main providers[7], voluntary sector providers data is to be included in future monitoring.

[7] Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire Care NHS Foundation Trust.

3. Access Targets position based on MHSDS

CCG	Part 2a	Prevalence Annual(2B)	Target Achieved	Part 1a
NHS Blackburn With Darwen CCG	60	3871	**2%**	37
NHS Blackpool CCG	850	2952	**29%**	470
NHS Chorley And South Ribble CCG	100	3227	**3%**	65
NHS East Lancashire CCG	150	8115	**2%**	105
NHS Fylde & Wyre CCG	120	2293	**5%**	70
NHS Greater Preston CCG	115	3975	**3%**	85
NHS Lancashire North CCG *	100	3059	**3%**	70
NHS West Lancashire CCG	60	2040	**3%**	30
Total	**1,555**	**29532**	**5.3%**	**932**

* Data unavailable for South Cumbria Practices for 2016/17 position therefore only Lancs North CCG position is included.

CCG trajectories for Eating Disorder

Pathway trajectories based on national clinical guidance

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 within 1 week	2016	2017	2018	2019	2020	2021
	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 within 4 weeks	2016	2017	2018	2019	2020	2021
	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

Pathway trajectories submitted for NHSE Planning Submission, based on the refresh request from NHSE for a number of CCGs to increase activity as part of the submission.

Routine (% seen within 4 weeks)

CCG	Q1 2017/18	Q1 2017/18	Q1 2017/18	Q1 2017/18
NHS BLACKBURN WITH DARWEN CCG	50%	50%	50%	50%
NHS BLACKPOOL CCG	100%	100%	100%	100%
NHS CHORLEY AND SOUTH RIBBLE CCG	40%	40%	60%	80%
NHS EAST LANCASHIRE CCG	50%	50%	50%	50%
NHS FYLDE & WYRE CCG	0%	0%	50%	50%
NHS GREATER PRESTON CCG	50%	55%	58%	62%
NHS LANCASHIRE NORTH CCG	33%	33%	33%	50%
NHS WEST LANCASHIRE CCG	100%	100%	100%	100%
Grand Total	**423%**	**428%**	**502%**	**542%**

Routine (No's seen within 4 weeks)

CCG	Q1 2017/18	Q1 2017/18	Q1 2017/18	Q1 2017/18
NHS BLACKBURN WITH DARWEN CCG	1	1	1	1
NHS BLACKPOOL CCG	1	2	2	2
NHS CHORLEY AND SOUTH RIBBLE CCG	2	2	3	4
NHS EAST LANCASHIRE CCG	2	2	2	2
NHS FYLDE & WYRE CCG	0	0	1	1
NHS GREATER PRESTON CCG	5	6	7	8
NHS LANCASHIRE NORTH CCG	1	1	1	2
NHS WEST LANCASHIRE CCG	10	10	10	10
Grand Total	**22**	**24**	**27**	**30**

Urgent (% seen within 1 week)

CCG	Q1 2017/18	Q1 2017/18	Q1 2017/18	Q1 2017/18
NHS BLACKBURN WITH DARWEN CCG	100%	100%	100%	100%
NHS BLACKPOOL CCG	100%	100%	100%	100%
NHS CHORLEY AND SOUTH RIBBLE CCG	100%	100%	100%	100%
NHS EAST LANCASHIRE CCG	50%	50%	50%	50%
NHS FYLDE & WYRE CCG	0%	0%	0%	100%
NHS GREATER PRESTON CCG	100%	100%	100%	100%
NHS LANCASHIRE NORTH CCG	0%	50%	50%	50%
NHS WEST LANCASHIRE CCG	100%	100%	100%	100%
Grand Total	**550%**	**600%**	**600%**	**700%**

Urgent (No's seen within 1 week)

CCG	Q1 2017/18	Q1 2017/18	Q1 2017/18	Q1 2017/18
NHS BLACKBURN WITH DARWEN CCG	1	1	1	1
NHS BLACKPOOL CCG	1	1	1	1
NHS CHORLEY AND SOUTH RIBBLE CCG	2	2	2	2
NHS EAST LANCASHIRE CCG	1	1	1	1
NHS FYLDE & WYRE CCG	0	0	0	1
NHS GREATER PRESTON CCG	5	5	5	5
NHS LANCASHIRE NORTH CCG	0	1	1	1
NHS WEST LANCASHIRE CCG	3	3	3	3
Grand Total	**13**	**14**	**14**	**15**

Workforce Baseline

The Healthier Lancashire and South Cumbria STP Local Workforce Action Board completed an initial baseline exercise to identify the current mental health workforce. While this still requires further validation, which is underway, it provides a good starting point to understand the collective picture.

Funded Posts - 2016

	Medical	Nursing and Midwifery	Allied Health Professional and Scientific, Therapeutic and Technical Staff	**Total Professionally Qualified Clinical Staff**	Support to Clinical Staff	Administrative and Infrastructure Staff	**GRAND TOTAL**
CYP	23	87	116	**226**	52	49	**327**
Adult IAPT	-	-	151	**151**	75	58	**284**
Perinatal	3	6	3	**12**	3	3	**17**
Crisis - CRHTTs	12	96	14	**122**	29	-	**151**
Liaison MH	12	46	3	**61**	3	9	**72**
EIP	3	23	12	**38**	9	9	**55**
Liaison & diversion	-	6	3	**9**	-	-	**9**
Total T.A.s	***52***	***264***	***301***	***617***	***171***	***127***	***915***
Core Acute	151	924	405	**1,480**	950	446	**2,876**
Core Community	125	773	342	**1,240**	796	374	**2,410**
Total Core	***275***	***1,697***	***747***	***2,720***	***1,746***	***820***	***5,286***
TOTAL	**327**	**1,961**	**1,048**	**3,337**	**1,917**	**947**	**6,201**

The Waterfall Modelling and forecasting helps to establish a visual representation of the potential workforce required to meet the requirements of the 5YFV MH and Stepping Forward documents.

Utilising this modelling, the following table illustrates the additional workforce required to deliver 'Stepping Forward' in Lancashire and South Cumbria. It suggests that mental health employers should create an additional 602 posts in the initial seven growth areas (130 for Children and young people); however services may equally choose to deliver care differently or use existing teams to deliver new targets.

