

Lincolnshire Local Transformation Plan

For Children and Young People's Mental Health and Wellbeing



NHS
South Lincolnshire
Clinical Commissioning Group

NHS
Lincolnshire West
Clinical Commissioning Group

NHS
South West Lincolnshire
Clinical Commissioning Group

NHS
Lincolnshire East
Clinical Commissioning Group

Lincolnshire
COUNTY COUNCIL
Working for a better future

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Version Control			
Date	Version	Date Due for Renewal	Reason for Renewal
Sept 2015	1.0	March 2016	

Acronyms

C&YP	Children & Young People
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CWD	Children with Disabilities
CYPP	Children & Young People's Plan
CYPSP	Children & Young People's Strategic Partnership
CYPVSF	C&YP Voluntary Sector Forum
JSNA	Joint Strategic Needs Assessment
LAC	Looked after Children/ Child
LCHS	Lincolnshire Community Health Services NHS Trust
LHS	Lincolnshire Health Services
LLDD	Learners with Learning Difficulties and/or Disabilities
LPCF	Lincolnshire Parent Carer Forum
LPFT	Lincolnshire Partnership NHS Foundation Trust
SEND	Special Educational Needs and/or Disabilities
SENDSAP	Special Educational Needs & Disability Statutory Assessment & Provision
ULHT	United Lincolnshire Hospitals NHS Trust
V4C	Voices for Choices
VCS	Voluntary/Community Sector

1. Executive Summary and Key Proposals

1.1 Background

- 1.1.1 Key agencies in Lincolnshire have come together to plan, develop and design a single approach to transform mental health and wellbeing services for Lincolnshire Children and Young People.
- 1.1.2 This Transformation Plan is consistent with the strategic outlook described in the multi-agency led Lincolnshire Crisis Care Concordat.
- 1.1.3 Lincolnshire has embraced the opportunity to review its existing services and develop its support for young people in line with best practice and national guidance, such as Future In Mind and Local Transformation Planning guidance. This plan sets out multiple priorities for service provision and ambitious aspirations for future provision that will require radical service transformation and ongoing joint working across agencies including Schools and Health and also Service Users.
- 1.1.4 The culmination of this strategy will include an executive action plan that will identify the work that needs to be undertaken to sustain continuous delivery, respond to changing local needs and empower the voice of Lincolnshire's young people.

1.2 Key Actions Undertaken To Date

- In-depth assessment has been carried out of the existing CAMHS provision, including the volume, capacity, specialism, effectiveness and location to aid future provision planning
- The views of a breadth of key stakeholders have been sought
- Collaboratively, the Local Authority and the four CCG's have explored the financial commitment to the service for the next three years in a challenging fiscal landscape and co-developed a further Section 75 Agreement
- Developed a multi-faceted, robust and comprehensive service specification with industry experts
- Ensured the appropriate breadth of services are joined up and are working in an integrated approach to meet the requirements and challenges to ensure a future proof service
- Enhanced development of various Pathways, including Behaviour , Self-Harm and Transition Pathways

1.3 Review

- 1.3.1 This Local Transformation Plan, collaboratively developed with CCG's, will be reviewed at the September 2015 Health and Well Being Board, shared with NHS Specialist Commissioning and other key agencies for input ¹ annually and actions will be monitored as

¹ Please note stakeholder communication plan on page 111

part of the monthly commissioning review meetings. Key measures will be developed to monitor the success of the Local Transformation Plan which will include:

- Engagement of multi agencies and input to annually revised Plan
- Work achieved in response to priorities identified by gap analysis
- Increased financial efficiency and spend
- Improved Outcomes for C&YP demonstrated through increased stakeholder engagement

1.3.2 The Local Transformation Plan will be approved by the Health and Wellbeing Board and the Women and Children's Board, with subsequent variations and annual action plan reviews subject to the same governance arrangements.

1.4 Executive Action Plan

1.4.1 Below is the Executive Action Plan which demonstrates the actions for 2015/16. It is intended that the Action Plan will set revised strategic and operational targets on an annual basis for the next three years. These targets should directly relate to the implementation of the Lincolnshire Transformation Plan and should include multiple agencies.

Strategic Milestones that will support implementation of the Lincolnshire Transformation Plan				
Ambition One: Improving public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled				
Ambition One Actions				
	Action	Timescale	Led By	Outcomes
1	Schools, Online Counselling Service, LPFT and other agencies as identified to work with Lincolnshire Youth Cabinet	March 2016	Schools, Xenzone, LPFT	<ul style="list-style-type: none"> • Raise awareness of Mental Health • Ensure service users feel comfortable talking about their needs with peers and in the School environment
2	Training days allocated within the CAMHS revised model to raise awareness with front line practitioners to increase their understanding of mental health issues	Ongoing	Agencies identify key staff, LPFT to deliver	<ul style="list-style-type: none"> • Increased awareness will lead to earlier intervention with service users, whilst their needs are at lower levels • C/YP feel more confident to raise and discuss mental health with their peers but also parents, carers and professionals

3	Training, sharing of promotional materials and best practice with professionals across multi-agencies	Ongoing	All	<ul style="list-style-type: none"> • Raise awareness of issues and encourage cross-sector learning and peer to peer support so learning can continue outside of direct training days • Practitioners feel empowered and engaged and more likely to spot early signs of mental health needs and respond • Promote the Local Transformation Plan
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Ambition Two: Timely access to clinically effective mental health support when Children and Young People need it

Ambition Two Actions

	Action	Timescale	Led By	Outcomes
4	Reduce routine waiting times from current CAMHS model resulting in a significantly shorter wait period for Lincolnshire YP than the national indicator recommends	Jan 2016	LPFT, LCC	<ul style="list-style-type: none"> • Young People are seen as soon as possible to stop their issues from escalating • Ensure our waiting times are comprehensive and in line with national trajectory, including waiting times for Eating Disorders • Service users and their families, Practitioners and other stakeholders are clear about the service they can expect
5	Implementation of emergency, out of hours and crisis support (Tier 3+)	Jan 2016	LPFT, LCC	<ul style="list-style-type: none"> • The most vulnerable young people are supported as they receive emergency intervention when required • Young people receive community based support as close to home as possible, leading to a reduction in inpatients and out of county provision, a reduction in travel time for the service user and better outcomes as the young person can stay closer to peers, family and existing support networks • Reduction of more costly, out of county provision
6	Waits for the service will be monitored and tracked through robust contract management	Jan 2016	LPFT, LCC	<ul style="list-style-type: none"> • Any issues can be identified as soon as is possible, a plan for

				<p>resolution identified and tracked</p> <ul style="list-style-type: none"> Any breaches in wait times can be understood and a plan put in place to monitor improvement Service users, their families and stakeholders can be confident in the local CAMHS offer Service is cost effective
7	Implementing a Single Point of Referral	Jan 2016	LCC LPFT	<ul style="list-style-type: none"> Simplifying access to the service Empowering self-referral If professionals understand how to access the service they will feel more confident to use it and will access the service when needed Access to the right service, first time Greater understanding of the needs of the local population Reducing inappropriate referrals
8	Implementing a dedicated community eating disorders service	Ongoing	LPFT, ULHT, LCC	<ul style="list-style-type: none"> Access to a dedicated community service delivering evidence based care. NICE concordant treatment to start within a maximum of 4 weeks from first contact

Ambition Three: Service built around the needs of children, young people and their families

Ambition Three Actions

	Action	Timescale	Led By	Outcomes
9	Engagement with children and young people through a variety of sources including Lost Luggage and Young Inspectors	Ongoing	LCC, LPFT	<ul style="list-style-type: none"> Young People are experts by experience and there should be no service about them, without them. By listening to the views of C/YP we will ensure the Local Transformation Plan reflects the needs of our local population We will increase the confidence of C/YP to challenge agencies when

				they aren't doing a good job and we can use this feedback as part of continuous service improvement
10	Empower Parents/Carers and families to understand the Local Transformation Plan by creating web based platform that explains the local universal services available	Ongoing	LCC, LPFT	<ul style="list-style-type: none"> Parents and Carers will know where they can go to access support Utilise digital tools effectively, offering people the opportunity to engage with services online rather than face to face as a first point of contact Online content is available anywhere, anytime which could support working families
11	Work in partnership with C/YP, their Parents and Carers in reviewing care pathways (such as Behaviour, Self-Harm and Transition pathways) and services to ensure these meet their needs	Ongoing	LCC, LPFT	<ul style="list-style-type: none"> Through participation, these views will be embedded into the service and as a result pathways can be improved
12	Ensure services are joined up locally	Ongoing	All	<ul style="list-style-type: none"> This will lead to reduction in costly duplicate working and share best practice across agencies Service users will feel supported by a range of agencies Service users can expect consistency from whichever agency they feel most comfortable to approach Young people receive the support they need and there are no gaps in service
13	Having lead commissioning arrangements in every CCG area for C/YPs mental health and wellbeing	Ongoing	CCG	<ul style="list-style-type: none"> This will lead to joined up and effective commissioning across the County

Ambition Four: Increased use of evidence based working and outcome monitoring

Ambition Four Actions

	Action	Timescale	Led By	Outcomes
14	The CAMHS model will include outcome monitoring such as CORC, CHI-ESQ, OOCAMHS, PROM and ROM and SDQ	Jan 2016	LPFT	<ul style="list-style-type: none"> C/YP will be active participants in their treatment

				<ul style="list-style-type: none"> Clinical improvements will be measured Rigorous measurement of outcomes becomes routine
15	The model will ensure an appropriately trained workforce reflective of C/YP IAPT is in place	Jan 2016- Jan 2018	LPFT	<ul style="list-style-type: none"> Improved skill set of the workforce Professionals working with C/YP are able to respond to a broader range of needs – a workforce will be developed with the right mix of skills and competencies to complement existing experience

Ambition Five: Making Mental Health support more visible and easily accessible for Children and Young People

Ambition Five Actions

	Action	Timescale	Led By	Outcomes
16	Implementation of the Single Point of Referral	Phased pilot by April 2016	LCC, LPFT	<ul style="list-style-type: none"> Simplifying access to the service Promoting universal services through web based platform which will help families and service users to understand what is out there to help them
17	Promotion of the Service / Promotion in Schools	April 2016	LPFT, LCC	<ul style="list-style-type: none"> Promoting how to access the service will help professionals feel that it is more accessible
18	Named Points of Contact	April 2016	All	<ul style="list-style-type: none"> Having named contacts will result in various outcomes; service users will know who to speak with, the point of contact will develop an overview of the service and any issues and therefore will be able to feedback key information, information can be quickly disseminated across agencies as the appropriate point of contact has already been identified Having a commissioner contact ensures the professionals know who to go to in order to expedite matters

19	Professional Advice Line	Phased pilot by April 2016	LCC, LPFT	<ul style="list-style-type: none"> Practitioners who are unsure whether or not to make a referral can seek advice Practitioners feel more confident about the service because they know who to contact Practitioners can get some initial advice and guidance quickly
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Ambition Six: Improved Care for Children and Young People in Crisis so they are treated in the right place at the right time and as close to home as possible

Ambition Six Actions

	Action	Timescale	Led By	Outcomes
20	Implementation of Tier 3 + service that will provide intensive home treatment	April 2016	LPFT	<ul style="list-style-type: none"> C/YP will receive intensive community based care that meet their wider educational and social care needs by ensuring all agencies work proactively together Providing a crisis response which compliments response provided by the Community Team in hours Reduce T4 Inpatient admissions Provides a crisis response Children can remain at home, close to family, friends and peers
21	The Local Transformation Plan will work in conjunction with the Mental Health Crisis Care Concordat	Ongoing	All	<ul style="list-style-type: none"> Children are treated at the right place, in the right timeframe as close to home as possible
22	Support the ongoing work stream on Section 136 Suites	Ongoing	LCC, Police	<ul style="list-style-type: none"> No Young Person in Lincolnshire should be detained in a cell as a place of safety
23	Establishment of pathways including Self Harm, Behaviour and Transition	Ongoing	LCC, Service Users	<ul style="list-style-type: none"> Stakeholders and professionals are clear on what treatments are available and seamless experience for those accessing the service

Ambition Seven: Improving Access for Parents to evidence based programmes of intervention and support to strengthen attachment between parent and child

Ambition Seven Actions

	Action	Timescale	Led By	Outcomes
24	Implementation of Perinatal Support	Ongoing	CCG LPFT	<ul style="list-style-type: none"> Newly commissioned Perinatal Community Mental Health Team (PCMHT) provide a specialised service for the prevention and treatment of Serious Mental Illness in the ante natal and post-natal period supporting Mother and Baby
25	Training and support for Parents	Ongoing	LPFT, LCC Social Care Team	<ul style="list-style-type: none"> Attachment work to enhance bond between parent and child, avoid early trauma and help build resilience and improve behaviour
26	Portage	Ongoing	LCC	<ul style="list-style-type: none"> Portage services provide help to very young children, 0-5 delivering a home visiting educational service for pre-school children with special educational needs and disabilities.

Ambition Eight: A better offer for the most Vulnerable children and Young People

Ambition Eight Actions

	Action	Timescale	Led By	Outcomes
27	Identify specific provision to support vulnerable groups including LAC and Care Leavers, those with a learning disability, those in contact with the youth justice system and those who have been sexually abused/exploited,	Jan 2016	LPFT	<ul style="list-style-type: none"> Children who have been sexually abused/exploited will receive comprehensive and specialist support If we are able to get the support right for our most vulnerable young people, it is more likely we will get it right for all Reduced wait times for our vulnerable groups so they are seen quicker

Ambition Nine: Improved Transparency and Accountability across the whole system

Ambition Nine Actions

	Action	Timescale	Led By	Outcomes
28	Ensure robust and transparent metrics in place and implementation of the Mental Health Services Data Set (MHSDS)	Jan 2016	LCC LPFT	<ul style="list-style-type: none"> • There are robust metrics covering access, waiting times, including referral to treatment and outcomes in the CAMHS contract which allow for benchmarking of services at local and national level • Service Users and their families can understand the service and level of care they can expect to receive • Robust targets enable monitoring and tracking of service provision • Breeches in targets can be identified and improved upon

29	Financial transparency	Sept 2015	LCC, CCG	<ul style="list-style-type: none"> • A clear financial breakdown of the monies contributed from the Local Authority and Clinical Commissioning Groups enables effective national benchmarking • Sharing of costs allocated to the model enables value for money benchmarking nationally
30	Set up local implementation groups to monitor progress against the Local Transformation Plan including risk	Nov 2015	LCC, LPFT	<ul style="list-style-type: none"> • Implementation meetings between the Provider, LCC and CCG's will ensure progress against delivery of plan is in line with timescales • Any issues can be addressed • Risks can be monitored and mitigated
31	Arrangements in place to hold multi agency boards for delivery	Nov-Dec 2015	LCC, CCG	<ul style="list-style-type: none"> • The appropriate monitoring mechanisms are identified • The progress of the LTP is captured on agenda of multi-agency boards including the Women & Children's Board and Health & Wellbeing Board

Ambition Ten: Professionals who work with Children and Young People are trained appropriately

Ambition Nine Actions

	Action	Timescale	Led By	Outcomes
32	Deliver training for Practitioners	Ongoing	LPFT, LCC, Agencies	<ul style="list-style-type: none"> • Practitioners need to raise through their Agency Lead (as identified in the Local Transformation Plan or Crisis Concordat) the training that they feel they will require. This should be amalgamated and time allocated for the most popular issues raised • Practitioners can access the Professional Advice Line for quick queries • Practitioners understand the Single Point of Referral process and feel confident to use it

33	Implement CYP IAPT Training – *First cohort identified and registered *Second cohort identified	*January 2016 *March 2016	LPFT, LCC	<ul style="list-style-type: none"> Identified staff from across key agencies receive appropriate training to improve the skillset of the broader workforce
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2. Current Service Provision – The Local Context and Case for Change

2.1 Overview

2.1.1 The Transition Plan aims to set out how; through integrative and collaborative partnership arrangements the Clinical Commissioning Groups, the Local Authority, Schools, and Health Services aim to secure effective, sufficient and sustainable services for C&YP with Mental Health and Emotional Well Being needs. Our approach, aims to ensure we have:

- the right support
- of the right quality
- at the right time
- in the right place
- for the right price

2.2 Local Context and Current Provision

2.2.1 Lincolnshire County Council has been delegated the lead commissioning function for specialist

CAMH Services via an Agreement with CCGs made under Section 75 of the NHS Act 2006.

2.2.2 Universal services are available to all children and young people, which are provided by Primary Care and service professionals e.g. General Practitioners, Health Visitors and School Nurses. These services offer; general advice and treatment for less severe problems; promote good mental health; aid the early identification of problems and refer to more targeted or specialist services. Schools have a vital role to play at this level. Please see Section 4 for further detail on additional services commissioned by Children's Services to support universal provision.

2.2.3 LCC has been delegated lead commissioning responsibility by the CCG's for CAMH Services, as set out below:

2.2.4 Mild to Moderate CAMHS - CAMHS for children and young people who are experiencing lower level to moderate mental health problems. Services include:

- Primary Mental Health Team offering:
 - Free training on understanding mental health concerns for all professionals working with children and young people aged 0-18 in Lincolnshire.
 - Consultation to professionals and families about specific concerns relating to a child's emotional wellbeing.
 - Assessment and treatment for children aged 0-18 with mild to moderate mental health concerns, normally 6-8 sessions. Maximum waiting time from referral to intervention should be 6 weeks.
- Looked After Children Team offering:
 - Training for foster carers, adoptive parents, leaving care workers and residential care staff.
 - Fast track access for assessment and treatment for Looked After Children and care leavers up to age 25. Maximum waiting time from referral to intervention should be 4 weeks.
- Therapeutic Services for Children; Sexually Harmful Behaviours and Victims of Sexual Abuse (including for those with non-diagnosable mental health concerns)

2.2.5 Moderate to Complex CAMHS – CAMHS for children and young people with more severe, complex and persistent mental health needs. Services include:

- Community Teams providing treatment via a range of therapies. Maximum waiting time from referral to intervention is 12 weeks.
- Forensic Psychology Service providing an assessment of risk and planning treatment for children and young people experiencing mental health issues who also pose a risk to the public or have offended.
- Self-Harm assessment & intervention service that assesses children and young people following admission onto paediatric wards following an incident of self-harm and presenting with suicidal ideation.
- Youth Offending Service providing consultation and advice to YOS Officers and assessment and treatment of mental health concerns, where this is indicated.

- Learning Disability Service for children and young people with moderate to severe learning disabilities and mental health concerns.

2.2.6 Inpatient CAMH services are commissioned by NHS England for children and young people with the most serious mental health problems. NHS England is responsible for commissioning inpatient services for all children in the country that may require intensive inpatient support. These are highly specialised services with a primary purpose of the assessment and treatment of severe and complex mental health disorders in children.

2.2.7 These services are part of a highly specialist pathway and provide for a level of complexity that cannot be provided for by comprehensive secondary, moderate community services. It is generally the complexity and severity rather than the nature of the disorder that determines the need for specialist care. Lincolnshire Children's Services continues to work with NHS England to consider alternative Tier 3 Plus commissioned services to reduce the number of C&YP requiring Tier 4 placements and to support those C&YP in Tier 4 units back into the community as a matter of priority.

2.2.8 Lincolnshire CCG's and LCC Adults Services currently commission the majority of local mental health services for those aged 18 and over and a Joint Mental Health Programme Board has been established to review and improve services in the future.

2.2.9 The performance of the existing CAMHS contract is closely monitored. We currently measure;

- Total number of referrals
- Referrals by source of referrer
- Inappropriate referrals by source of referral
- Referrals discharged in previous 12 months
- Referrals by reason of referral
- Maximum Wait from referral to intervention (broken down by area)
- Minimum Wait from referral to intervention (broken down by area)
- Average Wait from referral to intervention (broken down by area)
- Number of patients (broken down by area)
- Percentage seen within wait times (broken down by area)
- Wait to offered appointment (broken down by area)
- Face to Face Contacts
- DNA Rate
- Assessment, Consultation, Liaison and Social-Clinical recorded activity (broken down by area)
- Discharges- End of Care (broken down by area)
- Discharges – Ineligible (broken down by area)

- Interventions – Maximum Wait (broken down by area)
- Interventions – Minimum Wait (broken down by area)
- Interventions – Average Wait (broken down by area)
- Interventions – Number of Patients
- Total Number of referrals
- CHI-ESQ Questionnaires for Parents/Carers
- CHI-ESQ Questionnaires for Young People
- Staff Compliance
- Staff Training
- Staff Sickness
- Risk Register
- Overview of the Service Users, including recording Children in Public Care (LAC) those with a Child Protection Plan, those with CAF/TAC, those with Disabilities and Learning Disabilities

2.2.10 On an annual basis we also review;

- Stakeholder Engagement
- Annual Performance Summary
- Financial Review
- Business Continuity Planning
- Section 11
- CQC Reporting (if recent inspection has taken place)

2.3 2014/2015 Overview

2.3.1 **Please note that the data within the 2014/2015 overview references a tiered system. The new CAMHS model, in line with Future In Mind, will be a tierless system, with a seamless "step-up, step-down" approach.**

2.3.2 For 2014/15 the Local Authority has continued to lead on the commissioning of CAMHS on behalf of the CCG's alongside the commissioning of the CAMHS Primary Mental Health Team and CAMHS Looked After Children and Leaving Care teams. This service included is detailed above.

2.3.3 The presenting factors include;

- Anxiety
- Autistic Spectrum Disorder
- Behavioural problems

- Communication difficulties
- Depression
- Low Mood
- Other
- Psychosis
- Suicide Risk
- Child - Eating Disorder
- Emotional Disorder
- ADHD
- Abuse - Other (CAMHS)
- Self-harm
- Bereavement

2.3.4

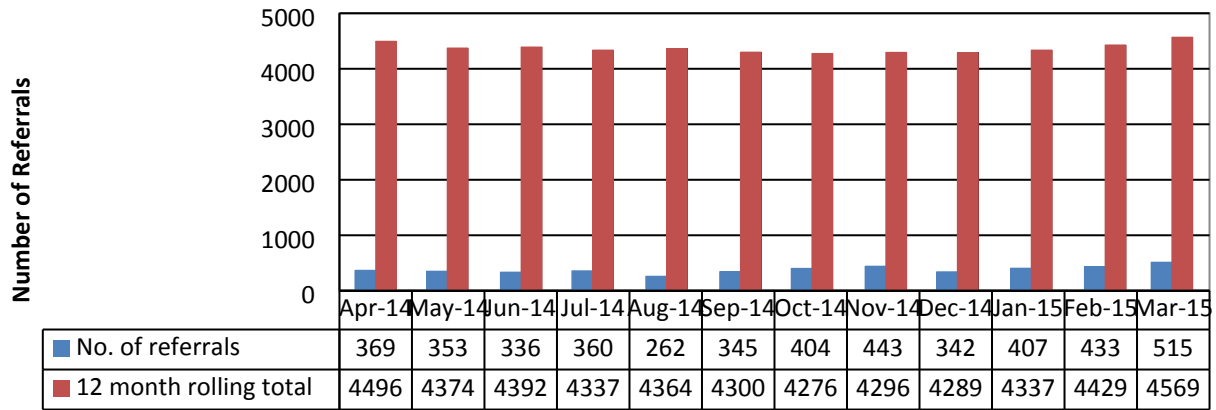
Since the 1st February 2013 the service has been commissioned to provide therapeutic interventions for young people who have experienced trauma relating to sexual abuse, alongside an additional service which provides assessment and treatment for young people who are displaying sexual behaviours considered harmful to others. The provider is required to provide exception reports for every referral which has been declined. In quarter 4 of 2014/15 the service received 46 referrals for therapeutic work in relation to post abuse and harmful behaviours. Whilst referral rates have shown a trend towards a gradual increase per year, the last quarter of 2014/2015 has shown a significant rise in referrals in relation to the previous 3 quarters (29, 21, and 23 respectively). From the 46 referrals there were 3 cases declined. On review this was appropriate for all 3 cases. The service continues to provide regular additional supervision on a monthly basis in relation to the clinical management of all cases referred for post abuse or harmful behaviours.

Number of Referrals Received and Accepted

2.3.5

The total number of referrals received into the service over the last 12 months is 4,569 (previous year was 4,577 but data for 2012/2013 is not comparative as YOS / Tier 3 etc were commissioned by PCTs.). The number of referrals declined has reduced by 2.5% (740 compared to 858 in 2013/14). The overall percentage of referrals declined within the service by 2014/15 is 16%. Tier 3 and CAMHS Learning Disability services have the highest rate of referrals declined, and this relates to referrals that do not meet the service criteria. The service has continued to monitor adherence to the commissioned service criteria and has found in the majority of cases a consistency in the application of the service criteria and thresholds during the referral screening process.

Fig 1. Total Number of Referrals



2.3.6

2.3.7

Figure 1 shows us that Q4 referral figures have remained relatively consistent with the previous 6 month averages. The exception was the lower figure in December, which is consistent with annual trends and the much higher figure referred for March, which is significantly higher than the previous 12 months.

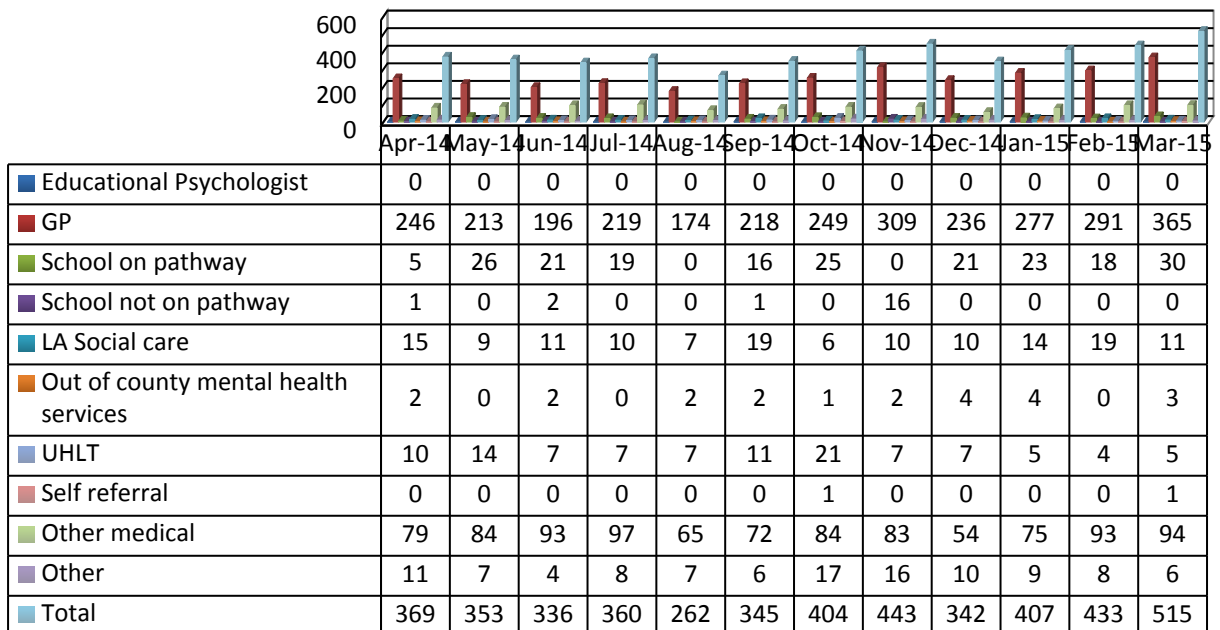
Reason for Referral

2.3.8

There are a number of presentations that will trigger a referral to CAMHS. For 2014/2015 the highest factor for referrals to Tier 2 CAMHS was Anxiety (492 referrals) followed by Low Mood (372 referrals) and Self Harm (242 referrals). There is a very similar picture in Tier 3 CAMHS with the highest number of referrals for Anxiety (776) Low Mood (623) and Self Harm (598) but a much higher number of referrals for Behaviour Problems with 534 referrals at Tier 3 compared to 95 referrals at Tier 2.

In terms of referrals by source, GP's are the highest refers at 2993 referrals over 2014/2015, followed by other Medical (which includes Nurses, Community Paediatrics) at 973 referrals and 204 from Schools.

Fig 2. Total Referrals by source of referral (excluding Therapeutic Services)



2.3.9

Figure 2 shows us that the number of referrals received via the school pathway has increased in Q4 , but GP's and the health pathway remains the pathway of choice for people accessing Community CAMHS.

2.3.10

Vulnerable Groups

Specific support is provided to Vulnerable Groups in the existing CAMH service; with LAC, Learning Difficulties and YOS having their own Key Performance Indicators. The service records whether users are LAC, CWD, LLDD etc.

2.3.11

Figure 3 shows there is an increase in the number of cases recorded that are also in receipt of TAC meetings or are registered with a Child protection plan.

2.3.12 **Attainment of Target Waits within the Service**

The wait from referral to intervention at Tier 3 has been consistently within the target time period throughout the last 12 months. 99% of patients have been seen at Tier 3 within the 12 week target, with the average wait being 3 weeks or less. This is a further improvement from the

2.3.13

The Primary Mental Health Team now shows an increase in the percentage of cases seen within the 6 week target. There was a dip in the month of January due to capacity issues, but the general trend since November 2014 has been of improvement, with an expectation that the team will continue to improve and attain the target wait within this first quarter of 2015.

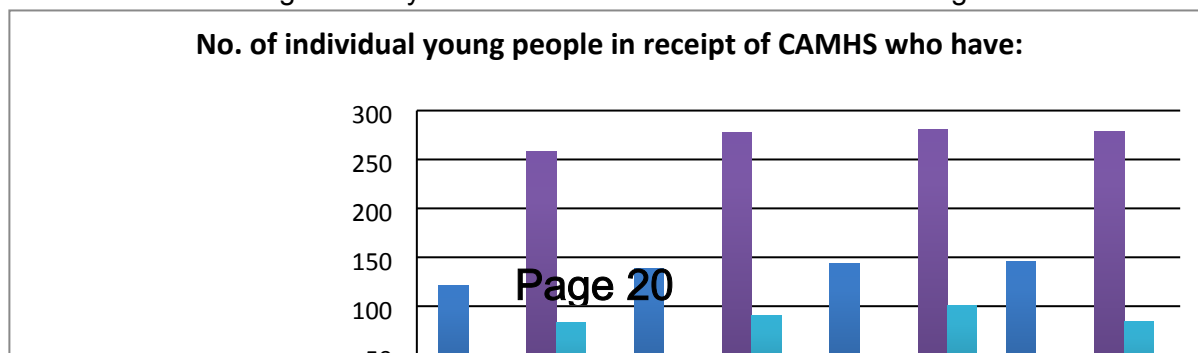
2.3.14

The performance of the LAC team in relation to the 4 week wait target has improved since November 2014. The percentage of cases seen within the 4 week target within quarter 4 has been 91, 88 and 100% respectively for January, February and March 2015.

2.3.15

The CAMHS Learning Disability and Diabetes services continue to manage with insufficient

2.3.16



capacity to manage the demand for the service. The percentage of cases seen within the target wait times reflects this issue.

- 2.3.17 The CAMHS YOS team continue to be below the target wait of 3 weeks due to the number of cases that DNA or cancel appointments. The DNA rate for CAMHS YOS is on average between 2 to 3 times higher than within the Primary and Tier 3 services. The CAMHS YOS team have implemented a text and call system to remind clients of scheduled appointments. This system is
- 2.3.18 however, reported to be increasing the number of cancellations received which ensures the number of cases seen within the 3 week target remains below the set performance week.

In comparison to the national wait of 18 weeks, the majority of targets for 2014/2015 are a 6 week wait, which in real terms for Lincolnshire service users, equates to them being seen 67% quicker than the national recommended timescale. For LAC this increases to 78% and for YOS, 83%.

The average wait time in 2014/2015 was;

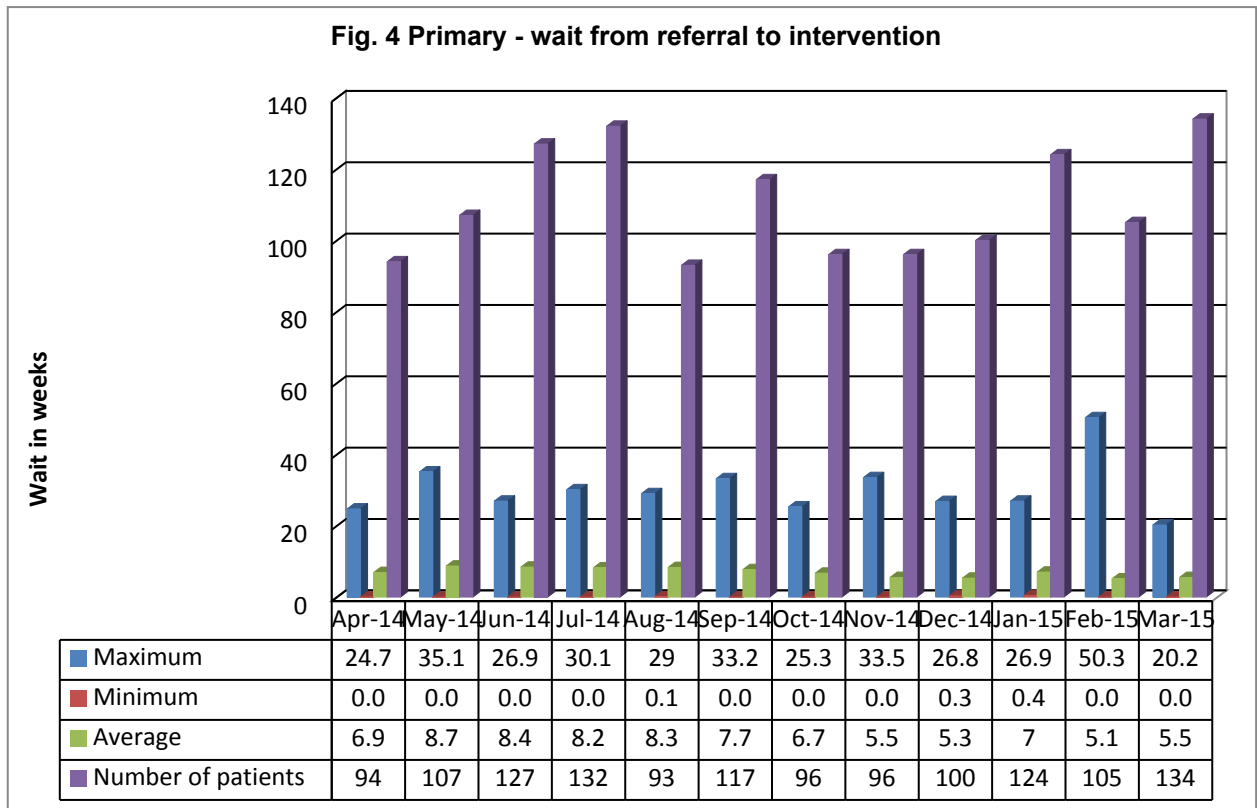
- 7 week wait for Tier 2 services
- 4 week wait for Looked After Children
- 8 week wait for Community Forensic
- 14 week wait for Learning Difficulties
- 2.3.19 ■ 6 week wait for YOS
- 9 week wait for Therapeutic Services at Tier 2
- 2.3.20 ■ 7 week wait for Harmful Behaviours at Tier 3
- 4 week wait for Therapeutic Support at Tier 3

Lincolnshire County Council already has stretching targets in place for our CAMH Service, which are closely measured and reported by exception.

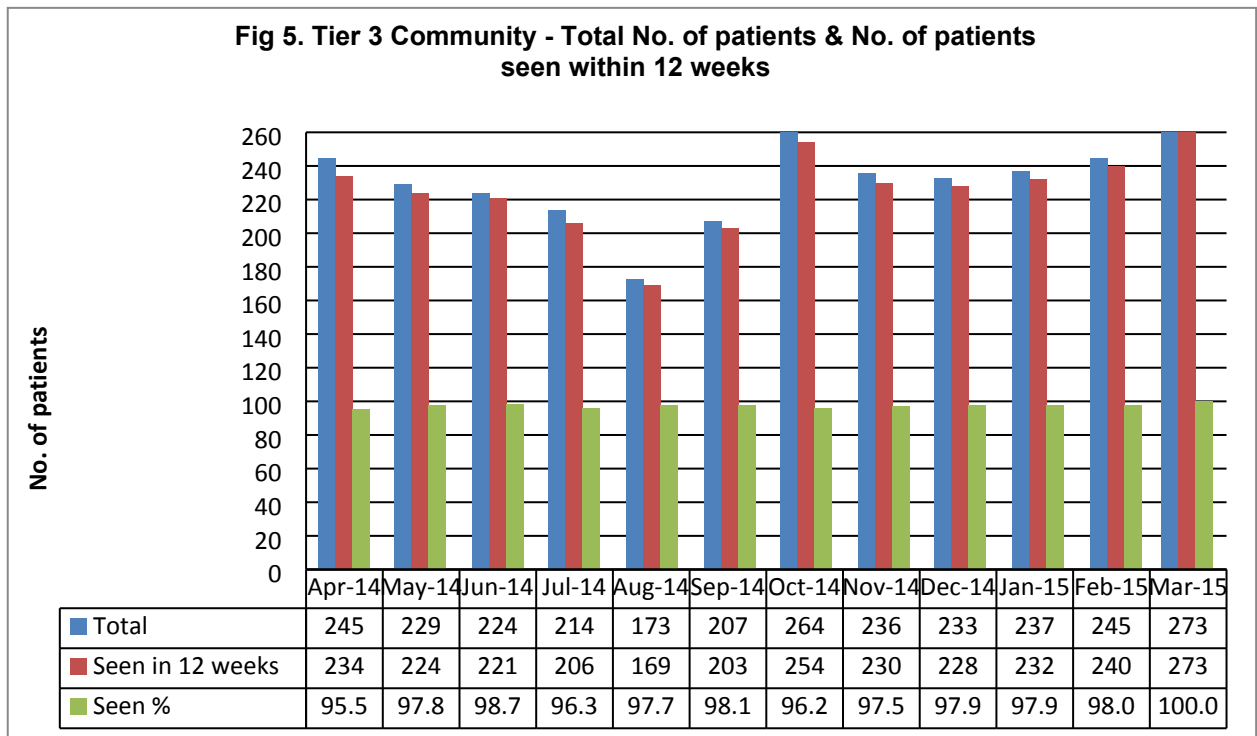
Key Performance Indicators for Wait times for the current service include:

- 6 week wait for Tier 2/Primary Services
- 4 week wait for Looked After Children
- 6 week wait for Community Forensic
- 12 week wait for Learning Difficulties
- 3 week wait for Youth Offending Services
- 12 week wait for Tier 3 Services
- 4 week wait for Diabetes Services
- 6 week wait for Therapeutic Services at Tier 2
- 6 week wait for Therapeutic Services at Tier 3
- 6 week wait for Harmful Behaviours at Tier 3

2.3.21



The Table above shows the wait from referral to intervention at Tier 2 CAMHS. It shows some breaches of targets throughout the year which are explored during the relevant contract management meeting, with a significant number of those breaches having been related to patient choice.