Expansion Posts by 2021

	Medical	Nursing and Midwifery	Allied Health Professional and Scientific, Therapeutic and Technical Staff	**Total Professionally Qualified Clinical Staff**	Support to Clinical Staff	Administrative and Infrastructure Staff	**GRAND TOTAL**
CYP	6	35	20	**61**	64	6	**130**
Adult IAPT	-	-	84	**84**	46	-	**130**
Perinatal	3	14	6	**23**	12	-	**35**
Crisis - CRHTTs	-	133	6	**139**	67	-	**206**
Liaison MH	9	12	- 3	**17**	- 3	6	**20**
EIP	3	35	6	**43**	20	9	**72**
Liaison & diversion	-	9	-	**9**	-	-	**9**
Total T.A.s	***20***	***237***	***119***	***377***	***206***	***20***	***602***
Core Acute	-	-	-	**-**	-	-	**-**
Core Community	-	-	-	**-**	-	-	**-**
Total Core	-	-	-	**-**	-	-	**-**
TOTAL	**20**	**237**	**119**	**377**	**206**	**20**	**602**

Appendix 4 - 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 1 disagreed with the objectives and the majority (75%) agreed fully with them. All groups of respondents (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
	early intervention and emotional health is so important I particularly welcome the role of Primary Mental Health Workers	**Comment noted.**
	Inclusion health there needs to be more of a focus on vulnerable young people who do not access main stream services	**Comment noted.** **Objective 6 "Complementary offer" amended to include a particular focus on vulnerable young people who do not access main stream services.**
	easier access at times of need is important.	**Comment noted.** **This is reflected in Objective 13 "CAMHS Redesign".**

	issues around how young people will be helped around relationships and things to do as these are the areas they tell us help to support them how will young people be helped where mental health and substance misuse issues come together what community support will be in place	**Comment noted.** **This is reflected in Objectives 1 "Mental Health Anti-Stigma Campaign", 2 "Resilience Framework" and 3 "Resilience Training Programme".** **CAMHS currently work in partnership with substance misuse services to support children and young people where mental health and substance misuse issues co-occur.** **Objective 13 "CAMHS Redesign" includes a requirement for providers to work in partnership with other services to ensure CYP and families are supported holistically.** **This is reflected in Objective 6 "Complementary offer" and Objective 13 "CAMHS Redesign".**

	Children in school are becoming increasingly aware of their mental health and wellbeing issues ad there have in the past been very little support for them.	**Comment noted.** **This relates to Section 3 "What we have achieved in Year 2": 15 Primary Mental Health workers delivering the single point of contact and rolling out youth mental health first aid training for schools and primary care.** **In addition, Objectives 3 "Resilience training programme in schools", Objective 4 "Mental Health first aid courses" and Objective 5 "Schools mental health first aid" will support this work on an ongoing basis.** **The new Green Paper seeks to address these, once the white paper is published we will refresh the plan accordingly.**
	Can't see any reference to implementing Risk Support/AMBIT	**Comment noted.** **Additional Objective added to the plan "By 31st March 2019 we will have developed and agreed a risk support approach in line with THRIVE and drawing on the findings from the AMBIT pilot in Blackburn".**

	The refreshed plan certainly includes many much needed priorities. However, I am slightly concerned that LGB & T young people (and those questioning their sexual orientation or gender identity) have not been considered as a priority in terms of the specific health inequalities that they experience.	**Comment noted.** **Section 1 "Principles" to be amended to list the nine protected characteristics including LGBT.** **In taking forward all of the objectives within the Transformation plan thorough and detailed equality impact and risk analysis are undertaken to support and drive the design and delivery of services. These EIRAs ensure that the needs of all vulnerable groups are identified and reflected in service redesign.**
	Section 1 - Principles' - Point 3 highlights the need to recognise and respond to the needs of CYP and families from protected characteristics, however LGB&T young people have not been mentioned at all in the document. Additionally, LGB&T CYP have not been identified as a vulnerable group in the Objectives section.	

	Earlier this year, Lancashire Care Foundation Trust conducted their Year 9 School Health Needs Assessment in which 8,058 Year 9 students across Lancashire were surveyed about mental health, prevalences of bullying, and risk behaviours. 4% of the respondents identified as lesbian, gay or bisexual (correlating closely with national estimates of LGB&T population demographics). The findings highlighted many stark disparities between LGB students and their heterosexual counterparts in relation to mental health, bullying and risk behaviours. Some of the most pertinent findings included: 26.8% of lesbian and gay YPs and 33.3% of bi YPs reported often feeling unhappy (compared to 5.8% of heterosexual YPs) 51.3% of lesbian and gay YPs and 62.5% of bi YPs reported often feeling lonely (compared to 13.7% of heterosexual YPs) 38.1% of lesbian and gay YPs and 47.7% of bi YPs have self-harmed (compared to 8.6% of heterosexual YPs) 33.3% of lesbian and gay YPs and 35.3% of bi YPs reported being recently bullied (compared to 9.4% of heterosexual YPs) 7.5% of lesbian and gay YPs and 22.7% of bi YPs reported having experienced domestic violence/abuse (compared to 6% of heterosexual YPs) 23.8% of lesbian and gay YPs and 19.1% of bi YPs did not feel they had a trusted adult in their lives (compared to 6.2% of heterosexual YPs) 30% of lesbian and gay YPs and 32.4% of bi YPs perceived themselves to be overweight (compared to 17.3% of heterosexual YPs) Additionally, LGB young people were far more likely to smoke and consume alcohol than their heterosexual counterparts, and were less likely to be eating regularly and healthily. With regard to trans young people and those YPs questioning their gender identity, referrals to NHS Gender Identity Development Services for Young People have increase more than tenfold since 2009. National research highlights that trans YPs and those questioning their gender identity are at far higher risk of poor mental health, self-harm and suicide than their cisgender counterparts. As an organisation, Lancashire LGBT feels that there should be stronger consideration of LGBT YPs and those questioning their sexual orientation and gender identity within this strategy. Should you wish to gain further information from us regarding these issues to help inform the refresh of the transformation plan, please feel free to contact us (Lancashire LGBT) on 01772 717461 or hello@lancslgbt.org.uk	

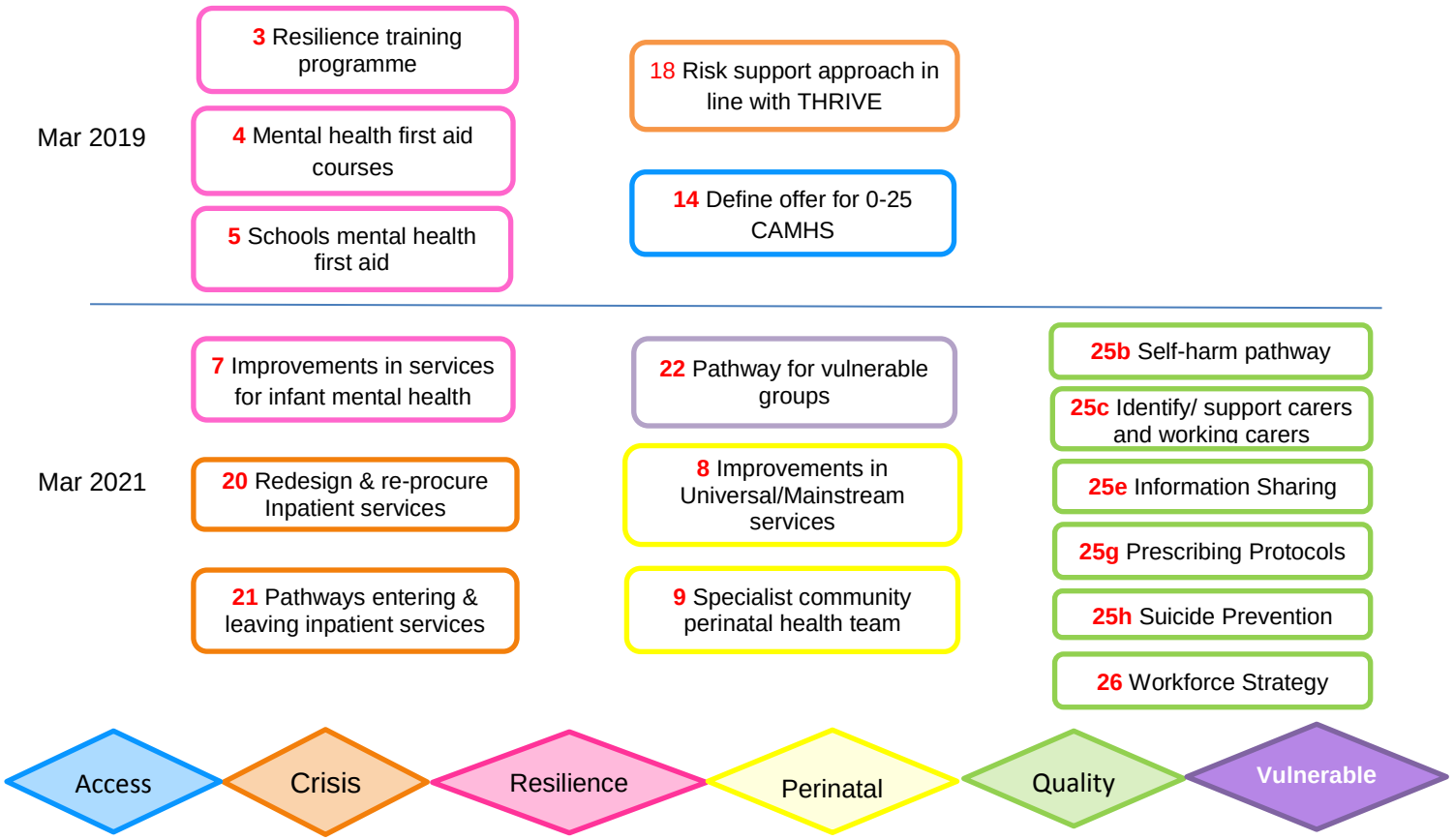
	I think there are a lot of Brilliant ideas and I am supportive of that but we do need to look at CAMHS going 24/7 or as close to that to support paediatric units/ED teams. This would potentially improve working relationships between agencies and teams and hopefully reduce admission rates and enable the child or young person to be managed in the community.	**Comments noted.** **This is reflected in Objective 12 "0-19".**
	the most vulnerable children appear to come last in the list of priorities. some of the prioritises within the plan have not met their deadlines, i.e. 0-19 CAMHS service by 30th September 2017, what are the contingency plans for this shortfall?	**Comments noted.** **The six key priorities going forward have been taken from the future in mind document[8]. The numbering of the objectives does not give any indication of the priority.** **We continue to work with providers to secure the provision of a 0-19 service. This is now Objective 12 "0-19".**
	huge improvements in all areas	**Comment noted.**
	24. c. By 31st March 2018 we will have scoped mechanisms to ensure that services consistently identify "carers and working carers", support carers Are we confident we have plans in place to deliver this? It is very short timescale.	**Comment noted.** **The date has been amended to March 2020 to reflect the Programme work.**

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

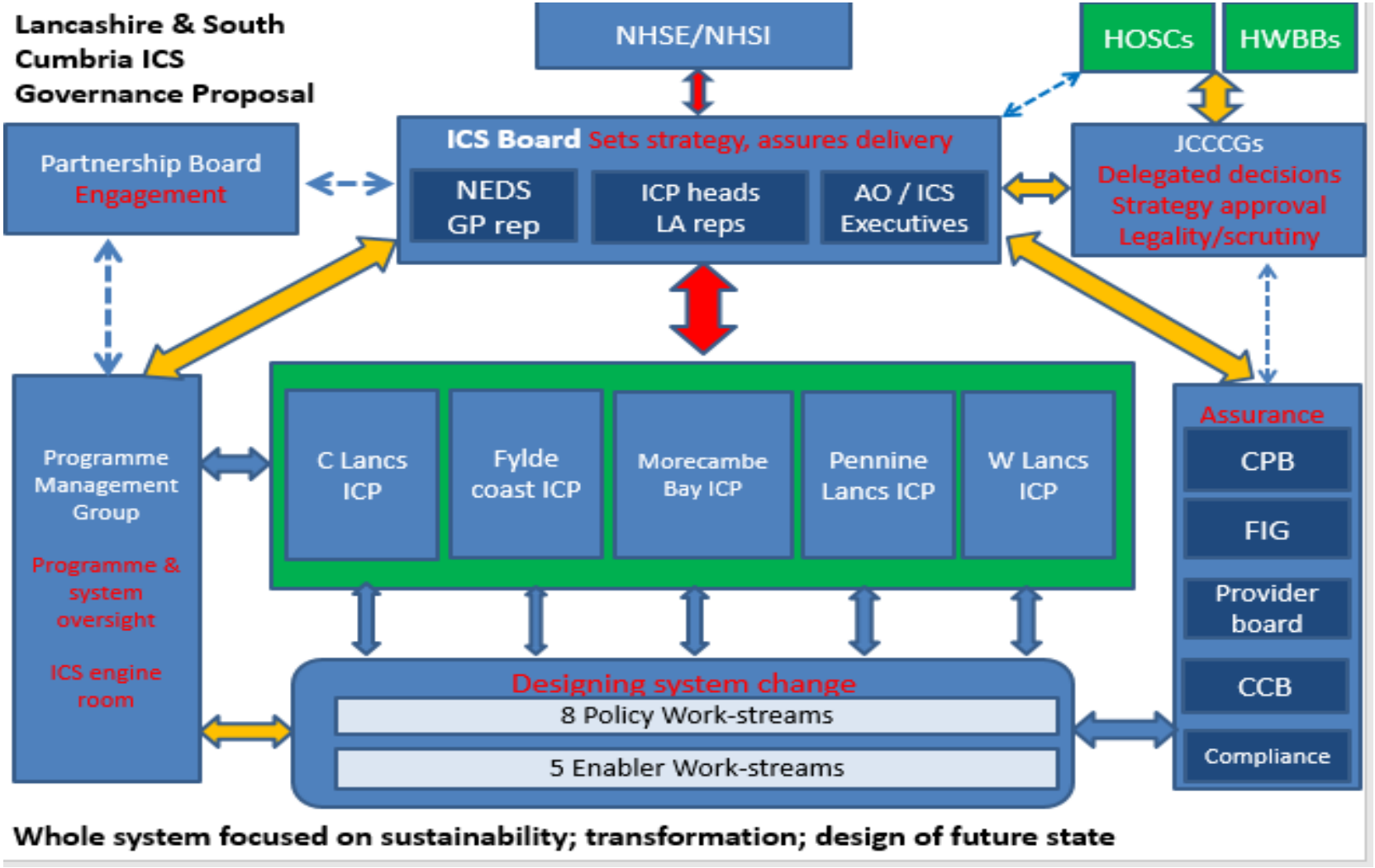
	Board Hijack	**In May 2017 the monthly Transformation board meeting was taken over (hijacked) by children and young people from across Lancashire and South Cumbria. Held in the evening to ensure accessibility for children and young people the event gave the children and young people a voice with the board and allowed them to dictate the running of the board, the agenda and have full control of the meeting. The CAHMS redesign will use the valuable information and recommendations from this event to form the redesign. A number of the recommendations from the CYP board Hi Jac are already underway, such as the recommendation that the website be simple and easy to read, we are currently in the process of co-producing the CYP website with children and young people to ensure that the language, design and functionality is appropriate and engaging.**