2.3.22

Figure 5 shows the total number of patients at Tier 3 CAMHS seen within the 12 week period;

throughout 2014/2015, the majority of Young People have been seen within the wait time, the lowest percentage achieved was 96%.

Open Cases within the Service

2.3.23

The average number of open cases held by the whole service each month is 1912. 66% of the cases are held within Tier 3, 22.5% are within Primary Mental Health with the remaining 11.5% of cases held within the smaller teams for specific vulnerable groups (LAC, YOS, LD, Community Forensic, and Diabetes). The majority of therapeutic services for post abuse and harmful behaviours are held within Tier 3 services.

Patient Experience

2.3.24

In 2014/2015 Patient Experience was measured through a number of mechanisms including OO-CAMHS, CORS and CHI-ESQ questionnaires. The Child Outcomes Rating Scale (CORS) taken at each session provide a means of tracking patient well-being. When treatment is successful CORS scores should increase over time. In order to attribute successful changes to factors other than individual variability, the difference between any two scores must exceed a statistical index, the reliable change index (RCI). With regard to the CORS, the RCI is 5 points or more. Thus, when a change of 5 points or more has been demonstrated it is highly likely that a significant change has occurred as perceived by the young person and carers following discharge from the Lincolnshire CAMHS Service. This is key data as it shows outcome of completed CAMHS interventions. The picture for 2014/2015 shows meaningful and clinically significant ORS change as a result of Young Peoples treatment at the point of discharge i.e. an average raw change over 5 points or more.

2.3.25

The CHI questionnaires measure Patient experience for both young people and their parents/ carers. The number of returns for young people for the period 1st January to 31st March is 172 with an overall satisfaction rate of 89.12% (the previous quarter satisfaction rate was 90.04%) The number of returns from parents and carers in the same period is 119, with an overall satisfaction rate of 89.87% (the previous quarter satisfaction rate was 92.24%.)

2.3.26

The CHI is a national tool. A series of statements are given and Young People are asked to pick from a list of responses, ranging from very true, to, not true. Statements include;

- I feel that people who saw me listened to me
- It was easy to talk to the people who saw me
- I was treated well by the people who saw me
- My views and worries are taken seriously
- I feel the people here know how to help me
- I have had the opportunity to have a say in deciding what sort of help and treatment I would get

2.3.27

As a snapshot, from 1st January – 31st March 2015;

- 79% Young People felt it was easy to talk to the people who saw them
- 94% Young People felt listened too

- 95% Young People felt they were treated well by the people who saw them
- 91% felt their views and worries were taken seriously
- 82% felt it was certainly true that the people here knew how to help them, with a further 17% responding this was partly true
- 78% would definitely recommend the service to friends or family, 18% said they might and only 0.58% said they wouldn't

2.3.28

For Parents;

- 92% felt the people who have seen their child listened to them
- 89% said it was easy to talk to the people who have seen their child
- 95% felt they had been treated well
- 89% felt their views and worries were taken seriously
- 76% felt they had the opportunity to have a say in deciding the help and treatment their child would get

2.3.29

As part of performance information, the Provider details feedback from the CHI questionnaires. This stakeholder feedback provides a full account of all comments provided by young people, parents and carers throughout the year. As a snapshot in Q4 from the 3 questions relating to service feedback, dislikes/service improvements and what is good about the service young people provided 251 comments of which 227 of these were positive. From the same three questions parents and carers provided 190 comments. 173 of these were positive. Negative comments are addressed through the contract management process and tracked for continuous service delivery improvement. The CHI comments are also provided for locality team to discuss in team meetings and responses for generic issues are addressed in the "You said – we did" boards placed within reception areas.

2.3.30

Staffing Compliance

Performance monitoring includes a staffing compliance report that shows information on staff compliance with appraisals, mandatory training records: including safe guarding training and attendance records. Staffing vacancies and sickness are also measured and in 2014/2015 the staff sickness for those staff directly attributable to CAMHS delivery was within the target rate.

The Service was subject to three CQUIN's in 2014/15 including;

CQUIN1 – Training sessions to Tier 2 Source of Referral

2.3.31

The required number of training sessions to GP's Children's Services and third sector organisations were provided. The impact on the use of the school pathway was however minimal. Feedback received from young people using Tier 2 services highlighted that they at times preferred to use the health pathway into the service as opposed to the school pathway.

CQUIN 2 – An increase to the Community CAMHS Chi Returns

2.3.32

The target number of returns has been achieved and therefore this CQUIN has been met. The

numbers received have been reported throughout the year. The comments received are also provided and the service has a feedback system “you said – we did” whereby all comments are responded to and displayed within the reception areas within local clinics.

CQUIN 3 – Accreditation with Quality Network for Community CAMHS (QNCC)

- 2.3.33 The service received two peer reviews in February 2015. . Both reports reviewed the service as operating within good practices, in particular the involvement with Lost Luggage (a young peoples forum), the implementation of OO-CAMHS and the staff’s positive attitude to the review process as a means of improving the service and clinical practices.
- 2.3.34 During the year 2014/15 Lincolnshire CAMHS services have built on the successes of the previous year and managed some challenging service issues. The service prides itself on its commitment to children and promoting positive mental health.
- 2.3.35 The implementation of OO CAMHS has enabled the service to evidence that it is successfully meeting young people’s needs. 2015 will ensure that all staff are trained in using OO-CAMHS so that the model is further embedded into the service model and clinical practice.

2.4 Poverty in Lincolnshire

- 2.4.1 Child poverty is one of the key risk factors that can negatively influence a child’s life chances. Children that live in poverty are at greater risk of social exclusion which, in turn, can lead to poor outcomes for the individual and for society as a whole.
- 2.4.2 In Lincolnshire, we consider that poverty is not only a matter of having limited financial resources but that it is also about the ability of families to access the means of lifting themselves out of poverty and of having the aspiration to do so. We also believe that a child’s life chances should not be limited by being born into a family from a low socio economic group but rather he or she should have the same opportunities for economic and social advancement as his or her better off peers. Children born into poverty are more likely to be at risk of poor educational attainment, poor health with a reduced life expectancy and greater exposure to crime. This can then lead to them not obtaining the skills and qualifications they need in order to be able to secure well paid employment, which then results in their not having the money they need to support their own families; a cycle of poverty is then created.
- 2.4.3 According to the latest figures there are just over 142,950 children and young people aged between 0 and 19 living in Lincolnshire, of which 22,730 (15.9%) live in poverty; of the total of those aged under 16 (121,636), 16.5% live in poverty. These figures are below the national

averages of 21.6% for under-16s and 20.9% for 0-19s. However, the data collected as part of our ongoing needs assessment has identified areas where there are high concentrations of children living in poverty, mainly in pockets within the major conurbations of Lincoln, Boston, Grantham and Gainsborough.

2.4.4 In recognition of these pockets of deprivation, the model has based its Hub locations to provide support to these areas.

2.4.5 The evidence from NI 116 data for 2007 and 2008 together with recent statistics produced by the department for Work and Pensions regarding children living in benefit claimant households shows that the wards with the highest number of children living in poverty have remained constant for the last four years. These same wards also show that the numbers of young people not in education, employment or training are higher than in more affluent areas.

2.4.6 A provisional analysis of health data suggests there may also be correlations in these areas with health inequalities. It is likely that both the contributory factors and successful approaches to tackling child poverty will be different in each area, taking account of sub district variations and local need; for example, the cost of transport affects people in all parts of the County but the lack of public transport is of particular concern in the coastal and remote rural areas.

2.4.7 It is also important to understand that the future child poverty picture nationally and in Lincolnshire will be influenced by the national economic situation and there is a real risk that the number of children living in poverty will increase. There are also likely to be changes in the characteristics of people experiencing child poverty in the future, brought about by a combination of the recession and subsequent national spending cuts that will result in more people being pushed towards poverty that do not fit the historic profile.

2.4.8 Lincolnshire is committed to minimising the number of children living in poverty and recognises that proposed solutions will need to take account of the needs of individuals, families and communities in ways that address their emotional and psychological issues.

3. Voice of the Child

3.1 Participation and Engagement

- 3.1.1 Listening to the thoughts, feedback, feelings, views and opinions of C&YP are paramount to ensure we are able to continuously improve and commission appropriate placements in the future and to shape the sufficiency of the required market place.
- 3.1.2 Throughout the journey of C&YP with Mental Health and Emotional Well Being needs, a high priority is given to ensuring that their views are captured, listened to and responded to, wherever possible. As the age range for these C&YP is so broad; strategies employed, which views can be captured and the method through which this is done, vary considerably.
- 3.1.3 Where we are seeking to capture the views of our youngest children, we work hard to do this in a way that takes account of the emotional age and the developmental stage of the young person when listening to their views. The expertise of those who have the relationship with the child or young person are utilised to ensure we capture these views. This may include support from a commissioned service provider, in house teams and those staff working within respite and residential homes.

Where it is possible to capture feedback, the voice of the child is central to our practice. C&YP

3.1.4 with Mental Health needs are encouraged in a range of ways to contribute their views and opinions and receive a varied level of consultation and participative engagement, ensuring that their concerns are heard and they are given the opportunity to input into their care and adapt services to best meet their needs.

3.2 Involving C&YP and Parents in Planning, Commissioning and Reviewing Services

3.2.1 The Young Inspectors Programme aims to give young people encouragement and support to become active volunteers, in inspecting services both within Lincolnshire County Council and externally which are accessed by children and young people. The program makes an active contribution to local authority's duty to positively engage with children and young people.

3.2.2 The young people are recruited from across Lincolnshire and trained in several different techniques of inspection. They are then supported while they go out and inspect services which C&YP use and feedback on their findings so that necessary action and improvements can be implemented.

3.2.3 Children and young people, and their parents/ carers are included in the review of services that benefit them by way of consultation, along with involvement in the development of service specifications and evaluation of tender bids as part of procurement processes.

3.2.4 Lincolnshire also has a set of requirements to ensure that children and young people are able to effectively participate in commissioning activities, with a checklist in place for effective practice and a self-assessment and planning tool that starts with why and how children and young people's engagement is valued and achieved in commissioning strategies, through to the workforce being equipped with knowledge and skills to undertake participation; resources and time allocated for these activities to take place and tailoring the approach to match the age, levels of understanding and developmental stages of the participants

3.2.5 The Lincolnshire Parent Carer Forum (LPCF) works to ensure that information is shared in a manner sensitive to the individual interests and concerns and does not overwhelm parent/carers with unnecessary information. This allows parent carers the opportunity to feed back to Lincolnshire County Council both individually and collectively on the development of new and existing services, and use a range of social media to do so. The LPCF works to promote parent carer leadership and the co-production and development of new projects that benefit them, working in an active and positive partnership with Lincolnshire County Council to promote diversity in the representation of parent carers views, needs and ideas to assist in the continual improvement and development of services for C&YP.

3.2.6 The views of C&YP are also a key performance indicator for those services which are delivered by an external Provider. As part of their contractual commitments, Providers are to demonstrate commitment to the Participation Charter. The Charter has four key principles of Participation:

1. Children have equal opportunity to be **involved**
2. Children are **valued**
3. The involvement of Children is a **visible commitment** which is properly resourced

4. The involvement of children is monitored, evaluated, reported and improved.

3.2.7 Providers are asked to demonstrate that their service is valued by stakeholders and feedback is sought in helping to improve the services. The Provider is required to consider how they can improve and must undertake stakeholder feedback as part of their analysis. This is reviewed during Contract Management Meetings which are held on a regular basis between the Provider, Children's Commissioning team and a Service Area Representative. Providers are evaluated against how well they are meeting these standards.

3.2.8 As part of on-going Contract Management Meetings, opportunities are considered and taken to involve parent/carers and their children in attending those meetings and for them to talk about their experience of a commissioned service.

3.2.9 Voices for Choices (V4C) is the Looked After Children's council in Lincolnshire and also includes care-leavers as members. All children and young people looked after in Lincolnshire are automatically members of V4C. As a result of listening to V4C feedback, the "Coming into Care Kits" given to all LAC have been updated and improved. The V4C have also instigated the creation of an "App" to provide readily available information for LAC.

3.2.10 The LAC Service also completes an annual "Tell Us" Survey, which encourages young people to give open and honest feedback about their experiences of Care. 2012/2013 saw the highest return of this Survey from Children and Young People and between 95-100% thought they were living in the right place. The Survey also indicated that Children and Young People are happy, enjoy School, have a good relationship with their Social Worker and have the opportunity to participate in a wide range of leisure activities.

3.2.11 There is also a Leaving Care Participation Forum group which meets bi-monthly and last year the group focussed on two main areas. The first was young people re-designing the Pathway Plan review template. The new template is now being used with a pilot group of young people to gain feedback and ensure it meets the needs of young people, including those with Mental Health needs. The second area was a review to develop a smart phone app through which young people can access advice and information.

3.2.12 Care leavers are involved in the Lincolnshire Participation Action Group (LPAG) which is a group that sits under the Children and Young People Strategic Partnership. The group have recently been working on anti-bullying processes.

3.3 Developing services in line with the views of young people

3.3.1 The most successful services are those that respond best to the needs of those that use them and Lincolnshire has long been committed to embedding service user/carer participation into development of its services.

3.3.2 Recent national policy has emphasised the need to put people who use services at the heart of commissioning and delivery, which is encapsulated in the concept of 'no decision about me without me'.

3.3.3 The CAMHS service will be driven by the following principles:

- Ensuring that service user participation is meaningful and central to service delivery
- Using national participation best practice developed and honed over recent years
- Carry out participation in partnership with commissioners and other providers/ stakeholders
- Ensure that any participation activity includes vulnerable groups of young people

3.3.4 Capturing the voice of the service users will be an integral part of continuous service development. We will do this by;

- Developing the young people's forum, Lost Luggage
- The development of young people's advisory boards/involvement group
- Focus groups on specific issues
- Benchmarking and monitoring participation in the service using Hear by Right, You're Welcome, HASCAS and QNCC standards
- Identifying participation leads to drive the work forward, who are supported by the Trust's Membership & Involvement Team
- Developing work with hard to reach groups
- Involving young people in the training of staff at all levels

In order to empower and engage our young people we will ensure;

3.3.5

- Offering choice on where a young person is seen, when they are seen and who they are seen by and who they are seen with (where clinically appropriate)
- Providing accurate, appropriate and jargon-free information for young people, their parents and carers to support them in making informed choices
- Recognising and responding to differences such as gender, ethnicity and age
- Ensuring that whatever choices are made are made with informed consent
- Reviewing each young person's needs, wants and treatment choices on a routine basis
- Considering flexibility even where the nature of a young person's mental health problems means that action has to be taken against that young person's will in order to safeguard their welfare

3.3.6 It will also be fundamental to ensure that the service tracks and monitors outcomes for the Young People. The service will evaluate the patient experience and outcomes throughout treatment and through the continued use of OO-CAMHS. These tools enable clinicians to closely monitor progress and step down or change therapeutic interventions as appropriate.

3.3.7 The service will place equal importance on both patient reported and clinically reported outcome measures, as each CAMHS clinical pathway, clearly defines measurement and evaluation points within the treatment journey. Clinically reported outcome measures will be measured via the

specific Psychometric tests that are undertaken at assessment; e.g. Moods and Feelings Questionnaire, Becks and Spence Anxiety Scale, NISONGSR (specifically designed for learning disabilities).

3.3.8 Patient related outcome measures are specifically included within the OO-CAMHS and process of review. These include Goals Based Questionnaires, CHI Experience of Service Questionnaires (used with both service users and families and carers) and the Outcomes Rating Scale which enables the young person to self-rate their progress and the Session Rating Scale which allows the person to assess therapeutic alliance and the appropriateness of treatment.

3.3.9 The service will ensure that the workforce is able to provide optimal results via the following initiatives:

- that the workforce is competent and capable of delivering the clinical intervention as intended by supervision of their intervention work, which includes continuing professional development and accessing specialist supervision as appropriate for specific types of interventions e.g. CBT; family work; Thera-play; EMDR
- Staff are trained in the use of OO CAMHS and CORC-including the administrative elements of the process to comply with data capture requirements that feedback from the data collection system and processes are used with service users and the workforce to help adjust and change interventions as appropriate.

3.3.10 This process of continual review and outcome monitoring will ensure a service user will be moved on to a different intervention as appropriate depending on the feedback from the service user; the scores on standardised assessments that indicate a lack of improvement via a particular intervention or service user will be discharged from the service in a timely manner if they are reporting progress.

3.4 Meeting the mental health needs of children and young people in Lincolnshire- what they say they need

3.4.1 Young people were consulted as part of a CAMHS review in Lincolnshire during 2014. The views of children and young people should be considered when setting up the service model. The groups consulted included:

- Young Inspectors
- Children in Care Council
- Care Leavers Forum
- Lost Luggage

3.4.2 The young people expressed specific requirements for supporting their mental health in a number of areas that they said were important to them:

- Communication between services, whilst respecting their confidentiality
- Support in schools and colleges, including access to quality information about mental

health, learning about mental health in PSHE and individual support

- Tools to help support their mental health – helplines, apps, websites and leaflets
- Advertisement about services around Lincolnshire
- Accessibility to services – clearer systems for dealing with issues, knowing who to contact and how to get help
- Self-referral to services – this could minimise the number of people they had to tell their story to
- Help in a crisis – a service that is accessible 24 hours a day, by phone, text or in person, alternatives to presenting at A&E, having someone they know to talk to and preventative approaches (not letting us get in a crisis – it might be too late)
- Systems should be in place to help young people work out what the problem is, along with what kind of help they might need – an online questionnaire that points them to the right service could help
- Living in Lincolnshire posed some problems in getting to appointments, including the expensive travel – the rurality makes young people feel isolated, better opening times and locations closer to home as well as drop-in centres would help
- Use of goal setting and structure to interventions would help CAMHS to be more effective
- Arrangements for transition were important and processes need to be in place

3.4.3 In addition, in the Healthwatch Lincolnshire report 'Hear Our Voice' – children and young people of Lincolnshire² 32% of children were unaware of what information on mental health was available and what support services can offer. 20% of young people in Lincolnshire also admitted to self-harming, with around 16% of children aged 11-13 reporting that they had self-harmed.

3.5 Lost Luggage – Young People's Voice within CAMHS

3.5.1 The Lost Luggage group which is the Young Peoples forum that continues to be a part of CAMHS and now plays an integral part to any service planning or reviews. Some of the updates from last year's report are:

- The website is being developed in partnership with Optima Graphic Design Company. The young people are submitting blogs to include on the site.
- In partnership with Media Project Manager from University of Lincoln Lost Luggage have produced a short film in relation to young people's experiences of mental health difficulties and stigma. This is being offered to secondary schools as a means of promoting awareness of mental health issues and the importance of seeking help early on.
- Lost Luggage continues to organise bake sale to raise some more funds. This is part of on-going fund raising plans which have occurred throughout the year.
- Some of the Lost Luggage members have put their names forward to be a Service User Governor, following a meeting with the Membership Team.
- Lost Luggage has provided input in the design and information included in the care

² Healthwatch Lincolnshire (2014). Hear our Voice – Children and Young People of Lincolnshire.

- plan folders developed for the service.
- Lost Luggage has provided input into the development of a script written by a theatre company who are planning to provide a play for younger children that promotes self-esteem and emotional awareness.

4. Joint Commissioning for Improved Outcomes – Making Change Happen

4.1 Joint Commissioning, Local Leadership and Governance Arrangements

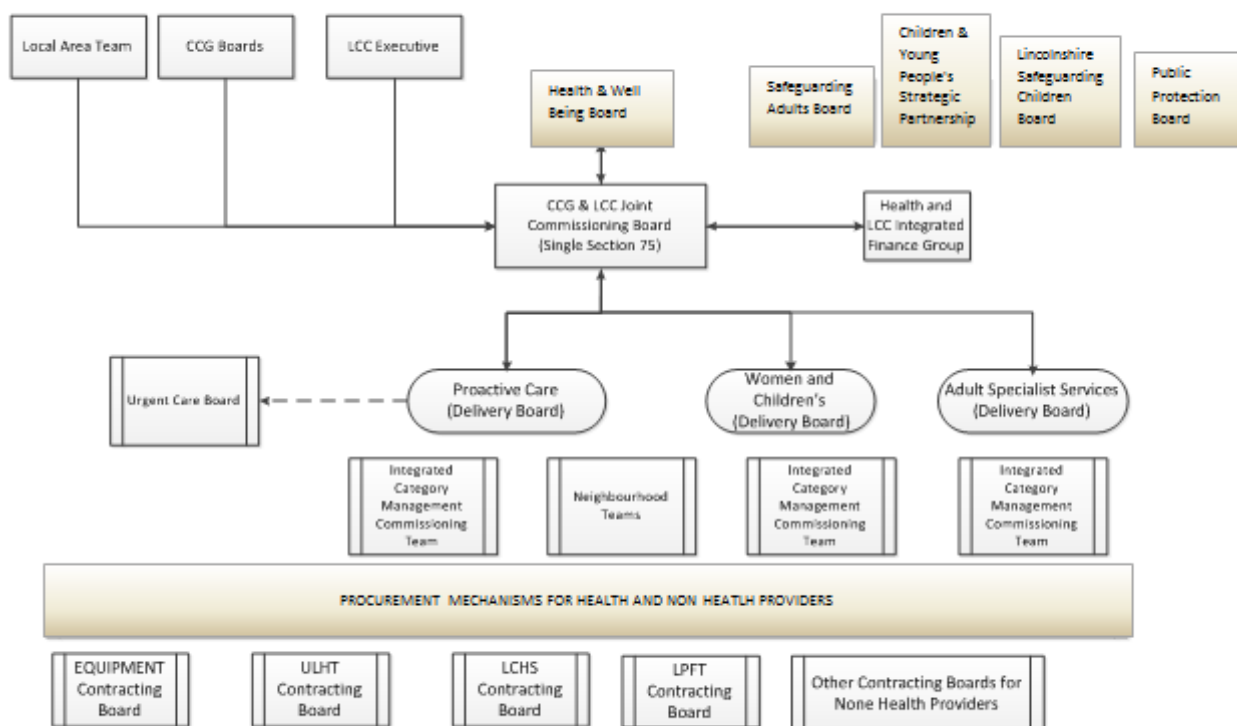
- 4.1.1 There is a Section 75 Agreement between Lincolnshire County Council and the four Lincolnshire Clinical Commissioning Groups; Lincolnshire East, West, South and South West. The Section 75 Agreement delegates the commissioning responsibility for Tier 2 and Tier 3 CAMH Services to the Local Authority, Lincolnshire County Council. The Agreement allows for the pooling of budgets between the CCG's and LCC to improve the efficiency and cost-effectiveness of the Service provision. It is intended that this will lead to an improvement in the way in which the joint Functions of the CCG's and the Local Authority are exercised in relation to providing social care, and health services and the management of associated funds.
- 4.1.2 A Section 75 Agreement also supports synergising business planning, integrated and lean working and reduces bureaucracy. As the delegated lead, the Local Authority has a number of requirements, including ensuring value for money, efficiency, monitoring of service provision and the end to end commissioning process.
- 4.1.3 LCC and the four CCG's have jointly funded an Assistant Director post to oversee the joint commissioning arrangements between the two bodies. This post is a key link in the joint commissioning arrangement detailed within this plan and is responsible for the Commissioning team. The Commissioning team oversee all aspects of commissioning arrangements for 0-25 years, including services for Mental Health and Emotional Wellbeing, Public Health Services, 0-5

Healthy Child Programme transfer from Public Health including Health Visiting in October 2015, LAC, CWD, SEND LLDD, Short Breaks.

4.1.4 Joint Commissioning Governance Structure - the diagram overleaf demonstrates our current joint commissioning governance structure.

4.1.5 The governance arrangements are intended to provide a framework for the delivery of multiple reviews and for achieving the priorities of the Health and Well Being strategy. These arrangements reflect the changing commissioning landscape and will enable health and social care commissioners to have joint engagement and ownership of joint commissioning arrangements providing integrated strategies to improve the health and social care needs of our communities

4.1.6 The Joint Commissioning Board (JCB) will oversee the commissioning of local services and activities on behalf of Lincolnshire County Council, the Lincolnshire CCG's and Local Area Team of NHS England. They will delegate work streams to a number of Joint Delivery Boards who will report and be accountable to the JCSB. One of these delivery boards focuses on Women and Children Delivery Board. The principle functions of the JCB is to lead at a strategic level the commissioning of integrated health and social care to meet the aspirations of the key stakeholders, commissioners and the outcomes of the Health and Well Being Strategy. The Board will also determine and monitor strategic Risk Management; will endorse Joint Commissioning Strategies to achieve agreed priorities and will report on progress to the Health and Wellbeing Board.



4.2 Good Practice Joint Commissioning

4.2.1 Lincolnshire Health and Social Care agencies have a long history of successful joint commissioning arrangements and in some instances this has culminated in a formal Section 75 agreement which describes arrangements for pooling of budgets. Both Lincolnshire County Council and the Lincolnshire CCG's have sought to increasingly co-ordinate their commissioning, taking joint responsibility for implementing strategies, whilst seeking to ensure improved outcomes, greater efficiencies and higher quality services. Some current examples of this joint funding approach include:

- S75 agreement between LCC and the CCG's for the delivery of Tier 2 and 3 CAMH services, where by LCC has been delegated lead commissioning responsibility for these services.
- S76 agreements to support the provision of short-breaks for CWD and SEND.
- S76 agreements to enhance the commissioning of speech & language therapy services and Specialist Nurse Training for CWD and SEND.
- Working with other Joint Delivery Boards to develop effective transition arrangements to help those C&YP with Mental Health needs prepare for adulthood, including living independently and employment.
- Commissioning lead for:
 - Consolidation and integration of specialist services including CAMHS, LAC & SEND
 - Early Years Services
 - Education Support Services
 - Development of commissioning strategies to support our four strategic outcomes

4.2.2 The Local Transformation Plan has been developed jointly by the Local Authority and the four Clinical Commissioning Groups.

4.2.3 Throughout the development process, the Plan has been shared across the four Clinical Commissioning groups for input and presented to Executive and Governing Board meetings across Lincolnshire.

4.2.4 The Local Transformation Plan will also go to the Women & Children's Board for input prior to submission.

4.3 Schools

4.3.1 There are 352 Schools in Lincolnshire including Nursery, Primary, Secondary, Specialist, Local Authority and Academy Schools. As at January 2015 there are 103,009 Pupils on roll across the county.

4.3.2 The Lincolnshire Research Observatory has the School Population Characteristics Data by type, in each of the four Clinical Commissioning Group areas from the 2013 and 2014 School Census. The table below shows the trends from 2013 to 2014 for Autistic Spectrum Disorder, Behavioural Emotional and Social Difficulties, Moderate Learning Difficulties and Profound and Multiple

Learning Difficulties for pupils across Lincolnshire.

Clinical Commissioning Group Area					
Need	Lincolnshire East CCG	Lincolnshire West CCG	South West Lincolnshire CCG	South Lincolnshire CCG	Total
2013					
ASD	311	555	118	141	1125
BESD	572	665	260	225	1722
MLD	795	732	273	317	2117
P&M LD	45	51	25	25	146
Total	1723	2003	676	708	5110
2014					
ASD	336	664	115	156	1271
BESD	634	471	266	191	1562
MLD	840	727	289	298	2154
P&M LD	40	64	27	28	159
Total	1850	1926	697	673	5146

4.3.3 The Lincolnshire Research Observatory data provides confirmation of the anecdotal perception that complex need in pupils is increasing. The table shows that Autism Spectrum Disorders and Profound and Multiple Learning Difficulties increased for pupils in 2014 and conversely, the number of children and young people with Behavioural, Emotional and Socially Challenging Behaviours and Moderate Learning Difficulties reduced during 2014.

4.3.4 Ensuring the educational attainment and support of pupils is an integral part of the Joint Strategic Needs Assessment. Lincolnshire County Council has committed to providing children with special educational needs & difficulties with the support and provision they need to make the best start in life as well as access to other services tailored to meet their needs. By providing children with the support they need at the appropriate time the local authority is preparing children and young people with special needs for the future.

4.3.5 The above data links into the recently commissioned Outreach Service; commissioned by Schools to respond to a trifecta of needs including Physical Disabilities, Autism and Learning Difficulties and Behavioural Support. The overall aim of the Outreach Service offers is to provide assessment and both short and medium term intervention, improvement or stabilisation and resolution for a range of SEN&D in Children and Young People as well as continuous professional development training for teaching staff, so that they can provide ongoing and longer term support for those complex needs as part of legacy building. Staff in Schools will benefit from continuous professional development opportunities accessed through outreach programmes with access to an annual programme of training, pupils will have a more comprehensive overview as to how their needs will be met longer term and early assessment and intervention is delivered in an inclusive mainstream environment within localities

The Outreach service will support:

- 4.3.6
- Autistic Spectrum Disorder, including those exhibiting behaviours associated with Autism

- Social communication challenges impact on their cognitive development and learning potential
- Mild, Moderate to severe learning difficulties
- Emotional Literacy
- Social, Emotional and Behavioural Difficulties
- Profound and Multiple Physical Disabilities
- Cognitive Disabilities
- Life Limiting Conditions
- Sensory Profiling
- Sensory Impact

4.3.7 Schools will also play a key role in the Outreach and Behavioural Support Services that form part of the multi-agency Behaviour Pathway that will work in conjunction with CAMHS. The Behaviour Pathway identifies four levels of need, with targeted and specialist CAMHS working with children, young people and their families at Level Three Specialist Assessment and Level Four Specialist Intervention, with a minimal role at Level One Early Help Prevention and Support Offer and Two Early Help Intervention Activity, providing intermittent support to other professionals at all levels and an annual programme of training.

- 4.3.8
- Level One: Early Help Prevention and Support
 - Level Two: Early Help Intervention Activity
 - Level Three: Specialist Assessment
 - Level Four: Specialist Intervention

4.3.9 Schools will play a key role in Levels One – Three and on a case by case basis linking in with other key agencies such as Early Help Consultants, Signs of Safety, Team Around the Child, Targeted and Co-ordinated support, Commissioned Services, Community Paediatrics, Educational Psychology, Specialist Teaching and Psychology Service and GP's.

4.3.10 As part of the stakeholder engagement process, Primary and Secondary Schools were asked to feed into the review. Lincoln College was also engaged as part of the review. The feedback from Schools noted Schools were unsure of the referral process, that more training is needed for professionals and that more support is needed for behavioural issues and strengthening information sharing.

4.3.11 In response to the feedback from Schools, the new CAMHS model will include robust support such as;

- A 9 – 5 professional advice line
- Training / consultation days
- The model has flexibility to provide specific sessions / blocks of time that can be used to provide the full suite of advice / liaison / agency support / consultation / collaboration on joint working and training sessions
- The development of self-help, psychosocial education materials, the directory of the local

CAMHS service and professional reassurance work, including joint assessment and post discharge case-working discussions.

4.3.12 Furthermore, in response to feedback, the new Single Point of Referral (further detailed in Section 6) will help to streamline access to the service and the Stakeholder Consultation Plan (see Section 10) will ensure that the new service is promoted across the county, helping key service users such as Schools, to understand and input to the new model.

4.3.13 Lincolnshire welcomed the opportunity to be involved in the Schools CAMHS Pilot Link, with all four Clinical Commissioning Group areas submitting an application. We shared the opportunity with our Schools to find those who would be willing to be involved in the trial and we received over 100 responses within the first day of enquiry. This equates to nearly a third of all Lincolnshire Schools and includes Primary, Secondary, Specialist and Academy Schools. We were unsuccessful in our application for the Pilot Scheme but we are committed to the ethos of our bid and intend to strengthen the role of Schools in CAMHS as part of our future model, mechanised through Local Transformation Planning, which Schools will be a key part of.

4.3.14 In addition to the above, Schools already work closely with a number of Universal Services, including Xenzone, the Online Counselling Service, which has previously provided training and consultation materials for PSHME lessons in Lincolnshire Schools. Further details on Xenzone and other locally commissioned services are available under Section 4.

4.4 Youth Justice Lincolnshire Secure Unit

4.4.1 We are fortunate to have a secure units based in Lincolnshire. This means that we already have effective joint collaborative working arrangements in place between NHS England, the Youth Justice Board and CCGs that support the following outcomes for Young People in secure settings:

- Ensure that settings are able to meet the Intercollegiate Healthcare Standards for children and young people in secure settings (CYPSS)
- Develop a better understanding of the healthcare needs of young people in the secure estate with particular attention to welfare children and girls
- Work collaboratively to commission future secure health provision and where necessary decommission existing provision.
- Support the delivery of the Comprehensive Health Assessment Tool (CHAT); AssetPlus (an end to end youth justice assessment framework). In addition, will put in place procedures to manage children and young people with clinical management of substance misuse needs
- Agree principles on information sharing to drive transparency and continuous improvement to services
- Work collaboratively to support commissioning of a robust service for children and young people in the CYPSE who exhibit harmful sexual behaviour
- Develop Liaison & Diversion services in Police Custody and Courts that are suitable to meet the needs of children and young people
- Work with the Transitions Forum to ensure appropriate health services are commissioned

and deliver to the transition age group.

- 4.4.2 All children and young people passing through the criminal justice system are assessed. Through this Comprehensive Health Assessment Tool (CHAT) and referral to appropriate treatment and support, it is expected that individual service users' mental health, learning disability, substance misuse or other vulnerabilities will be addressed to improve their health, and contribute to a reduction in reoffending.
- 4.4.3 We will work with NHS England, Public Health England, the Police, Police and Crime Commissioners (PCCs) and Clinical Commissioning Groups (CCGs) to ensure robust care pathways for victims and appropriate referral at a time of crisis including psycho-social intervention that may be required at the time of presentation, and ongoing therapeutic support.
- 4.4.4 CAMHS professionals from within Lincolnshire's secure setting will work with relevant agencies to ensure that the appropriate support is in place for those children and young people in transition from a secure setting.

4.5 NHS Specialist Commissioning

- 4.5.1 Lincolnshire attends regional meetings which have representation from NHS Specialist Commissioning (please see section 7 for more detail.) During 2014/2015 Lincolnshire has attended a number of national events, including those focusing on Future In Mind implementation.
- 4.5.2 The Local Transformation Plan is being shared with NHS Specialist Commissioning for comments ahead of submission. Comments received back from NHS Specialist Commissioning shall be implemented to the Plan accordingly.

4.6 Mental Health Crisis Concordat

- 4.6.1 Although this is particularly relevant to adult mental health, there are clear synergies with CAMHS. A number of key agencies in Lincolnshire have agreed to be signatories to the Lincolnshire Mental Health Crisis Concordat. This includes;

- Lincolnshire County Council
- Lincolnshire Clinical Commissioning Groups (CCG's)
- NHS England Local Area Team
- (Primary Care Commissioners)
- Lincolnshire Police

- Lincolnshire Ambulance Service
- Lincolnshire Partnership NHS Foundation Trust
- Foundation Trust
- United Lincolnshire Hospitals Trust
- Public Health
- Lincolnshire Community Health Services
- Lincolnshire Addaction
- Lincolnshire Carers Partnership
- Lincolnshire Shine Network.

4.6.2 The Concordat declaration supports equality between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in Lincolnshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers', and make sure that services work together safely and effectively
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and Social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing

4.6.3 Lincolnshire already has a large number of Mental Health services and initiatives in place: which form our urgent care pathway such as;

- Single Point of Referral for Mental Health Services
- Crisis Resolution Home Treatment Service
- Crisis Houses
- Section 136 Suite
- ISA with Lincolnshire Police regarding Diversion and Liaison
- Memorandum of Understanding with Police Negotiators
- Street Triage Car

- Older Adults Liaison Service (Acute Hospital Based)
- CAMHS Self Harm and Liaison Service
- Self-referral to talking therapies (IAPT)
- Emergency Duty Social Work Team
- Fast track re-referral process
- Carers Assessment
- Carers Emergency Response Plan
- Carers Short Break Scheme
- Managed Care Network and SHINE Network

4.6.4

With reference to Section 136 Suite, there is a clear local operational protocol in place. The purpose of this is to ensure that care of service users placed on Section 136 and taken to Section 136 assessment suites are cared for in a safe and appropriate manner. The Policy sets out the powers as in law provided by the Mental Health Act 1983 as amended by the Mental Health Act 2007. The protocol and its procedures apply to all statutory agencies that fulfil a role in the undertakings and requirements of S136.

4.6.5

The aim of the protocol is to ensure:

- All agencies that are party to this protocol are aware of their roles and responsibilities.
- Persons detained under S136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as practicable
- Persons with mental health issues detained for criminal offences, are processed with due regard to the law. A mental disorder whilst correctly taken into consideration is not an automatic bar to due criminal process
- All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.