Appendix 5 Mental Health Transformation Plan Timeline

Children and Young People's Resilience, Emotional Wellbeing and Mental Health Transformation Plan Timeline.


Mar 2019
3 Resilience training programme
4 Mental health first aid courses
5 Schools mental health first aid
18 Risk support approach in line with THRIVE
14 Define offer for 0-25 CAMHS
Mar 2021
7 Improvements in services for infant mental health
20 Redesign & re-procure Inpatient services
21 Pathways entering & leaving inpatient services
22 Pathway for vulnerable groups
8 Improvements in Universal/Mainstream services
9 Specialist community perinatal health team
25b Self-harm pathway
25c Identify/ support carers and working carers
25e Information Sharing
25g Prescribing Protocols
25h Suicide Prevention
26 Workforce Strategy
Access
Crisis
Resilience
Perinatal
Quality
Vulnerable

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



Joint Committee of Clinical Commissioning Group's

Title of Paper	Perinatal Mental Health Community Service Development		
Date of Meeting		Agenda Item	6

Lead Author	Louise Giles / Paul Hopley	
Purpose of the Report	For Discussion	X
	For Information	
	For Approval	X
Executive Summary	Wave 2 of the National Perinatal Mental Health Community Services development fund has been launched. STPs are invited to submit investment proposals for the development of specialist teams during 2018/19. This is predicated on evidence that Mother and Baby Inpatient Units that serve large populations should be closely integrated with Specialist Mental Health Teams that provide direct services, consultation and advice to maternity, other Mental Health and Community Services. This ensures that; • Information is available for women, partners / family and professionals at all stages of their perinatal period. • Treatment is timely, evidence based, effective, personalised and compassionate. • Training, supervision and consultation are provided, especially to vulnerable mothers or direct family. In particular this will help reduce the risk of suicide in the perinatal period.	
Recommendations	To approve the proposal of the development and implementation of the Specialist Perinatal Community Team as per the national requirements outlined in the Mental Health Five Year Forward View.	

	To endorse a phased implementation. This will be required to mitigate any financial gaps from the allocated national transformational monies vs the local required investment for the Specialist team.
Equality Impact & Risk Assessment Completed	Yes – LCFT and the SCN have undertaken this as part of the bid development which resulted in a number of engagement exercises.
Patient and Public Engagement Completed	Yes – LCFT and the SCN have undertaken a number of engagement exercises which have also included relevant clinical groups. There is a follow up engagement event planned on the 23rd February with 80 stakeholders currently registered to attend.
Financial Implications	Yes – Please see below risk.
Risk Identified	Yes
If Yes : Risk	Financial Risk: Additional national baseline funding levels for Specialist Perinatal Mental Health are detailed in the Mental Health Five Year Forward View implementation plan and are as follows; • 19/20 is 73.5m (Indicative LSC share is £2.2m) • 20/21 is 98m (Indicative LSC share is £2.9m) The confirmed amount for LSC will be determined by the technical allocations formula. It will increase between the two years. There are national transformation monies for 18/19 of £40m (Indicative LSC share is £1.2m) The team as outlined in the presentation for 18/19 equates to a full year cost of operating the specialist team is £1,952,529. This leaves the LSC with a potential funding gap for 18/19 of **£752k.** **Mitigating Actions:** The outcome of the bid will not be known until May 2018 and the planned implementation would be from August 2018 and this would reduce the in-year cost to £1,301,686.

	This would reduce the potential funding gap to £101k. **Phased Implementation of Workforce**: This would mitigate remaining financial risk, as the team would be recruited within two phases which would not be expected to exceed the £1.2m indicative allocation. Following confirmation, this will need to be worked up into a full phased implementation for 18/19 to confirm that the mitigating actions will reduce the risk in full.
Report Authorised by:	Debbie Nixon

Preparing for Specialist Community Perinatal Services

Wave 2 Funding Application

NHS
Lancashire Care
NHS Foundation Trust

Specialist Services
Secure Services
Mental Health
Community Services
Children and Families

Supporting Health and Wellbeing

Implementing the 5 Year Forward View for Mental Health

Lancashire Care NHS Foundation Trust

Objective

"To support at least 30,000 more women each year can access evidence-based specialist perinatal mental health care"

"The objective above is clear that by 2020/21, specialist perinatal mental health services must be available to meet the needs of women in all areas."

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Case for Change

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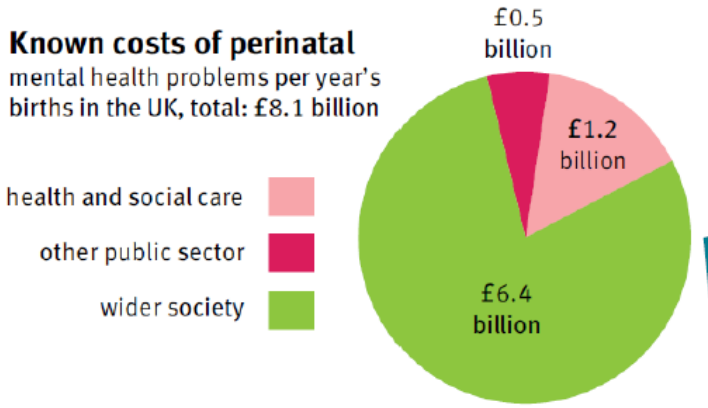
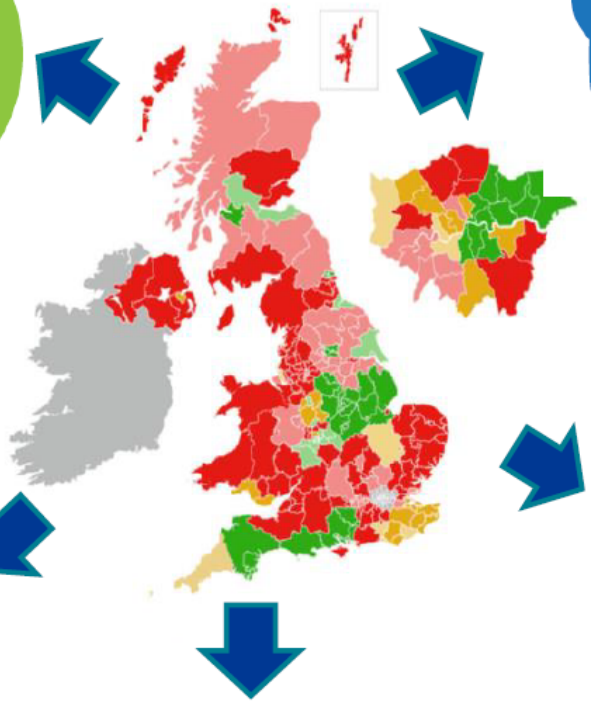
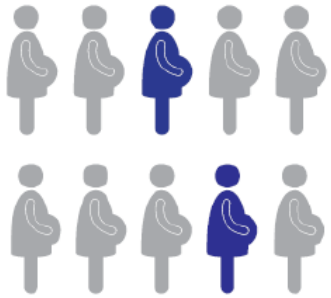
Known costs of perinatal mental health problems per year's births in the UK, total: £8.1 billion