4.6.6

The Section 136 Suite will provide;

A “place of safety” whilst potential mental health needs are assessed under the Mental Health Act and any necessary arrangements should be made for their on-going care. The suite will accept referrals from all age groups.

4.6.7

Lincolnshire has two sites available. The objectives of our local protocol include:

- To work in collaboration with the Police and Acute Hospitals to ensure that any member of the public placed on Section 136 is taken to the most appropriate place of safety based on their presenting needs
- To have their needs assessed from a mental health perspective and further management determined either on an informal basis or subject to further Mental Health Act Legislation
- To ensure that assessments are carried out in a timely and clinically appropriate manner in accordance with MHA 1983.

4.6.8

The Concordat also focuses on the actions that are required by a breadth of agencies as part of

continuous service improvement for Lincolnshire. There is an action plan in place. The action plan is about improving those services and addressing the gaps by providing an effective pathway to improve crisis care responses.

4.6.9

The action plan is broken down into five areas with the correlating measures of success identified beneath each bullet point:

- Commissioning to allow earlier intervention and responsive crisis services
 - People in crisis referred to mental health secondary care services are seen within 4 hours
 - Aspire to 0% Suicides in Lincolnshire
 - 80% of non mental health staff to have received mental health training over the next 3 years with 35% trained by December 2016
- Access to support before crisis point
 - Increase the number of self-referrals to talking therapies
 - Publish a directory of services that promote good mental health and wellbeing by December 2015
- Urgent and emergency access to crisis care
 - All Section 136 requests for transport are responded to within 30 minutes
 - A reduction in use of Section 136 police powers
 - A reduction in the use of police cells solely as a place of safety
 - Crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week.
 - Service users and GP's have access to a local 24 hour helpline staffed by mental health and social care professionals
 - Increase in the use of crisis houses as an alternative to admission
- Quality of treatment and care when in crisis
 - At least a 50% increase in the satisfaction rate of people using mental health services
 - 70% of carers report feeling more included and 'know appropriate pathways to help
- Recovery, staying well and preventing future crises
 - Increase in the number of self-help groups supported by the mental health networks
 - At least 5000 health passports distributed by March 2016
 - 30% reduction in the number of people with a mental illness needing a crisis intervention service by March 2018.

Mental Health Crisis Concordat – Action Plan

4.6.10 Please see page 42 for the Overall Summary of actions for the Crisis Care Concordat. A number of the Crisis Care Concordat actions link into the Local Transformation Plan, such as 1.1, 1.2, 1.3, 1.4, 1.7, 1.8, 1.9, 1.11, 2.5, 3.3, 3.6, 3.10, 4.5, 5.3 which includes actions such as "Commission an intensive community assessment and treatment service for children and young people (CAMHs Tier 3+)" and "Review and create clear pathways and protocols for referring to mental health services via Single Point of Referral" as well as "Establish baseline of access to psychological therapies for children and young people and set trajectory for improvement."

4.6.11 The Local Transformation Plan will link into the Crisis Care Concordat to ensure that the strategic aims from the Concordat and the Plan correlate and work well in conjunction without duplicating

workloads. The Local Transformation Plan and the Crisis Care Concordat both have identified senior leads for their relevant actions; ensuring non duplication of work can be monitored through the named Lead in each area.

Overall Summary				
Action				
ID	Action	Lead	Due finish	Outcomes
1.1	Clear waiting time limits in line with National Standards will be put into commissioned services	Mental Health Commissioning Leads	Ongoing	Prevention of avoidable crisis and equality of access
1.2	We will complete a gap analysis between current provision and the declaration vision to inform actions and focus priority improvements	Concordat Steering Group	March 2015	Focussed commissioning on areas needing improvement
1.3	We will review existing mental health training across all agencies signed up to the declaration to develop and deliver joint training where the need is identified	Concordat Steering Group	June 2015	A training needs analysis will inform the development of the programme. Longer term all staff will have the right skills and training to respond to mental health crises appropriately.
1.4	Commission a full Mental Health Liaison Team on acute hospital sites	Mental Health Commissioning Leads	Sept 2015	People know they will receive the appropriate treatment in hospital sites
1.5	Link with Lincolnshire Suicide Prevention Forum to identify Suicide at risk groups to inform commissioning cycle	Public Health with Mental Health Commissioning Leads Police	April 2015	Those groups known to be at higher risk of suicide will be identified, such as people in the care of mental health services and criminal justice services
1.6	Review Cambridgeshire STOP Suicide Campaign. Use learning to implement in Lincolnshire	Public Health Mental Health Commissioning Leads Police	March 2016	Reduced suicides in Lincolnshire
1.7	Increase input to JSNA on mental health crisis to show demographic representation specifically with regard to protected equality characteristics	Mental Health Commissioning Leads	Ongoing	Commissioners have robust data with which to commission services

1.8	Publish a full Mental Health Needs Assessment for Lincolnshire	Public Health	June 2015	Commissioners have robust data with which to commission services
1.9	Complete a green light review on all crisis services	LD & Autism Commissioning Lead with LPFT	October 2015	Mental Health Crisis services will make reasonable adjustments to support people with LD and Autism
1.10	Commission a Carers Support Network Service	Adult Social Care	October 2015	Carers receive the support they need
1.11	Commission an intensive community assessment and treatment service for children and young people (CAMHs Tier 3+)	LCC Children's Services Commissioning	December 2015	Currently in progress. Bidding for transformational monies
2.1	Monitor the implementation and effectiveness of the National Criminal Justice and Liaison Service pilot. Use lessons learnt to inform the development of local services	Lincolnshire Police	Bi Monthly	There will be access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence and are in police custody or going through court proceedings
2.2	Develop partnerships with voluntary sector providers and service users to understand and respond to inequalities in access to mental health services.	ASC with CCG Mental Health Leads	Ongoing	Partnership groups will be established to enable parity of esteem for everyone with a mental health need
2.3	Develop support for carers in line with changes to the Care Act	ASC with other providers	March 2015 Onwards	People will feel protected when their circumstances make them vulnerable
2.4	Promote early self-referrals to talking therapies (IAPT) to avoid crisis	LPFT	Ongoing	People receive support at an early stage to improve their health and wellbeing
2.5	Establish baseline of advice and information services available to support good mental health	Concordat Steering Group	July 2015	Directory of services that promote good mental health

3.1	Review and create clear pathways and protocols for referring to mental health services via SPA and NHS 111	LPFT with CCG Mental Health Leads	October 2015	People know who to contact to access Mental Health Services
3.2	Scope the provision of a free 24/7 helpline number of people in mental health crisis	Mental Health Commissioning Leads	October 2015	People in crisis can receive help at any time
3.3	Establish baseline of access to psychological therapies for children and young people and set trajectory for improvement	LCC Children's Services	October 2015	Children and young people have better access to talking therapies to prevent crisis occurring
3.4	Conduct a full review of S136 Health Based Place of Safety to include: <ul style="list-style-type: none"> > Roles of partner agencies > Process > Provision of beds > Minimum Staffing > Diversion before Detention > Pathways > Intoxication > Conveyance > Training > Cultural Change > CQC Compliance 	Mental Health Commissioning Leads with Acute Services Lincolnshire Police EMAS AMHPs Louth & District Medical Services	September 2015	The efficiency, response and running of the suite is appropriate to the needs of the partners and people of Lincolnshire
3.5	Develop agreed local protocols between key partners around S135 MHA warrants to facilitate partnership working with a 'no surprise approach' including: <ul style="list-style-type: none"> > Criteria for attendance > Conveyance > Use of force 	Lincolnshire Police with AMHPs EMAS Magistrates Court	September 2015	People subject to this are dealt with in a professional joined up approach

3.6	Develop crisis services for under 18's, including 136 facility	LCC Children's Commissioning with LPFT	September 2015	Equality of access for all ages
3.7	Develop training and education about existing policies, powers, and procedures to all partners	Concordat Steering Group	September 2015	All staff trained to enable a rapid response to people in crisis
3.8	Establish peak demand times and target triage car intelligently to promote liaison and diversion	MH Commissioning Leads with EMAS LPFT	May 2015	People in crisis are helped at the right time, in the right place, by the right services
3.9	Review crisis house criteria and policies	MH Commissioning Leads	October 2015	An effective, safe alternative to admission
3.10	Complete a review of crisis and home treatment services	MH Commissioning Leads with LPFT	July 2015	People in crisis receive quality & effective services
4.1	Ensure all agencies have a policy or procedure to identify and involve carers at the point of crisis where possible	Concordat Steering Group	November 2015	Improved understanding of an individual's needs. Carers are recognised and valued as experts
4.2	Further develop referral pathways and improved communication strategies to enable all carers to be offered a Carers Assessment	LCC Adult Social Care with Other Providers	November 2015	Carers receive the support they need to continue with the caring role. This aligns to the Care Act - April 2015
4.3	Develop Carer and Service User learning, self-management and self-referral programmes	Carers Partnership Making Space Lincolnshire MH Networks and Other Providers	December 2015	Improved mental well-being in order to enable carers and individuals to self-manage symptoms preventing carer breakdown
4.4	Enhance and further develop community mentoring support for people with a mental illness and their carers, to support low level need	Carers Partnership Making Space Lincolnshire MH Networks and Other Providers	December 2015	Emotional support and understanding available when needed to improve wellbeing

4.5	Develop robust monitoring and evaluation systems across all agencies to monitor and improve the quality of care given and response received to people in crisis.	MH Commissioning Leads with LPFT	January 2016	Systems are in place for review, regulation and reporting within the local mental health provider services
5.1	Promotion and awareness campaign of Lincolnshire's Mental Health Networks: Shine Managed Care Network Dementia Network Carers Services	SHINE and LPFT	Review February 2016	A range of preventative services and support available to people with a mental health illness
5.2	Promote "12 steps to mental health" in line with the Public Health Campaign	Public Health	Ongoing	Increased awareness of methods for self-care
5.3	Promote 'time to change' anti-stigma campaign across Lincolnshire	Concordat Steering Group	Rolling Programme Annual review	Improved community acceptance and support
5.4	Scope the development and roll-out a health passport 'all about me' to all those with a mental illness	All About ME Steering group	September 2015	People have a better understanding of an individual's needs and wishes
5.5	Scope the current market position for the role of the voluntary and community sector in mental health crisis recovery	Specialist Adult Services Joint Commissioning Team	December 2015	All sectors are considered in crisis recovery plans
5.7	Complete an evaluation of the Wellbeing Service	Public Health	May 2016	Clear understanding of the impact of the network and what works for people with Mental Health needs

5. Understanding Needs & Performance – Promoting Resilience, Prevention and Early Intervention

5.1 Prevalence Rates and Local Population

- 5.1.1 Some young people can have mental health problems that continue into adult life, unless they are recognised early and receive appropriate treatment. It is known that around half of lifetime mental illness (not including dementia) begins by age 14 and around 75% begin by age 18. At the same time, it has been identified that effective treatments for mental health can improve the life chances of children and young people, and therefore can minimise the impact on the long term health of the population and the cost of services³.
- 5.1.2 The financial impact of not recognising and treating children’s mental health problems in a timely way can be significant. Mental health problems in children and young people are associated with excess costs estimated between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. health, education, social services and youth justice) and also include the direct costs to the family regarding the child’s needs. However, there are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems. The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.
- 5.1.3 Over the last 10 years, policy has acknowledged the importance of children and young people’s mental health and the challenge of developing their resilience, emotional well-being and mental health. The focus has been on^{4 5}:
- Developing comprehensive, integrated provision that puts children, young people and their families at the heart of what happens – through active participation
 - Acting early and intervening at the right time
 - Coordinated, integrated and collaborative working
 - Safe and sustainable services
 - Skilled workforce
 - A focus on knowledge and evidence base
 - Strong leadership, accountability and assurance
 - Challenging the stigma of mental health through the whole system.
- 5.1.4 More recently an all age mental health strategy and accompanying outcomes framework (2013/14) has been produced – ‘No Health Without Mental Health’⁶. The mental health strategy states that mental health is everyone’s business and focuses on the prevention of mental health problems, promoting mental wellbeing and intervening early to improve the future outcomes for children and young people, alongside delivery of evidence based and timely interventions in childhood and

³ Department of Health, No Health without Mental Health 2011.

⁴ National Service Framework, 2003; Every Child Matters 2003; The Children’s Act 2004 (updated 2008)

⁵ Report of the National Advisory Council for Children’s Mental Health 2010

⁶ Department of Health, No Health without Mental Health,2010

adolescence, which, in some cases, can avert mental health problems continuing into adulthood.

5.1.5 The key principles of other relevant policy and guidance are:

- A parity of esteem with physical health services, and tackling physical health issues in people with mental health problems
- Participation for children, young people and families
- A focus on families and children in vulnerable circumstances
- A public health approach from birth
- A responsibility for schools to develop the right culture and ethos to support children and young people's well-being and to promote confidence and self-esteem ⁷
- Tackling stigma and discrimination⁸⁹

5.1.6 Comprehensive support for children and young people with emotional and mental health problems or disorders should be provided through a network of services that include:

- Universal services, all professionals who work with children on a day to day basis, such as early years or primary care (Tier 1 CAMHS)
- Targeted services such as Primary Mental Health Workers, youth offending services offering short term, brief interventions for mild to moderate or newly emerging mental health needs (Tier 2 CAMHS)
- Specialist multi-disciplinary community CAMHS teams (Tier 3 CAMHS)
- Highly specialist services, such as in-patient services, or very specialised outpatient services (Tier 4 CAMHS)

5.1.7 These services are not exclusively provided by the NHS. As children and young people's mental health affects all aspects of their lives, service provision needs to be commissioned and designed on a multi-agency basis. There are a range of models of CAMHS provision across the country, which tend to be largely based on the model of tiered provision outlined above, however the report from the Health Select Committee (2014) outlines that such distinctions between types of service is outdated and unhelpful, and that an integrated service structured around the needs of children and young people would be more effective. In addition, it has been suggested that it is vital to bridge the gap between community and inpatient services, through the development of Tier 3 plus models of crisis and intensive home treatment.

5.1.8 This Local Transformation Plan intends to set out how Lincolnshire will improve services for our Young People not only in line with national guidance and best practice but because in Lincolnshire we believe every child, in every part of the County, should achieve their potential.

⁷ DfE/DH SEND code of practice – 0-25 years, 2014

⁸ HM Government, Healthy Lives, Healthy People, 2010

⁹ Department for Education, Mental health and behaviour in schools, 2014

5.2 Children's and young people's mental health in Lincolnshire - What is our JSNA telling us?

- 5.2.1 The current population in Lincolnshire of children and young people aged 0-18 years is estimated at around 139,720. It is predicted to increase by around 6.6% by 2020 with the highest rise being within the 5 to 9 year old group.
- 5.2.2 Many adverse factors can impact on mental health- one of which is deprivation. It is known that people who live in deprived areas generally have worse mental health. In Lincolnshire, higher levels of deprivation are experienced in the east of the county, particularly along the coast, with areas inland generally experiencing less deprivation. In the west of the county the more deprived areas tend to be confined to the urban areas of Lincoln, Grantham and Gainsborough. Just over 4% of Lincolnshire's population (approximately 30,500 people) live in areas that are in the top 10% most deprived areas nationally. In addition, 11.8% of the population live in an area constituting one of the fifth most deprived areas of England. This compares favourably against 19.8% for the England population. However, Lincoln (28.7%) and East Lindsey (22.9%) districts have higher proportions of their populations living in the fifth most deprived areas compared to the England average. South Kesteven (n=29,770) and East Lindsey (n= 25, 671) have the highest populations of children and young people under the age of 18 and Boston has the lowest (n=13,573). Both South and North Kesteven are the areas that have lowest deprivation in Lincolnshire.
- 5.2.3 Poor economic circumstances and deprivation are associated with reduced health in children, higher demand for primary health care services and poor nutrition. These factors and the circumstances in which children find themselves can lower resilience to mental health problems and impact on the overall demand on mental health services. This would suggest that demand for mental health services in these areas may be higher than estimated.
- 5.2.4 The ethnicity of Lincolnshire as a whole tends to be made up of a majority of White British populations, at around 92% of the total population, with the next largest group is usually 'White other' at around 2%. There is a spread of people from other ethnicities in each area of Lincolnshire where they are represented as a small percentage. Services should take into consideration that the population is still diverse within Lincolnshire, albeit mostly made up from people of a White British origin; provision must be available for all who are likely to use the services from the minority populations.

5.3 Predicted prevalence of mental health in children and young people in Lincolnshire

5.3.1 The following data has been obtained by applying prevalence rates from research on children's mental health in two epidemiological needs assessment snapshots undertaken by Public Health and Associate Development Solutions in 2014^{10 11}. The most up-to-date research dates back to 2004, therefore although it may seem to indicate the actual prevalence of mental health in Lincolnshire, it should be considered as an estimate only in order to inform service development. Needs may vary by region and should be considered in the context of other key determinants, what is known about the demand on services and in light of the variation in geography across Lincolnshire. All of the estimates for district and CCG area should be considered alongside the data in order to plan a responsive, locality based service.

Overall prevalence

5.3.2 Based on epidemiological evidence, the current potential prevalence of mental health disorders in the 5-18 year population for Lincolnshire is 12,856 individuals. If the prevalence rates for under 5 year olds are included then this would increase to 17,373. From within this population it is not known what proportion are seen entirely within Universal Services, albeit with possible consultation and advice support from CAMHS, and therefore do not require referral to specialised CAMHS. Overall, the proportion of those with mental health disorders or mental health problems who are referred to CAMHS is thought to be around 10-25% (Fombonne 2002), suggesting that there is potentially a large unmet need.

5.3.3 The total number of referrals to Lincolnshire CAMHS at Tier 2 and Tier 3 in the 11 months between April 2013 and Feb 2014 was 4,357 across the whole age range. For 2014-2015 the total number of referrals was 4569. However, it should be noted that this number may not represent single individual cases and could include some individuals with more than one condition requiring CAMHS intervention or repeat referrals during the year. Taking the referral figures as individual cases and applying them to the estimated prevalence of mental health disorders in Lincolnshire gives an annual referral rate of those with mental health disorders to CAMHS of 25% (27% if extrapolated to 12 months of referrals). Whilst this is in line with Fombonne's prevalence rates, it does also include children aged 0-5 years old. Of referrals made to CAMHS during this period, 3575 were deemed to meet the referral criteria for the service, which would suggest that the annual referral rate was around 20.5%. This figure would fall within the percentages suggested by Fombonne.

Prevalence by age group

Pre-school children (2-4 years)

5.3.4 There is little data about the prevalence rates of mental health disorders in pre-school age children. The most recent research found that the average prevalence rate of any mental health disorder in this age group to be 19.6% (Egger, H et al 2006). When considered alongside current population estimates, the estimated prevalence of mental health disorders across this age range in Lincolnshire is 4,517.