28% relate to the mother

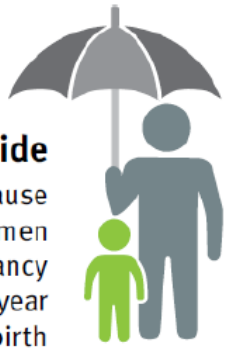
72% relate to the child





Up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth

Suicide is a leading cause of death for women during pregnancy and in the year after giving birth



Variation and inequality: in 2014 fewer than **15%** of localities provided specialist services for women with complex or severe conditions at the full level recommended in NICE guidance, and more than **40%** provided **no service at all**.

Source: LSE and Centre for Mental Health, *The cost of perinatal mental health problems* (2014) and Maternal Mental Health Alliance (map)

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Perinatal Mental Health: Commitments

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Mental Health Five Year Forward View & Implementation Plan

- Implementing the Five Year Forward View for Mental Health outlines a phased approach to **build capacity and capability in specialist perinatal mental health services** (community and inpatient).
- Outcomes focused on improving access and experience of care with joined up approaches; early diagnosis and intervention; and greater transparency and openness to support reduced stigma.

Funding

- **£365m** from 2015/16-2020/21 (prices in £m increase on 14/15)

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
	15	15	30	60	105	140

  - 2016/17- 2018/19 – setting infrastructure, incl. investment in workforce development, MBU procurement and pump-priming community services.
  - 2019/20 onwards – new money begins flowing to CCG baselines.

What do NHS England Want to See?

All *women can access appropriate, high-quality specialist mental health care, closer to home, when they need it during the perinatal period.*

Women and their families have a positive experience of care, with services joined up around them.

There is earlier diagnosis and intervention, and women are supported to recover and fewer women and their infants suffer avoidable harm.

There is more awareness, openness and transparency around perinatal mental health in order that partners, families, employers and the public can support women

Planning, Progress & Priorities: Five Year Phasing

Lancashire Care
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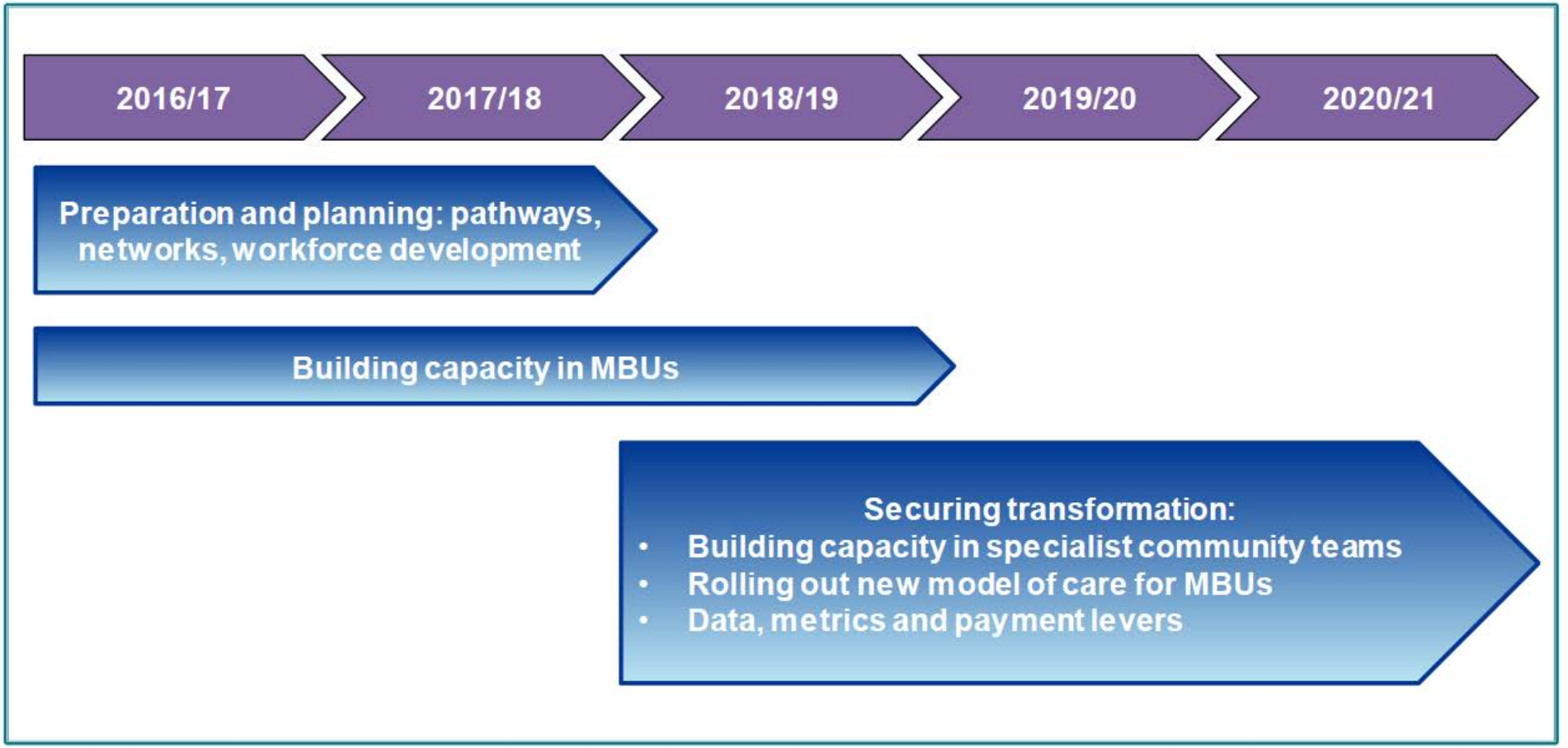

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Planning, Progress & Priorities: Five Year Phasing

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Preparation and planning

- Develop and publish robust, **evidence-based care pathways** that incentivise early intervention, holistic approaches to care and recovery to support commissioning and delivery.
- Invest in **perinatal MH networks** and ensure operating in all regions of the country to provide clinical expertise and leadership and support strategic planning (including local workforce strategies).
- Develop and deliver comprehensive **workforce strategy** to increase supply of specialist workforce. Develop and publish **MDT skills and competency framework** for recognition, treatment and support for women with perinatal mental health problems and support initiatives for education and training.