¹⁰ Associate Development Solutions (2014) Lincolnshire CAMHS Needs Assessment snapshot

¹¹ Firth, R (2014) Lincolnshire CAMHS – Brief Epidemiological Review, Public Health Lincolnshire

School-age children (5-10 years and 11-16 years)

- 5.3.5 Prevalence estimates in this age range are from an Office of National Statistics report by Green et al (2004). Mental health problems among children are found to be greater in boys than in girls and can affect 10.2% of boys and 5.1% of girls aged 5-10. When applied to current population estimates, this suggests a total prevalence of mental health disorders in Lincolnshire at 3,291, increasing by 600 cases by 2020.
- 5.3.6 Prevalence of mental health problems also increases as children enter adolescence with rates in the 11-15 year age group being 12.6% in boys and 10.3% in girls. Estimates would suggest a prevalence of 5,665 individuals with mental health disorders. However, due to the projection of a minor decline in this age group in Lincolnshire, cases could decrease, although this number is negligible given the degree of uncertainty around which these estimates have been made.

Early adulthood years (17-18 years)

- 5.3.7 As young people enter adulthood the rates of mental health disorders are likely to align with those seen in adult populations. Therefore, for this age group, prevalence data from the Adult Psychiatric Morbidity in England survey (McManus et al, 2007) - a prevalence of 23% - has been applied. This population is also projected to decrease by 2020 so whilst current cases are estimated at 4,000 across Lincolnshire, a decrease of 481 cases is projected by 2020.

Prevalence of specific mental health problems in Lincolnshire

- 5.3.8 According to prevalence data, conduct disorders in 5-16 year olds are predicted to be the highest potential mental health problem amongst children and young people in Lincolnshire, at 47% of all mental health problems. This is followed by emotional disorders at 29% of all mental health problems.
- 5.3.0 Autistic Spectrum Disorders in 5-10 year olds is predicted to be around 11.49 % of all mental health problems in Lincolnshire.
- 5.3.10 Whilst the actual referral data in 2013/2014 shows a difference in the percentages of children presenting in Lincolnshire CAMHS with specific mental health problems to those estimated above, behavioural problems was still the second highest reason for referral at 22%, followed by anxiety, depression and low mood at 33%, and self-harm accounted for 17% of all referrals. It must be noted that these are children and young people who were referred to the Tier 2 and Tier 3 service, and therefore does not account for those who may have been supported in Universal Services or their mental health problems having not been identified. In addition, during this period, the Lincolnshire service did not receive any referrals for children with Autistic Spectrum Disorders, however during this time, children with ASD were seen by another service and the data was unavailable.

Children who may have additional mental health needs due to their circumstances

- 5.3.11 Particular consideration of provision should be made for most children who have additional needs, or who are considered to be in vulnerable circumstances, as they are said to have increased prevalence rates of diagnosable mental health disorder at around 40 – 49%^{12 13}.
- 5.3.12 This would include children who are looked after, those with Special Educational Needs and young offenders. If a prevalence rate at the lower end is applied to the current numbers of children in Lincolnshire, then this would equate to around 7595 children across the age range, who may have a complexity of needs including mental health. The data regarding children and young people with a learning disability was not available, however, they will also present with a complexity of needs, and may have higher rates of mental health problems at around 36%.¹⁴
- 5.3.13 A recent Health Needs Assessment (HNA) undertaken for Lincolnshire's Youth Offending Service (YOS) (2014)¹⁵ states that the mental health needs of this group of children could be at least 3 times more likely than in the non-offending population. An examination of the ASSET assessment scores for the YOS in Lincolnshire suggested that 10% of children involved in offending had higher risk factors that could indicate the development of mental health issues that could require intervention. However, the ASSET also reported that 43% of young people engaged with the YOS had reported that they had 'emotions or thoughts' that affected their daily functioning. 40% of young offenders had evidence of mental health issues and 45% had been referred to or had contact with mental health services, however, of these only 8.1% had been formally diagnosed with mental illness. Around 29% of the group in the audit had self-harmed and 10% had attempted suicide. These issues in particular suggest the need for pro-active prevention and early intervention around self-harm and suicidal behaviour.

¹² Ford T, Vostanis, P, Meltzer H and Goodman R. (2007) Psychiatric disorder among British children looked after by the local authority: comparison with children in private households. *BJ Psych*, 190; 319-325.

¹³ Emerson, E (2003). Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability. *Journal of Intellectual Disability research*, 47 (1) 51-58

¹⁴ People with learning disabilities in England (2011)

¹⁵ Lincolnshire Public Health Directorate (2014) Lincolnshire Youth Offending Service: Health Needs Assessment.

5.4 Population

- 5.4.1 Lincolnshire is the 4th largest County in England. It is a 'big place' and the Children & Young People Strategic Partnership (CYPSP) has equally big aspirations for all children, young people and families who live here.
- 5.4.2 Lincolnshire is currently home to 718,000 residents with approximately 22% of the total population under 19 years of age.

Population (ONS Mid-2012 estimates) 0-19 inclusive

District	Under 5	5 to 10	11 to 15	16 to 17	18 to 19	Total
Boston	4,052	3,965	3,485	1,514	1,334	14,350
East Lindsey	6,459	7,233	7,218	3,101	2,753	26,764
Lincoln	5,749	5,340	4,489	2,009	4,604	22,191
North Kesteven	5,777	6,839	6,644	2,640	2,253	24,153
South Holland	4,689	5,151	5,010	2,105	1,775	18,730
South Kesteven	7,557	8,895	8,218	3,629	2,835	31,134
West Lindsey	4,534	5,483	5,464	2,471	2,044	19,996
Lincolnshire	38,817	42,906	40,528	17,469	17,598	157,318

- 5.4.3 By 2021 all age groups are projected to grow, with the exception of the 20-24 age-group, which is set to decrease by nearly 1,500 people. The largest increase is projected in the 75 plus age group, from approximately 68,000 people to 93,000.
- 5.4.4 People from non-white British backgrounds living in Lincolnshire have doubled from 3% in 2001 to 6% in 2007. Districts with the highest number of people who are from non-white British backgrounds are Boston, Lincoln and South Kesteven. 12% of Lincolnshire's population, (using Index of Multiple Deprivation (IMD) 2010), now live within the 20% most deprived areas of England.
- 5.4.6 Projected population levels indicate that ongoing support at the various levels of need for those with mental health and emotional wellbeing requirements will continue to be integral in the longer term to ensure that the increasing demand from increasing population figures for Lincolnshire can be effectively supported.

5.5 Supporting Strategies

- 5.5.1 This strategy is supported by and is embedded in conjunction with our:

- All Age Autism Strategy

- Joint Strategic Needs Assessment (JSNA)
- Joint Health & Wellbeing Strategy
- Looked after Children Strategy
- LAC Placement Sufficiency Strategy
- Pledge to Looked After Children
- Participation Strategy
- Children & Young People's Plan (CYPP)
- Youth Housing Strategy
- Child Poverty Strategy
- Early Help Strategy
- Care Leaver's Charter

5.6 Local Needs, Local Priorities and the importance of Child Mental Health within existing planning guidance

Joint Strategic Needs Assessment (JSNA)

- 5.6.1 The JSNA process aims to provide a comprehensive analysis of current and future local needs across a range of issues, utilising a wide range of quantitative and qualitative data, including user, patient and community views.
- 5.6.2 The requirement to produce a JSNA has been a statutory duty on county wide local authorities and local NHS since 2007. This duty has been further enhanced by the current Health and Social Care Bill. The Coalition Government has placed the Joint Strategic Needs Assessment at the heart of its proposals with regard to the future of local health improvement.
- 5.6.3 The approach we are adopting for the JSNA in Lincolnshire is one of continuous improvement. We have already made great steps in improving our current JSNA, but are clear that there is far more we can do to develop it further. As part of this improvement we have presented the JSNA in a different way this year. We have created new groupings of data so that you are able to view the JSNA based on the traditional core themed areas but can also now look at the information based on the priorities set out by Sir Michael Marmot in his review of health inequalities in England (Fair Society, Healthy Lives 2010) and also view it by topic areas.
- 5.6.4 The 2013 JSNA annual update overview report provides an overview of key developments since the 2012 update report; and the subsequent 2011 Strategy. Key areas which support C&YP include:
- Mental Health
 - Breastfeeding initiation
 - Childhood Immunisation

- Childhood Obesity and Weight Problems
- Educational Attainment
- Housing
- Looked After Children
- Pregnancy and Maternal Health
- Special Educational Needs
- Teenage Pregnancy
- Young People within the Criminal Justice System

Joint Health and Wellbeing Strategy (JHWS)

- 5.6.5 The production of the Joint Health and Wellbeing Strategy is a new legal requirement under the Health and Social Care Act 2012. NHS Lincolnshire and Lincolnshire County Council have agreed and published the JHWS for Lincolnshire 2013 - 2018. This is the first Joint Health and Wellbeing Strategy for Lincolnshire and is a key driver for integrative joint commissioning arrangements for C&YP. It has been produced by the Lincolnshire Shadow Health and Wellbeing Board and is based on the five priorities identified in the Joint Strategic Needs Assessment for Lincolnshire.
- 5.6.6 The JHWS is an approach that aims to inform and influence decisions about health and social care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing. It includes key outcomes which the board wishes to support commissioners and providers of services to deliver over the coming five years.
- 5.6.7 There are five main themes, with mental health running throughout the document:
- Promoting healthier lifestyles
 - Improve health and wellbeing of older people
 - Delivering high quality systematic care for major causes of ill health and disability
 - Improve health and social outcomes for children and reduce inequalities
 - Tackling the social determinants of health
- 5.6.8 We need to make sure that the strategy will make a real impact on C&YP's quality of life, health and wellbeing and will reduce the gap between the healthiest and least healthy people in the county.
- 5.6.9 It is a requirement that all Joint Commissioning Strategies developed by the JCB will take account of priority needs identified through the JSNA and Joint H&WB Strategy. In addition to the JSNA, the commissioning of services will also be informed via consideration of local political priorities; National Policy and Guidance, community/user feedback, demographic information and specialist needs assessments that target specific groups.

- 5.6.10 The Health and Well Being Strategy includes specific focus on C&YP. Of the five key themes, the priority for children is outlined below.
- 5.6.11 **Theme:** Improve health and social outcomes for children and reduce inequalities **Outcome:** Ensure all children get the best possible start in life and achieve their potential.
- 5.6.12 Some of the key objectives include;
- Target specific vulnerable groups to ensure appropriate support is available to narrow the gap in terms of social, education and health outcomes for looked after children, travellers, young carers, children with disabilities and special education needs, teenage parents or children whose parents have mental health conditions including post-natal depression
 - Develop and analyse a robust dataset (quantitative and qualitative data) utilising data from a range of different areas and agencies to impact on the Emotional and Mental Health Wellbeing of children and young people in Lincolnshire
 - Strengthen the existing joint commissioning board on Emotional and Mental Health Wellbeing to support the recommendations from the National Mental Health Strategy

The Joint Health and Well Being Strategy 2013-2018 – Mid Term Report

- 5.6.13 ■ The Mid Term Report focuses on primary and secondary measures across agencies to monitor and track improvements

Part of these measures include;

- A focus on hospital admissions, attainment and closing the gap for vulnerable groups
 - Supporting young people with mental health concerns into good quality work
 - Delivering the Lincolnshire Homelessness Strategy, with a particular focus on addressing the needs of people with complex and mental health needs
 - Improving people's sense of mental wellbeing
- 5.6.14 Lincolnshire County Council and Lincolnshire Partnership Foundation Trust continue to develop a constructive mental health promotion framework.

The Children and Young People's Plan 2013/16

- 5.6.15 This plan sets out how Lincolnshire County Council will work with its partners to achieve its overall 'vision'. It is based on evidence of past performance, needs assessments, consultation with local families and agreed priorities between service users and partners.

The Vision

"Every child in every part of the County should achieve their potential"

Our Priorities

- (Ensuring families can access) **Early Help**
- **Families Working Together** (To help turn around lives of families)

- **The Lincolnshire Youth Offer** (Ensuring young people have access to Positive Activities, Education and Employment with Training)

Strategic Outcomes

- Healthy and Safe
- Develop their potential in their early years and are ready for school
- Learn and Achieve
- Ready for Adult Life

Shared Outcomes

- Early Help Offer
- Early Intervention and Prevention
- Effective Safeguarding

5.6.16 Details of the full Children and Young Peoples Plan can be found at [Children and Young Peoples Plan](#).

Local Offer

5.6.17 The Special Educational Needs & Disability (SEN+D) reforms within the Children and Families Act 2014 are designed to:

- improve the outcomes for children and young people with Special Educational Needs and Disabilities and their families;
- improve the process for accessing services by having clear, single, cohesive pathways;
- improve the level and transparency of information and support available to families;
- increase the level of choice and control children, young people and their families have over the services and support they receive.

5.6.18 As part of this, Children's Services are ensuring that records and information pages around universal services for families, children and young people, and inclusive, targeted and specialised services for children and young people with SEN+D are kept up to date. The work to improve information for families with children and young people with SEN+D is known as the Local Offer. You will be required to complete a template which provides details of the services being delivered. These details will be uploaded to the Family Services Directory at www.lincolnshire.gov.uk/fsd

Early Help Offer/Strategy

5.6.19 Lincolnshire's Early Help Offer identifies the need for help for children and families as soon as problems start to emerge, or when there is a strong likelihood that problems will emerge in the future.

5.6.20 The Early Help Offer is not just for very young children as problems may also emerge at any point throughout childhood and adolescence. The Early Help Offer includes universal and targeted services designed to reduce or prevent specific problems from escalating or becoming entrenched.

5.6.21 Crucially for parents, it is envisaged that, in time, the Early Help Offer will provide the 'front door' through which they and professionals access additional support at any level.

5.7 Supporting Legislation, Policies and Procedures

5.7.1 This Transformation Plan intends to deliver services that require all Local Authority commissioned services to comply with all relevant legislation, which includes any updates and amendments.

5.7.2 Listed below are some of the relevant legislation for Mental Health and Emotional Well Being. It is not meant to be exhaustive:

- The Children and Families Act 2014
- The Children Act 1989 and 2004
- The Adoption and Children Act 2002
- Education Act 1996, 2002 and 2011
- Health and Social Care Act 2001, 2008 and 2012
- Safeguarding of Vulnerable Groups Act 2006
- Mental Health Act 1983 and Code of Practice (Amended 2007)
- Mental Capacity Act 2005
- Care Act 2014
- Working Together to Safeguard Children 2013
- Social Value Act 2012
- Human Medicines Regulations 2012
- Housing Act 1996
- The Equality Act 2010
- National Health Service Act 2006
- Sex Offenders Act 1997 as amended by part 2 of the Sexual Offences Act 2003
- Police and Justice Act 2006

5.7.3 There are several national standards and relevant guidance that are applicable to children and young people's mental health and CAMHS. This includes, but is not limited to:

- Department of Health, No Health Without Mental Health, 2011
- Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) <http://www.cypiapt.org/children-and-young-peoples-project.php>
- CYP IAPT Principles in CAMHS Services: Values and Standards "Delivering With and Delivering Well", 2014
- Special Educational Needs and Disability (SEND) Code of Practice 2014
- The Care Quality Commission's Essential Standards of Quality and Safety
- Department of Health, You're Welcome Quality Criteria, 2011

- National Youth Agency, Hear By Right – Standards for young people’s participation, 2006
- The National Service Framework for Children, Young People and Maternity Services (2004) – disabled children, young people and those with complex needs (Standard 8) and The Mental Health and Psychological Well-being of Children and Young People (Standard 9)
- The NHS Choice of Provider initiative
- Personal Budgets Guidance
- NHS England (2015) Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)
- NHSE National Specification for Transitions from CAMHS Guidance (2015)
- Recommendations from the House of Commons health Committee on Children’s and Adolescent’ mental health and CAMHS (2014)
- Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (2014)
- Achieving Better Access to Mental Health Services by 2020 (2014)
- Future in mind – Promoting, protecting and improving our children and young people's mental health and well being
- Promoting the health and welfare of looked-after children - Statutory guidance for local authorities, clinical commissioning groups and NHS England
- Lincolnshire All Age Autism Strategy 2015-2018

5.7.4 NICE guidance relating to children and young people’s emotional well-being and mental health:

CG9 Eating Disorders 2004
 CG16 Self-harm 2004
 CG26 Post-traumatic stress disorder
 CG28 Depression in Children and Young People 2005
 CG31 Obsessive Compulsive Disorder and Body Dysmorphic Disorder 2005
 CG38 Bipolar Disorder 2006
 CG72 Attention Deficit Disorder 2009
 CG77 Antisocial personality disorder 2009
 CG78 Borderline personality disorder 2009
 CG112 Anxiety 2011
 CG128 Autism diagnosis in children and young people 2011
 CG133 Self-harm: longer term management 2011
 CG155 Psychosis and schizophrenia in children and young people 2013
 CG158 Anti-social and conduct disorders in children and young people 2013
 CG170 Autism 2013
 PH4 Interventions to reduce substance misuse among vulnerable young people 2007
 PH12 Social and emotional well-being for children and young people 2008

PH20 Social and emotional well-being in secondary schools 2009
PH28 Looked-after children and young people 2010
PH40 Social and emotional well-being: early years 2012
QS48 Depression in children and young people 2013
QS59 Anti-social behaviour and conduct disorders in children and young people pathway 2014
In development – Children’s attachment (2015); Sexually harmful behaviour in young people (2016)
JG Comment on Strategy Doc for YOS

- 5.7.5 Applicable standards set out in guidance and/or issued by a competent body:
- [Quality Network for Community CAMHS Standards](#)
 - [Quality Network for Inpatient CAMHS Standards](#)
 - [Youth Wellbeing Directory & ACE V Quality Standards](#)
 - [Child Outcome Research Consortium \(CORC\)](#)
 - [Choice and Partnership Approach \(CAPA\)](#)
- 5.7.6 CYP IAPT Accreditation Council (NHS England) [values and standards](#) following a wide consultation with professionals, children / young people, parents and carers

5.8 Additional Services

5.8.1 There are additional services that are commissioned by Children's Services that work in conjunction with more specialist support. Tier 1 services are available to all children and young people and are provided by universal service professionals, Primary Care and specialist support staff e.g. General Practitioners, Health Visitors and School Nurses. Universal services provide advice, support and guidance for low level problems as well as working with service users to promote resilience, prevention and early intervention.

5.8.2 These services include:

Online Counselling

5.8.3 Kooth is an Online Counselling Support service for children and young people in Lincolnshire who are aged 11-25 with emotional or mental health concerns. The service was commissioned in recognition of the children and young people who don't need to access Children and Adolescent Mental Health Services (CAMHS) but still need support for less severe mental health problems that are more likely to be short-lived, but which may affect their psychological and emotional well-being causing concern to themselves, their families and friends.

5.8.4 The service helps young people manage their emotional wellbeing concerns at the earliest opportunity before these problems escalate resulting in the possible need for more specialist service intervention.

5.8.5 The service offers a friendly, safe and easy to use website (Kooth.com) which is accessible 24 hours a day. The service also offers access to counselling services seven days a week including daytime and evenings, 365 days a year.

5.8.6 Support can be provided through:

- Website – including access to articles, podcasts, peer support
- Chat with Counsellors
- Messaging
- Group chats/Forums
- Bookable appointments with Counsellors at a time to suit the young person
- Referral to CAMHS where threshold criteria are met
- Signposting to relevant Lincolnshire services

5.8.7 Currently, the top presenting issues include:

- Anxiety
- Stress
- Family Relationships
- Friendships
- Self-Worth
- Self-Harm

5.8.8 The predominate benefits of an online service include access to support outside of Business / School hours, active participation from users through the use of blogs, chats and online diaries and mobile accessible help. The recent performance information shows that 76% of access happens outside of office hours.

Preparing for Adulthood

5.8.9 As a young person approaches the age of 14 they will commence their transition into adulthood. If the young person has a Mental Health need, Adult Care may become involved if the individual is likely to be eligible for services from the age of 18.

5.8.10 Adult Care will provide information to the young person and their family from the age of 14 and in some instances will attend transition reviews. After the young person becomes 17 a Practitioner from the Intake Team will undertake an Adult Care assessment to determine eligibility to adult care services and ascertain any presenting needs. In addition to the Adult Care assessment a Continuing Health Care assessment will be completed to ascertain health care needs. If the young person is eligible for Adult Care services the Practitioner will work with the individual and their family to develop a Personal Plan which will detail how their needs will be met when they are 18.

Outreach Support Services

5.8.11 Lincolnshire Outreach Support Service offers access to high quality specialist teaching advice, professional development training and direct engagement work with pupils from qualified

practitioners to School staff in all phases of education. Outreach is delivered by a number of locality based providers located across the County and primarily seeks to improve outcomes for pupils with a range of needs including (but not exhaustive too) Autism, Physical Disabilities, moderate to severe Learning Difficulties, Challenging Behaviours and Social Communication challenges which impact on cognitive development and learning potential.

5.8.12 Outreach support is currently delivered via a number of identified Schools and is one component of the holistic package of support for Schools which works in conjunction with other elements such as Children and Adolescent Mental Health Services, Youth Offending Services, Locality Targeted Teams, Online Counselling Support and Families Working Together.

5.8.13 Outreach seeks to build the capacity and resilience of School Staff in receipt of Outreach support by providing specialist advice and training through telephone and email helplines, providing direct contact work with pupils and developing partnerships and locality working with all stakeholders. As a result of accessing the support available the opportunities for pupils with complex needs to remain in mainstream education shall increase and Schools can increase their ability to respond to the challenging, complex and increasing need of young people. Pupils can reach their potential and progress can be achieved.

5.8.14 The overall aim of the Outreach Service offers is to provide assessment and both short and medium term intervention, improvement or stabilisation and resolution for a range of SEN&D and Behavioural Needs in Children and Young People as well as continuous professional development training for teaching and non-teaching staff, so that they can provide ongoing and longer term support for those complex needs as part of legacy building.

5.8.15 The Service will also play a key role in the holistic package of Universal support services, accessible by all Schools across Lincolnshire.

Specialist Community Perinatal Mental Health Teams

5.8.16 The Perinatal Community Mental Health Team (PCMHT) provides a specialised service for the prevention and treatment of Serious Mental Illness in the ante natal and post-natal period in order to maximise the mental and emotional well-being of mother and infant. The team is multidisciplinary, comprising of a Consultant Psychiatrist and specialist CPN's and a Social Worker with the knowledge, skills, competencies and experience to offer expert advice, treatment and care, supported by administrative/secretarial staff.
For further detail, please see Section 6.

School Nursing

5.8.17 The School Nursing service provides services to all school entry age -19 year olds. All children, young people and their families have an allocated health professional as a point of contact if they are receiving individual services and a team contact if receiving universal services. School Nurses contribute to health needs assessment, provide services in community environments and work with young people and school staff to promote health and well-being within a school setting.

5.8.18 School Nurses are part of teams providing on-going additional services for vulnerable children, young people and families requiring longer term support for a range of special needs such as disadvantage, disability, mental health or substance misuse and risk-taking behaviours. School nurses also form part of the high intensity multi-agency services for children, young people and

families where there are child protection or safeguarding concerns.

Youth Housing

- 5.8.19 The provider of the service is the Lincolnshire Support Partnership (LSP) – a consortium of four existing supported accommodation Providers: NACRO (Lead consortium member), Axiom Housing Association, Lincolnshire Employment Accommodation Project Ltd (LEAP), and Nottingham Community Housing Association (NCHA).
- 5.8.20 County wide provision includes: general needs, complex needs, young parents and emergency accommodation. .
- 5.8.21 The service provides support for young people aged 16-17 years old and care leavers aged 18 – 21 years (up to 24 years where they are in higher education) who are homeless or at risk of homelessness.
- 5.8.22 Supported housing is available for young people that are identified by Children's Services and will already have received help with homeless prevention and housing advice, together with an assessment of their support requirements.
- 5.8.23 The young person will receive support to develop life skills, manage their accommodation and develop and sustain their ability to live independently in the community. This support will enable them to access independent accommodation as soon as possible i.e. at the point where they are able to successfully maintain a tenancy. Equally, the young person will receive support to foster good family relationships to enable them to return home where safe and appropriate to do so.

Advocacy Services

- 5.8.24 This new model of provision began on the 1st July 2015. Total Voice Lincolnshire provides an independent county wide statutory and non-statutory advocacy service for Adults and Children and Young People.
- 5.8.25 Total Voice is a consortia arrangement and this partnership consists of VoiceAbility, as the lead provider, together with Barnardos, Age UK and Lincs2Advice.
- 5.8.26 Advocacy enables people to speak for themselves so that their views, wishes and opinions about their care and well-being are heard and understood. Advocates help individuals to get information and think through the available options. Advocates do not provide advice or make decisions on someone's behalf.
- 5.8.27 There is a single point of Referral for the service and this is managed by the Lincs2Advice arm of the consortia, offering enhanced information and signposting where applicable. Those who are eligible and require 1-1 specialist advocacy will be allocated an advocate.

Portage

- 5.8.28 Portage is a home-visiting educational service for pre-school children with additional support needs and their families. It is an approach to support families who could not access settings-based services. Its key features are:
 - regular home-visiting

- supporting children to develop play, communication, learning and relationships
- supporting families to play and learn together with their child

- 5.8.29 Children can be referred to portage from birth by parents/carers or other agencies. There are currently eight portage services, commissioned by LCC, operating across Lincolnshire with approximately 360 home visits per month.
- 5.8.30 The services' total caseload has been just above 150 for the past three years. Referrals come from parents and other professionals, who recognise the value of the portage services. Portage monitor the impact of their work with individual families using the portage checklist, to focus on small developmental steps and show progress, as well as through longer-term targets that link to the development goals in the Early Years Foundation Stage Profile.

Specialist Commissioned services for SEND

- 5.8.31 The commissioning team work closely with the SEND teams and with stakeholders to ensure that the services being commissioned meet the needs and required outcomes of all those who need to access these services.
- 5.8.32 A range of services are commissioned, from countywide services such as domiciliary care services to individual placements in schools/colleges. An up to date list of all of these services is available from the commissioning team.

Employment, Education & Training

- 5.8.33 Welfare 2 Work is a specialist team within Lincolnshire County Council providing support to Children and Young Adults between ages of 14-25 with Learning Disabilities with all aspects surrounding employment.
- 5.8.34 The team provides support to individuals who are seeking paid, voluntary or self-employment, apprenticeships or work experience. The support provided includes confidence building, job coaching, travel training, work preparation training and 1:1 job searching.
- 5.8.35 Referrals to this service can be made from Practitioners, Schools and Colleges or through a Self-Referral. An Initial Assessment will be carried out to enable the team to find out more about the individual and whether the service can provide the right type of support. In addition there are work schemes for Disabled people includes Access to work and Pathways to work programs.

Early Years

- 5.8.36 Early Support Care Co-ordination (ESCO) is committed to improving the delivery of services for disabled children, young people and their families. It enables services to co-ordinate their activity better and provide families with a single point of contact and continuity through key working and face to face information sharing and signposting.
- 5.8.37 ESCO is committed to raising standards for children with disabilities within Lincolnshire and can provide a service for children and young people between the ages of birth to 18 years while unmet care co-ordination needs are present from their disabilities. This can include;

- Long term complex health needs including those with disability
- Life limiting conditions and palliative care
- Cognitive, sensory and/or physical impairment that significantly impacts on daily living
- Autistic Spectrum Disorder
- Children and young people whose behaviour is associated with other impairments such as severe learning disabilities

5.8.38 The Sensory Education and Support Service (SESS) offers support and specialist teaching to children with a sensory impairment and aims to ensure that young people with a sensory loss gain access to their educational environment and make progression in order to raise aspiration and maximise development. Services are in place to support visual impairment; hearing impairment and multi -sensory impairments who work with pre-school children at home and in Early Years settings.

5.8.39 **All Age Autism Strategy**

There is a county wide Autism Strategy in place that all services should link into. The aims of this strategy are:

- To share an ambitious model for promoting and enabling the best care, support, enablement and social inclusion of people with autism of all ages and their families / carers in Lincolnshire.
- To inspire commissioners and Suppliers in the local authority, health and non-statutory sectors to commission and deliver a better future for local people living with autism.
- To ensure Lincolnshire reflects national policy and adheres to current legislation.
- To ensure Lincolnshire uses resources efficiently and effectively

5.8.40 In addition other Lincolnshire services include;

- Educational Psychologists working with 4-19 year olds
- Centre for Grief and Loss Counselling
- Health Visitors
- Counselling support for Adoption services
- Looked After Children Educational Services Team
- Youth Offending Services

6. Service Transformation

- Improving Access to Effective Support – A System without Tiers
- Care for the Most Vulnerable
- Developing the Workforce

6.1 New Model of Service Delivery

6.1.1 Lincolnshire County Council has invested 18 months of time and resource into reviewing the existing CAMH Service and drafting a new model of delivery before entering into a period of robust negotiation with the existing Provider with both parties providing partnership working and constructive challenge.

Stakeholder engagement was undertaken with 55 stakeholder groups including;

- Children's Centres
- GP's
- CCG's
- Social Care Team
- Existing Provider of CAMHS including Psychiatrists
- Adult Mental Health Teams
- Children & Young People Voluntary Sector Forum
- Health Visitors
- Other counselling Providers
- Lincoln College
- Primary Schools
- Secondary Schools including Academies
- Head of Regulated Services for Fostering and Adoption
- Parent and Carer Forums
- Additional Needs Teams
- Educational Psychiatrists
- SEND Teams
- Young Carers
- ULHT
- Youth Offending
- Front line delivery staff

6.1.2 Following the stakeholder engagement, Lincolnshire County Council commissioned industry experts, 'Associate Development Solutions' to support with the redesign of a CAMHS Service Specification that will give improved availability and effectiveness of mental health interventions for children in Lincolnshire; moving from a tier based delivery model to one that provides evidence based pathways of care and increased access to psychological therapies.

6.1.3 In order to deliver the principles of a CYP IAPT model local CAMH Services will be required to undergo a process of transformation, operating within the following parameters:

- Providing Community Mental Health Services for all children and young people, from birth up to the age of 18 years (or 25 years of age for care leavers), in the county of Lincolnshire.
- Functioning as part of a multi-agency pathway of provision, which meets the emotional well-being and mental health needs of children, young people and their parents/carers in Lincolnshire

- Providing screening, assessment, short and medium term intervention, stabilisation and resolution for a range of newly emerging or low severity mental health problems in children and young people, and on-going treatment and management of more severe, long term and/or complex mental health conditions.
- Care being provided through evidence based interventions with an agreed step up and step down model from pre CAMHS through to specialist Tier 4 services,
- Routine outcome monitoring and feedback being used to influence treatment and service design.
- Addressing the needs of children and young people who have particular vulnerability to mental health problems
- Services that are appropriate to age, development and presentation/diagnosis and are culturally competent; delivered within the context of the young person's family situation.
- Operating a flexible, capacity and demand based model that will ensure that provision is responsive to the mental health needs of children and young people in Lincolnshire.
- Supporting children and young people locally, through a hub and spoke model, ensuring that their needs are met at the times they want to be seen through flexible opening hours and in environments that support their age and developmental/maturity.
- Providing training, support and consultation to Universal Services, specifically working with schools, in order to support capacity building, the provision of early help, and aid early identification of mental health problems in children and young people, ensuring timely access to more specialist interventions when necessary.

6.1.4 The remodelled service will operate according to CYP IAPT principles and include the following key elements of service:

- A Single Point of Referral
- Pre CAMHS support
- An integrated CAMHS provision delivering evidenced based pathways and focused on outcomes.
- Access to crisis intervention and home treatment 24 hours a day, 7 days a week in the form of a Tier 3+ service
- A community based eating disorder service (CEDS-CYP)
- Support to vulnerable groups
- Care and support through transition

6.1.5 For more detail please review sections 6.2 – 6.12

6.2 A Single Point of Referral

6.2.1 All referral will be received via a Single Point of Referral.

6.2.2 The CAMHS service will have clear eligibility criteria and referral processes which will be accessible and understandable.

6.2.3 All referrals will be received via the Single Point of Referral, (SPR), into a daily 'intake' triage function. This will prioritise referrals and classify them as emergency, urgent, and non-urgent, thus ensuring the assessment appointments offered are in line with the contract's KPIs.

6.2.4 A clear self-referral process will be in place for children, young people and parents or carers.

6.3 Pre CAMHS support

6.3.1 This represents an early help offer.

6.3.2 CAMHS staff will be accessible to offer support and guidance and be visible, working in community settings to establish professional relationships to improve outcomes for Children and young people.

6.3.3 CAMHS staff will offer support, training and consultation to Universal Services, including schools and neighbourhood teams, to build capacity around early help and emotional and mental health promotion and prevention.

6.3.4 CAMHS staff will be actively involved in meetings, where all partner agencies have a role to play to ensure the most appropriate services are put into place for children and young people. They will have a clear understanding of, and work in collaboration with, other professionals ensuring effective planning and delivery of services and effective communication between agencies to promote collaborative working in the engagement of young people and their families.

6.3.5 The main service delivery features will be:

- A 9-5 professional advice line
- Consultation and training days that have sufficient flexibility to provide specific sessions on advice / liaison / agency support / consultation / collaboration and joint working.
- The development of self-help psychosocial education materials and a directory of the local CAMH Services.

6.4 An integrated CAMHS provision delivering, evidenced based pathways focused on outcomes.

6.4.1 Reflective of CYP IAPT, the Lincolnshire CAMHS service specification is based on the development of treatment pathways and specific support pathways, taking into account both NICE guidelines and local demand for CAMHS services. The pathways are built on a tiered / stepped approach and are focussed on early intervention and prevention. They also utilise the best evidence available for the diagnosis and management of the various conditions presenting to the service. Where relevant pathways identify the roles of the various partner agencies at the different stage of the pathway.

6.4.2 The NICE clinical pathways are underpinned by both patient reported and clinically reported outcome measures to remove 'clinical drift' and will work in harmony with the Care Programme Approach (CPA) review processes, when required.

6.4.3 Assessment processes will operate on a principle of the most skilled clinicians being available to deliver "getting it right first time, every time". The young person will be matched to each clinical pathway by an assessment process that includes an objective psychometric measure/test to work in conjunction with clinical and comprehensive psychosocial assessment ensuring the model contains a robust benchmarking and objective consistency.

- 6.4.4 The adherence to NICE guidance and the introduction of objective and specific psychometric tests within the assessment process will result in robust and consistent classification of severity of condition and ensure children and young people commence on the most appropriate clinical pathway. This is supported by a clear functional distinction between mild to moderate, moderate to severe and Tier 3+ (crisis management).
- 6.4.5 There will be an expectation that the service will offer access to a full range of self-help materials and, within a stepped care model, will deliver appropriate group interventions as an alternative to 1-1 care.
- 6.4.6 Specific pathways being developed for delivery are:
- Depression
 - Anxiety
 - Obsessive Compulsive Disorder & Body Dysmorphic Disorder
 - Post-Traumatic Stress Disorder
 - Self-Harm
 - Eating Disorders
 - Physical Health
 - Behaviour/ adjustment/ attachment difficulties
 - Harmful sexualised behaviour
 - Psychosis
 - Learning Disability
- 6.4.7 Delivering effective interventions involves clinicians applying parallel sets of knowledge and skills. There will always be some young people for whom clinical guideline recommendations are not appropriate, and situations in which the recommendations are not readily applicable. These pathways do not, therefore, override the individual clinicians' responsibility to make appropriate decisions in the circumstances of the individual young person, in consultation with them and/or their carer.

6.5 Tier 3+ service

- 6.5.1 The model is based on the development of a specific CAMHS crisis and intensive home treatment service but one that is part of the stepped provision within CAMHS. The target population for a Tier 3+ service would include:
- Children and young people meeting the criteria for moderate to severe CAMHS as a minimum requirement
 - Where mental health needs and emotional disturbance is to a degree where the level of risk the young person poses cannot be contained by moderate to severe CAMHS alone, but assessment and intensive monitoring and treatment by a specialist community service could provide an alternative to admission to Tier 4 services
 - Those whose deterioration in mental state and functioning renders them liable for admission to an inpatient unit.
 - Those requiring discharge from an acute inpatient service following an episode of care
 - Those children and young people requiring an intensive acute care pathway
- 6.5.2 The types of needs that would be met would include:
- Severe depression/emotional disorders
 - Newly presenting or acute untreated psychosis.
 - Obsessive Compulsive Disorder
 - Imminent risk of suicide or history of serious self-harm

- Imminent risk of harm to others
- In cases of diagnostic uncertainty when a period of assessment within a stepped care model is required, which cannot be managed within the CAMHS community team without the support described above; home treatment would complement rather than replace the existing package of care.
- When there is a primary diagnosis of eating disorder and the young person needs an acute intervention in relation to complexity of risk, mental illness [e.g. Depression] and/or low BMI requiring emergency intervention
- Co-existing substance misuse issues and mild to moderate learning and communication difficulties.
- Referrals accepted up to the age of 18 years. The Intensive Home Treatment service would work proactively where adult services may be indicated from 17.5 years.
- The child or young person will be in need of an acute care pathway rather than for example assertive outreach due to issues of engagement or a 2nd opinion/re formulation that could not be achieved by inter locality working at a Tier 3 level.

6.5.3 The Objectives of the service would include:

- To ensure that children and young people with acute mental health problems, including those which are complex, severe and persistent, receive intensive community-based services that meet their wider educational and social care needs. To maintain clarity of role and function, this is protected and distinct from the role of the community CAMHS team.
- Close working with locality Community Team colleagues to deliver multi-professional service which supports case coordination responsibilities at a community level in accordance with CPA.
- Ensuring the service complies with all regulatory, professional and statutory requirements
- Supporting multi-agency working using a 'team around the child' approach.
- Provide crisis response and crisis support out of hours, which supports the care provided by Community Team in hours.
- To undertake gatekeeping function for admission to T4 services where young person presents with on-going complex issues and risks that require in-patient service

6.6 A community based eating disorder service (CEDS-CYP)

6.6.1 Currently young people with an eating disorder are cared for by Tier 3 CAMHS, and from age 16, access support from adult eating disorder services.