Building capacity

- **Increase mother and baby unit provision**, including delivery of new MBUs and increasing existing capacity where needed.
- Develop and implement strategic **collaborative commissioning models** so that inpatient mother and baby units serve the needs of large populations and are closely integrated with specialised community perinatal mental health teams.

Securing transformation

- Ensure that NICE-recommended, **specialist community perinatal services** are available in each locality, which provides direct services, consultation and advice to maternity, other MH and community services.
- Develop **data and outcomes measures** for perinatal mental health services (including maternal and infant outcomes) to measure and monitor improvement, activity and service provision, and review other levers to drive improvements.

Building a Better Service: Our Principles

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- Good services **promote prevention, early detection, diagnosis and effective treatment.** They are part of a **clinical network.**
- Providers and commissioners work in **partnership with parents and their families** to design, develop and improve the delivery of services to meet local need.
- Services require planning over a large footprint for economies of scale, with partnership working across mental and physical organisations with an expectation to **share information** and data as appropriate.
- **Information** is available for women, partners/family and professionals at all stages about mental health and wellbeing during the perinatal period.
- A good service will have a **comprehensive perinatal mental health strategy** and there should be **clear patient pathways** which promote **seamless, integrated and comprehensive care** for women and their families, and across organisational and professional boundaries.
- **Treatment is timely, evidence based, effective, personalised and compassionate**.
- **Training, supervision and consultation** provided by specialist perinatal teams. The specialist service should also ensure there is engagement with services that provide for vulnerable mothers, their partners, infants and families who are **at risk** of experiencing mental disorder during the perinatal period.
- Mother and Baby Units should be closely **integrated** with specialised community teams to promote early discharge and seamless continuity of care.

Sources: *JCP for Mental Health, Guidance for Commissioners of Perinatal Mental health Services* (2012), *NICE, APMH guidance (2014), London Strategic Clinical Network, Draft PMH Service Specification (2016), NHS IQ, Improving Access to Perinatal Mental Health Services in England – A Review, (2015).*

What's Happened? MBU Developments

Lancashire Care
NHS Foundation Trust

Support for expanding **Mother and Baby unit** capacity

- eight extra beds in existing units commissioned on sustainable basis
- Contracts for four new, eight-bedded units awarded and implementation has started:
  - North West – Lancashire Care FT (July 2018)
  - East Anglia - Norfolk and Suffolk FT (operational early 2019)
  - South West – Devon Partnership Trust (early 2019)
  - South East Coast – Kent and Medway Partnership Trust (July 2018)
- Investment in existing MBUs for quality improvement initiatives.

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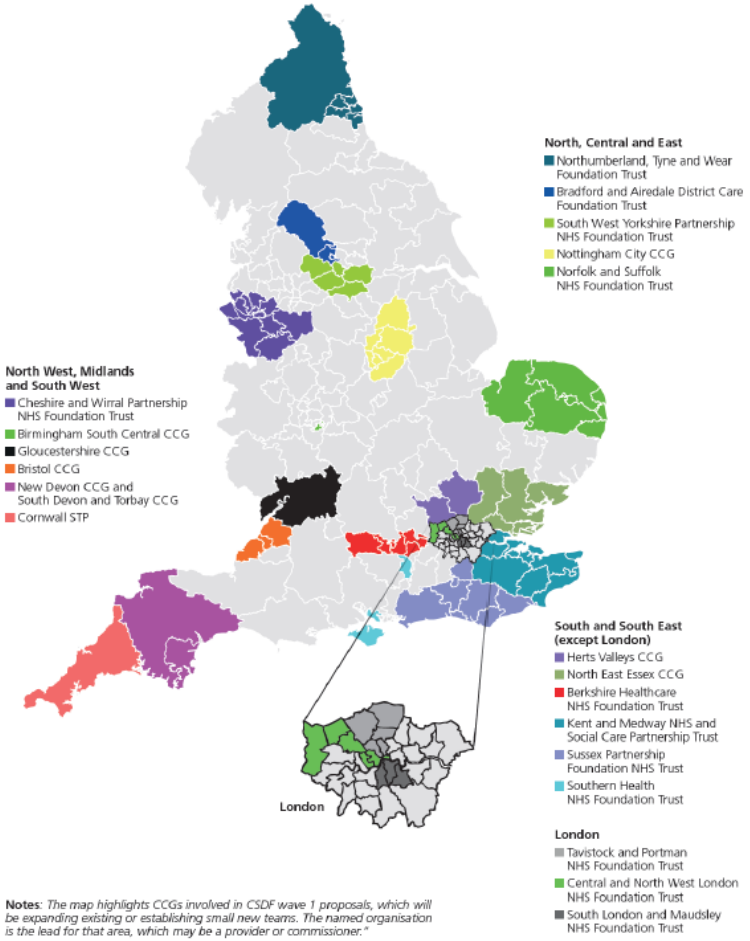
What's Happened? Specialist Community Services

Lancashire Care
NHS Foundation Trust

Support for developing specialist PMH teams through **Community Services Development Fund**.

- Wave 1 - £40m to 20 areas 16/17-18/19
- Wave 1 coverage: 90 CCGs, 6 STPs
- **Over 236** new specialist staff recruited to date, including **21 consultant psychiatrists, 105 PMH practitioners (nurses and OTs), 28 psychologists.**
- **Over 5,000 additional women** accessed these services between April and December 2017. Expected to exceed 6,000 by end of 2017/18.

Specialist perinatal mental health community teams – Community Services Development Fund Wave 1



Notes: *The map highlights CCGs involved in CSDF wave 1 proposals, which will be expanding existing or establishing small new teams. The named organisation is the lead for that area, which may be a provider or commissioner."*

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What's Happened? Specialist Community Services

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Wave 2 of the perinatal mental health community services development fund has been launched – STPs are invited to submit investment proposals for the development of specialist teams during 2018/19.

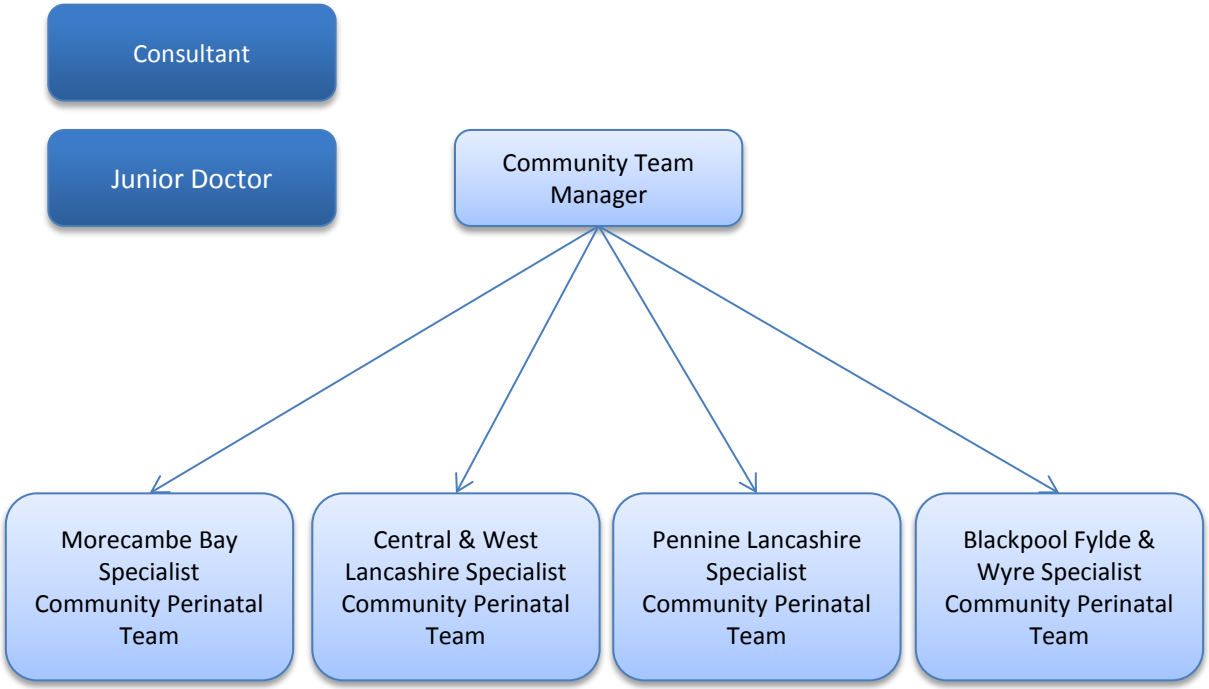
Additional national baseline funding levels for specialist perinatal mental health are detailed in the Mental Health Five Year Forward View implementation plan.

Allocations from 2019/20 onwards will be made to all CCGs in England based on the NHSE standard funding formula, supporting sustainable commissioning of specialist perinatal mental health services.

Specialist Community Teams Proposed Structure

Lancashire Care NHS Foundation Trust

4 Teams to manage Specialist Community Perinatal Services across the Lancashire & South Cumbria STP Footprint



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Specialist Community Teams Based on Royal College Guidelines and Expert Advice

Lancashire Care NHS Foundation Trust

Role	Proposed
Consultant	2 WTE
Junior Doctor	2 WTE
Specialist Community Psychiatric Nurse	12 WTE
Link Health Visitor	Existing Services
Link Liaison Midwife	Existing services
Clinical Psychologist	2 WTE
Mobilisation Manager (Year 1)	1 WTE
Community Team Manager	1 WTE
Occupational therapist	2 WTE
Community Nursery Nurse	Split of approx. 5.0 WTES
Health & Wellbeing Practitioner	
Admin/Sec	Minimum 2.5 WTE

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CCG Breakdown

CCG Area	Live Births	%	2018-19	2019-20
Morecambe Bay	*3024*	*16.29%*	*318,145*	*308,301*
East Lancs	*4724*	*25.45%*	*496,996*	*481,619*
Greater Preston	*1879*	*10.12%*	*197,683*	*191,567*
Chorley & South Ribble	*2477*	*13.35%*	*260,597*	*252,534*
Fylde&Wyre	*1599*	*8.62%*	*168,225*	*163,020*
West Lancs	*1076*	*5.80%*	*113,202*	*109,700*
BwD	*2115*	*11.40%*	*222,512*	*215,627*
Blackpool	*1665*	*8.97%*	*175,169*	*169,749*
STP Totals	**18559**		**1,952,529**	**1,892,117**

Based upon 18559 Births in Lancashire & South Cumbria and advice given from Dr Alain Gregoire we propose this staffing model

This staffing model as been costed at:
£1,952,529 year 1 & ongoing costs of £1,892,117 (Including 20% relief for Nurses and Nursery Nurses only and non pay costs estimated at **£212,280**)

Provision 9-5 Mon-Fri

Each CCG area's live births have been calculated as a % of the total live births for the STP area. This % split has then been applied to the total cost of the Specialist Community Teams to calculate each CCGs contribution

Specialist Community Teams
A Phased Implementation

Lancashire Care
NHS Foundation Trust

3 Phases for implementation – Recommended by NHSE after failed wave 1 bid

Phase	One	Two	Three
Area	Barrow-In-Furness Blackburn	Grown from Barrow-In-Furness to establish Morecambe Bay Team Grown from Blackburn to establish Pennine Lancashire Team	Implement in Blackpool, Fylde & Wyre and Central & West Lancashire
Rationale	Commencing provision in targeted localities that currently have no perinatal services	Encompass the wider areas with no perinatal provision when ready and gathering learning to inform remaining rollouts	Building upon and supplementing existing provision
Timescale	First 2/3 Months	First 3 months to 8 months	8 months onwards

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Specialist Community Teams Our Model By Team

Lancashire Care NHS Foundation Trust

Role	Phase 2 (Expanded from Phase 1)		Phase 3		Total
	Pennine Lancashire	Morecambe Bay	Blackpool, Fylde & Wyre	Central & West Lancashire	
Consultant	0.7	0.4	0.3	0.6	2
Junior Doctor	0.7	0.4	0.3	0.6	2
Specialist Community Psychiatric Nurse	4	2	2	4	12
Link Health Visitor	Use existing services				0
Link Liaison Midwife	Use existing services				0
Clinical Psychologist	0.7	0.4	0.3	0.6	2
Community Team Manager	1				1
Occupational therapist	0.7	0.4	0.3	0.6	2
Social Worker	Recommended removed				
Community Nursery Nurse / Community Wellbeing Practitioner	2	1	0.7	1.3	5
Admin/Sec	2.5				2.5

Supporting Health and Wellbeing

Joint Committee of Clinical Commissioning Group's

Title of Paper	A briefing on the Lancashire and South Cumbria Commissioning Policy Development & Implementation Working Group's (CPDIG's) review of clinical commissioning policies.		
Date of Meeting	01.03.2018	Agenda Item	8

Lead Author	Rebecca Higgs IFR Policy Development Manager, NHS Midlands and Lancashire CSU Senior Workstream Lead: Jonathan Horgan, Chair of the CPDIG, Head of Medicines and IFR/Policy Services, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The CPDIG has undertaken a review of existing CCG policies on dilatation and curettage, hysteroscopy, hip arthroscopy and cosmetic procedures. This review is now complete and revised and updated policies have been prepared. The JC CCG is asked to ratify the policies.	
Recommendations	That Pan-Lancashire policies on the following procedures are ratified; dilatation and curettage, hysteroscopy, hip arthroscopy and cosmetic procedures.	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	Yes	
Financial Implications	No	
Risk Identified	No	
If Yes : Risk		
Report Authorised by:		

Briefing for the Joint Committee of CCGs (JC CCG) on the review of clinical commissioning policies.

Introduction

1. This report is to appraise the JC CCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to review the existing Lancashire and South Cumbria commissioning policies on *dilatation and curettage and hysteroscopy* and *hip arthroscopy* and to revise the existing eligibility requirements for 24 procedures contained in intervention specific policies in to a new, collaborative policy on *cosmetic procedures*.

CPDIG review process

2. The review of the policies was conducted to ensure they continue to reflect the current evidence base and support CCGs in the effective management of available resources.

3. The development and review of the policies has been completed in accordance with the process approved by the CPDIG, which has been shared previously. The JC CCG should be aware that for a number of policies this process, including the evidence review and setting of the initial criteria, commenced under the predecessor group; the Lancashire Commissioning Policies Group (CPG).

4. The following steps were undertaken during the review of the policies; an evidence review by an allocated policy lead, public engagement, stakeholders, including primary and secondary care clinicians, were given an opportunity to comment on the policies and the Healthier Lancashire and South Cumbria's Care Professionals Board (CPB) was consulted. The financial implications were considered and an Equality Impact and Risk (EIA) Assessment was undertaken. Amendments were made to the policies during the consultative process.

5. The policies were presented to the CPB on the following dates; 27.10.2017: *Policy for Cosmetic Procedures*, 24.11.2017: Policies for *Dilatation and Curettage, Hysteroscopy* and 22.12.2017: *Policy for Hip Arthroscopy*. The Board provided their support for all the policies to proceed to ratification, pending the completion of the public engagement process.

6. The CPDIG were presented with the outcome of the public engagement period on all four policies on the 15.02.2018[1-3], when members agreed that no changes were required to the Policies for *Dilatation and Curettage, Hysteroscopy* and *Hip Arthroscopy*. However, a number of limited changes were agreed for the *Policy for Cosmetic Procedures* to provide further clarity on the CCGs position regarding areas such as psychological impact and the scope of the policy, which members of the

public had queried during the engagement exercise. Members then agreed that the policies were ready for ratification.

7. The existing Pan Lancashire and South Cumbria Policy for Dilatation and Curettage and Hysteroscopy has been separated into two intervention specific policies, however there have been no change to the policy criteria. The *Policy for Hip Arthroscopy* remains unchanged for all CCGs, except NHS Blackpool CCG who currently have a criteria-based policy for this intervention. The policy will therefore reduce patient access to this service in that area. The *Policy for Cosmetic Procedures* contains eligibility criteria for 24 procedures. There is a variance in the existing policy criteria enforced by CCGs for these procedures, therefore the impact of the revised policy on access to these services varies depending on both the CCG and procedure in question. Copies of the policies are available to view via the following links:

   Policy for Dilatation and Curettage: https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EQHMzg9V4a5Kjh7NfWZH1z0BFZrwv99TatShPyiEy0JJBQ
   Policy for Hysteroscopy: https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EdVLsoLvNAZPpmzqErfW88sBXMadQjdlpIZlAbZFNAfF5g
   Policy for Hip Arthroscopy https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EbfFgeirBaFDonZ5Ag--tacBVKD-ll4z2fEgdJ8AjoKA2Q
   Policy for Cosmetic Procedures https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EZGkNoWd3ddAr7rZXTC8gvABBlHc4pw9r6i3jg_aZ3DBkQ

8. A stage one Equality and Impact Risk Assessment (EIA) has been undertaken on the policies for *Dilatation and Curettage*[4] *and Hysteroscopy*[5] and no areas of concern were highlighted. A stage two EIA has been undertaken on the *Policy for Hip Arthroscopy*[6], this highlighted risk in relation to the lack of response in the engagement exercise. However, the CPDIG were satisfied that reasonable attempts at engagement had been undertaken for this policy and it would not be appropriate to carry out a further engagement exercise.

9. A stage two EIA has been undertaken on the *Policy for Cosmetic Procedures*[7]. The EIA initially identified a risk score of 9 for this policy because of the potential impact on patients with protected characteristics. Legal advice was therefore sought on this area[8] and extensive public engagement was undertaken to mitigate this risk. As a result, amendments were made to the Policy for Cosmetic Procedures and the risk score was revised to 6. The CPDIG was content that all possible steps had been taken to mitigate this risk.

Financial implications

10. As there are no changes to either the *Policy for Hysteroscopy* or the *Policy for Dilatation and Curettage* the updated policies for these procedures are not expected to have a financial implication.

11. The *Policy for Hip Arthroscopy* is not expected to have a negative financial implication for any CCG. It would be expected that NHS Blackpool CCG will incur a cost improvement as a result of the return to their previous position of not routinely commissioning this intervention. However, the existing criteria-based policy was only ratified in January 2017 and this is not historically an area of high activity therefore the overall impact is expected to be low.

12. The baseline data provided by Midlands and Lancashire Commissioning Support Unit's (MLCSU's) Business Intelligence (BI) Team on expenditure levels for these procedures in the 12 months prior to February 2017 when this workstream was initiated demonstrated the expenditure on *dilatation and curettage and hysteroscopy* during that period across Lancashire and South Cumbria was £1,571,689 and the expenditure on hip arthroscopy for the same period was £55,571.[9]

13. The changes to the *Policy for Cosmetic Procedures* are expected to have a positive impact and reduce CCGs overall expenditure on these procedures. However, the CPDIG have identified that the ability to precisely forecast the expected change in expenditure levels for the procedures where policy criteria have been amended is impeded due to the level at which data regarding existing expenditure is available.

14. However, for those procedures that have moved from criteria-based policies to a position of "not routinely commissioned" the CPDIG expects that activity and expenditure levels will decrease significantly. A reduction of 90% has therefore been applied to the expenditure on these procedures in the financial year 2016-2017 to forecast the possible savings that may occur. A 100% decrease has not been applied as the possibility for activity to occur due to exceptionality via the Individual Funding Request (IFR) route will remain. This has demonstrated that on these procedures alone, a potential saving of £333,670 may be expected across Lancashire and South Cumbria in the financial year that follows provider implementation.

15. The overall potential financial impact and the limitations of the available data were detailed in a briefing paper and considered by the CPDIG in February 2018, who agreed that activity levels would be monitored post-ratification to provide a fuller understanding of the total cost reduction experienced.[10]

Conclusion

16. The JC CCG is asked to ratify the following policies on behalf of all eight CCGs and to rescind the existing intervention specific policies:

    - The revised *Policy for Dilatation and Curettage*
    - The revised *Policy for Hysteroscopy*
    - The updated *Policy for Hip Arthroscopy*
    - The revised *Policy for Cosmetic Procedures*

17. Once the JC CCG has taken a decision on the recommendations within this paper arrangements will be made for the collaborative implementation of the policies.

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