6.6.2 As part of its new delivery, future CAMHS provision will include a CEDS-CYP, which will implement a NICE Guidance eating disorder pathway to include Anorexia Nervosa, Bulimia, Binge Eating and Atypical Eating Disorders

6.6.3 Whilst this new team will deliver a discrete service, delivered by staff with the relevant skills, competencies and training; they will work closely with other CAMHS services to enable young people with an eating disorder to access the full range of supportive interventions available.

6.6.4 The team will develop a clear 'stepped care' approach which will include escalation to inpatient facilities if required.

6.6.5 Clear transition protocols/ joint working will be developed with the adult eating disorder service.

6.6.6 The team will be based together, but will operate out of all of the local CAMHS hubs and will also offer a home treatment and family support element.

6.6.7 The team will be able to offer:

- Psychiatric assessment
- Medical assessment
- Rapid response
- Staff trained in evidence based psychological interventions for eating disorders
- Home treatment and family support

6.6.8 24 hour delivery will be provided by the combining of two approaches:

- The core team will operate across Monday to Friday, 8 until 8, with home support being in place 7 days a week, when required.
- Urgent support out of these hours will be provided by the CAMHS Tier 3+ service, working in partnership with the local acute Trust; when there is a primary diagnosis of eating disorder and the young person needs an acute intervention in relation to complexity of risk, mental illness [e.g. Depression] and/or low BMI requiring emergency intervention.

6.6.9 Paediatric support to the service will be provided through a shared care protocol with the local acute Trust

6.6.10 The core team will consist of:

Consultant Psychiatrist:	1.00
Psychology 8B Clinical Lead	1.00
Band 7 Nurse Senior Therapist:	1.00
Band 6 Nurses:	4.00
Band 4 Community Support:	2.00
Band 6 Dietician:	0.40
Band 2 Admin:	1.00

6.6.11 The result of this approach will ensure that wait and access timings for eating disorders are met.

6.6.12 The risk model used, in terms of urgency, features:

- Emergency telephone response in 4 hours followed by an emergency face to face assessment in 13 hours
- Urgent face to face assessment in 72 hours
- Treatment start, maximum of 1 week for emergency/ urgent maximum of 4 weeks for routine eating disorder classification.

6.6.13 The service is committed to data collection and completing data request requirements. The contract governance arrangements between commissioners and providers have a strong history of monitoring service demand and capacity. Therefore the obligation to meet the standard by 2020 will be robustly monitored, using 2016 data collected, by the service, to inform Contracting KPI trajectories. This will include predicted referral rates based on both demand and unmet need to ensure that the Eating Disorder Services have incremental trajectory percentage increases that aspire to achieve with the aim of setting a 95% tolerance level by 2020.

6.6.14 Based on 2014/2015 data and the Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide, we anticipate a referral of 100 children per year. Integral to the successful implementation of the Community Eating Disorder Service will

be the development of appropriate tracking measurements; such as 95% of all cases accepted receive a NICE concordant treatment package by 2018. As part of establishing the performance baseline the service will look at the referrals received and the number of cases receiving NICE concordant treatment packages.

- 6.6.15 The commitment to developing the Community Eating Disorder Service will include continuous utilisation of CQUIN measurements to benchmark the service in line with national trajectory.

6.7 Support to vulnerable groups

6.7.1 Children and young people with vulnerabilities that predispose them to mental health problems due to their biological or social history should be able to access and receive high quality support at an early enough stage to stop entrenchment and escalation of need. The service needs to be clear about the access and support available to vulnerable individuals. Lincolnshire is committed to reducing health inequalities and it is clear that children, young people and their families who have vulnerabilities and complex needs should not have to fight for services. Looked After Children for example, are particularly likely to feel disempowered and may have less support due to their social and family context. In response to this, the model proposes to meet the needs of vulnerable groups as outlined below, to ensure that irrespective of vulnerabilities all children receive support and that inequalities can be redressed. The remodelled service will ensure the full spectrum of need, including those young people especially vulnerable to mental health problems is met, this will include:

- 6.7.2
- Looked After Children and Care Leavers
 - Those with Learning Disabilities
 - Those at risk or in contact with the Youth Justice System
 - Those who have been sexually abused or exploited

6.7.3 Support for children and young people especially vulnerable to mental health problems will not be delivered as standalone services; they will be part of the community provision, delivered in evidence based pathways but the contract still requires the resource allocated to support these vulnerable groups is explicit.

6.7.4 In not providing standalone 'teams', the model will instead be based on a QIPP (Quality, Innovation, and Productivity & Prevention) principle to basing the specific resource allocation within the core clinical provision. This is to ensure a more cost effective and clinically integrated provision improving continuity of care and continuity planning.

Looked After Children

6.7.5 Building on the good practice already within the existing contract; the service will be responsive, delivered by skilled staff that have the specialist experience and qualifications to work with LAC, including Adopted children.

This includes:

- Consultation, advice and support to foster carers/ residential social workers and adopted parents via a direct, flexible and rapid response
- Assistance with placement stability including behavioural management strategies to help prevent breakdown of placements
- Specialist mental health and psychological assessment and direct intervention with young people to address their mental health needs
- Training in areas such as attachment and other mental health issues of LAC

- Provision of (and access to) therapy and direct work with children and young people.
- Co-ordination and liaison with Tier 3+ to provide a consistent approach should gate keeping to Tier 4 be recommended

6.7.6 We have also commissioned a wait time of 4 weeks for our Looked After Children

Children with a Learning Disability

6.7.7 Reflective of Greenlight principles, young people with a learning disability will be enabled to access the full range of services on offer.

6.7.8 However, acknowledging the importance of meeting need; there will continue to be a dedicated and specialist learning disability care pathway guiding this client groups experience from referral into the service to the point of discharge. This pathway will provide highly specialist mental health assessment using tools and assessment material specifically devised for use with this client group, completed by suitably qualified staff, specialist in the Learning Disability field, which will inform the need for specialist therapeutic intervention.

6.7.9 Following assessment, the young person will be placed into one of four learning disability intervention pathways (specifically: anxiety; depression; eating difficulties; or self-harm/challenging behaviour), where a bespoke package of specialist care will be offered, with specific focus on the need for augmentation of therapeutic materials and an approach to ensure the specific learning needs of the individual are taken into account.

6.7.10 The therapeutic interventions delivered will include those set out in the NICE guidelines relating to specific clinical conditions, but differentiated to the individual levels of learning, as appropriate, or more specialist interventions where mainstream approaches are not appropriate, e.g. sensory approaches/intensive interaction/ environmental support packages/non-language based therapeutic interventions/creative/non-directive therapies

6.7.11 There will be a strong emphasis on multiagency working and support packages, during intervention, in addition to utilising and enhancing the already existing and very strong links to local partners in care in specialist services in Lincolnshire.

6.7.12 Children with learning disabilities will have equitable access to the full range of CAMHS services available through this provision, but in addition, the presence of a specialist care pathway for learning disabilities through CAMHS will ensure this group will continue to receive equal opportunity for access to appropriate treatment and therapeutic interventions.

6.7.13 We have commissioned a wait time of 6 weeks for Learning Disability

Young people in contact with the Youth Justice System

6.7.14 We are a registered member of the Academy for Justice Commissioning, a learning toolkit which identifies, supports and promote excellence in public service commissioning. The group is responsible for:

- strengthening the reputation of social and justice commissioning by driving up standards and increasing value for money
- identifying and sharing good practice in public service commissioning
- providing learning and development opportunities for social and justice commissioners and actively encouraging networking and debate
- sponsoring and stimulating relevant research
- promoting the accreditation of learning provision in social and justice commissioning and

- related subjects, and the attainment of standards marks by learning providers
- strengthening links with other commissioning stakeholders through active networking, collaboration and partnership working

6.7.15 Currently the provider service has CAMHS workers embedded within local YOS teams. To move away from 'silo working', in the new model of care whilst the CAMH Service will be expected to work closely with YOS, workers will no longer be embedded, but instead this vulnerable group will be given access to the most appropriate care pathway to meet their needs.

6.7.16 Assessments will be designed to ensure early identification of those in contact with the YJS and this will ensure a strong multi-disciplinary/ agency approach is put in place to support the young person.

6.7.17 We have commissioned a wait time of 3 weeks for young people in contact with the YJS.

6.8 Care and support through transition

6.8.1 Transitions will be managed in accordance with the NHSE National Guidance and specification

6.8.2 Transition should take place at a time that is right for the child and young person and they should be kept fully informed and involved throughout the process.

6.8.3 Those requiring transition will be identified by the care coordinator. Who, to ensure a smooth transition plan is developed and implemented, will adhere to the following process:

- A lead person from each service will be identified to be responsible for the operational elements of, ensuring a single point of referral with allocated lead professionals.
- the young person will be identified and referred at least 6 months prior to their 18th birthday (18.5 years for LAC)
- The young person (and where appropriate their parent or carer) will be involved in the planning and decision making and will be prepared in advance for the transition meetings; this will include the use of clear adolescent-friendly information to the young person about the range of adult services (including how to access options such as the open-access Open Minds service)

6.8.4 For those with complex or severe needs the Care Programme Approach (CPA) will be used. This will include a formal transition CPA meeting involving CAMHS and AMHS (plus any other appropriate services). For those not formally under the CPA the same principles of joint transition meetings will apply. The purpose of which are the completion of a transition treatment Plan including both Risk and Crisis Contingency planning.

6.8.5 The frequency of joint / transition meetings will be agreed at these forums. A clinically appropriate number of appointments will be offered during this "hand over period". The specific needs of more vulnerable individuals such as young people with learning or physical disability, LAC clients, homeless young people etc. will be taken into account addressed and other appropriate professionals involved in order to create a plan that is holistic, seamless and inclusive.

6.9 Waits and Access

6.9.1 The new CAMHS model has amended the wait times as below. There are two response rate targets; 1) Service and Presentation Type and 2) Urgency. The young person should always be subject to the quicker of the two response targets, based on their individual need.

6.9.2 Urgency, waits include the following classifications:

Emergency

- CAMHS telephone response within 4 hours
- Face-to-face emergency response within 13 hours (24/7)

Urgent

- Face to face within 72 hours

Routine

- 6.9.3 ○ Face to face within 6 weeks

The service presentation time is six weeks, with vulnerable groups further supported by the following access times:

- Self-Harm Assessment and Intervention Service: 24 Hours
- Specialist CAMHS Support to LAC: 4 weeks
- Young people in contact with the YJS: 3 week
- Community Eating Disorder –
 - Face to Face emergency response: 13 hours
 - Face to Face urgent response: 72 hours
 - Treatment start: within 1 week for urgent cases and 4 weeks for routine

6.10 Standards and Outcomes

- 6.10.1 CAMHS will embed the use of service feedback and outcome measures to improve clinical practice and patient outcomes alongside monitoring the experience of service received. The use of these tools will enable clinician's to work collaboratively with young people and their families to monitor progress, identify potential risks, change therapeutic interventions, or step down the interventions as appropriate.

- 6.10.2 The service will use review measures and session by session tools. The tools will provide information to help understand the nature of the difficulties for the young person and family; the aims and goals of the interventions provided; the effectiveness of the interventions and therapeutic alliance; and overall patient and parent/carer experience of the service.

- 6.10.3 The minimum measures used will be:

Strengths and Difficulties Questionnaire (SDQ) and Revised Child Anxiety and Depression Scale (RCADS) – Review measures

Goal Based Outcomes (GBO) – process tracking

Symptom Rating Scales to track and monitor symptom improvement/condition.

Outcomes Orientated CAMHS (SRS and ORS measure) – session by session/ frequent use tool
CHI-ESQ – Patient Experience of Service questionnaire – review measure for patient and carer's overall service experience

Patient Reported Outcome Measures (PROMs) - assess the quality of care delivered to patients from the patient perspective

6.11 Therapies to be offered

- 6.11.1 The transformation of the service will mean the following therapeutic interventions will be available to achieve the NICE Guidance treatment pathways:

- CBT
- Brief Solution Focused Therapy

- Psychosocial education
- Individual Therapy
- Group work
- Counselling
- Psychiatric Intervention
- Psychotherapeutic Intervention
- Long Term Therapeutic Work
- Medication
- Play work
- Art Therapy
- Family Therapy
- Behavioural Therapy
- Filial Therapy
- Theraplay

To further enhance the CYP IAPT offering:

- 6.11.2
- Generic Short Term Brief Therapy
 - CBT for depression and anxiety
 - Parenting interventions for conduct disorder: this will include parenting groups based on “Nurtured Heart” principles.
 - Systemic Family Practice
 - Interpersonal Psychotherapy for adolescents (IPT-A) for depression
 - 6Dyadic Developmental Psychotherapy
 - EMDR

6.12 Overview of treatment pathways and therapeutic interventions/treatment options (Please see page 79)

6.13 Workforce Requirements

6.13.1 It is expected that:

- The workforce will be competent and capable of delivering the required clinical interventions
- Will receive regular supervision of their intervention work, which includes continuing professional development and accessing specialist supervision as appropriate for specific types of interventions e.g. CBT; family work; theraplay; EMDR.
- Staff are trained in the use of OO CAMHS and CORC-including the administrative elements of the process to comply with data capture requirements that feedback from the data collection system and processes are used with service users and the workforce to help adjust and change interventions as appropriate.

6.13.2 In order to develop the workforce and ensure the full range of therapeutic interventions can be offered, when the new model is implemented, this will include a full skills gap analysis which will enable a training plan to be formulated.

6.13.3 As part of the gap analysis that will be undertaken by the provider, the skill set of the staff delivering the contract will be addressed and any requirements will be captured and progressed accordingly. The gap analysis will include a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix

6.13.4 The local provider has substantial experience of delivering a range of therapeutic interventions, but in light of the transformational service redesign moving to a CYP- IAPT based delivery model; significant training monies have been identified in the budget for 2015/16 and 2016/17 in

acknowledgement of the likely skill development needs of the service.

- 6.13.5 The current workforce of 96 FTE is aligned to a traditional Tier 2 and 3 CAMHS model, with support provided to universal services.
- 6.13.6 The transformational model is a direct move away from the Tiered model of service delivery and the workforce re-profiling and skill mix sees a workforce of 110 FTE- provide an increased range of provision which includes:
- Tier 3 plus operating 24/7- seven days a week
 - Eating Disorder Service,
 - Extended operating hours for community clinical provision
 - Enhanced services for vulnerable groups.
- 6.13.7 The Transformational workforce model of 110 FTE also includes new roles, making best use of the resources available (eg Psychology Assistants and Group worker role profiles)

6.14 Perinatal services

- 6.14.1 As part of their strong commitment to the development of perinatal services, Lincolnshire Clinical Commissioning Groups have recently invested in the development of a Lincolnshire wide perinatal team.
- 6.14.2 The Perinatal Community Mental Health Team (PCMHT) provides a specialised service for the prevention and treatment of Serious Mental Illness in the ante natal and post-natal period in order to maximise the mental and emotional well-being of mother and infant. The team is multidisciplinary, comprising of a Consultant Psychiatrist and specialist CPN's and a Social Worker with the knowledge, skills, competencies and experience to offer expert advice, treatment and care, supported by administrative/secretarial staff.
- 6.14.3 The purpose of the team is to ensure that all women of reproductive age with a current, or previous, serious mental illness have access to advice and information on the risks of pregnancy and childbirth on their mental health and the health of the foetus/infant, including the risks and benefits of psychotropic medication.
- 6.14.4 The team supports women in their own community safely, and effectively, avoiding unnecessary admission, working in conjunction with Specialised In-Patient Mother and Baby Units to provide alternatives to admission and provide treatment and support for women following discharge after an in-patient stay.
- 6.14.5 As part of the perinatal support, a dedicated section on maternal mental health has been developed as part of the Lincolnshire Healthy Families website, ensuring facts and advice can be accessed whenever it is needed the most.
- 6.14.6 The website includes information about antenatal depression and anxiety, postnatal depression, fathers and depression, where to seek help and other helpful resources for maternal mental health.
- 6.14.7 To help provide support through shared experiences, the website features real life stories from mums who have had their own struggles with maternal mental health as part of a peer to peer support approach.
- 6.14.8 The focus for the CAMHS interface with the PCMHT which currently provides the Lincolnshire

perinatal services will be to:-

- Ensure staff from PCMHT can access timely CAMHS advice, consultation and training as part of both the pre CAMHS consultation and training offer and as part of Specialist CAMHS provision.
- Improve the referral response by CAMHS to other children within a family where a parent has been identified as having severe and enduring mental health concerns, to improve the emotional wellbeing and mental health of these children.
- Ensure CAMHS staff working with Looked After Children liaise closely, (and work jointly as appropriate), with PCMHT staff to provide comprehensive, responsive and flexible mental health interventions to these young mothers / mothers-to-be given the health inequalities and additional vulnerabilities known to be present in this client group.
- Build on and develop the current child clinical psychology consultative input to the Family Nurse Partnership service. This is a community based service that is currently available in a specific area of Lincolnshire (Boston and Skegness) and which specifically works with first time mothers to be who are under the age of 20 years. This is a service which is currently funded by NHS England but which is due to shortly become the commissioning responsibility of LCC. Some of its service users are in contact with PCMHT; some are Looked After Children. The current planned service transformation will enable these interfaces with CAMHS to consolidate and develop further.

Pathway → ↓Treatment	Depression	Anxiety – General Anxiety	Anxiety – OCD & BDD	PTSD	Self-harm	Eating Disorders	MH impact on physical health	Attachment Difficulties	Harmful sexualised behaviour
CBT	.	*	*	*	*	*	*		*
Brief solution focussed	*	*	*		*	*	*		
Play work								*	
Art therapy					*		*	*	
Family therapy	*	*	*	*	*	*	*		
Psycho-social/ education	*	*	*	*	*	*	*	*	*
Individual therapy	*	*	*	*	*		*		*
Group work	*	*	*	*	*				
Counselling								*	
Psychiatric intervention	*	*	*	*	*	*	*	*	*
Psycho-therapeutic intervention								*	*
Long term therapeutic work						*		*	*
Medication	*	*	*	*	*	*	*	*	*
Behavioural therapy	*	*	*	*	*	*	*		*
Filial therapy								*	
Theraplay								*	

6.15 Principles of Service Delivery

6.15.1 The following principles will apply for all children and young people with mental health needs in Lincolnshire.

6.15.2 The Service will:

6.15.3 Work in partnership with other agencies and services

- Promote emotional resilience in children and young people, as well as supporting other agencies in assisting in the prevention and promotion of children's emotional well-being and good mental health
- Work with all relevant agencies to ensure the services for children and young people with mental health problems are flexible, coordinated and address their individual needs, providing an evidence-based, holistic approach, where possible
- Work with all relevant agencies and services to ensure that children and young people with new or emerging mental health problems are identified and supported at the earliest opportunity before their problems escalate, through integrated pathways and collaborative approaches
- Work collaboratively with other relevant agencies to regularly review care plans and ensure that progress is being made, and that the most appropriate services are in place to meet the needs of the child or young person along the care pathway

6.15.4 Develop capacity

- Develop the skills, knowledge and capacity of professionals working with children and young people to enable them to recognise mental health concerns and to enable access to appropriate services to meet their needs at the right time
- Provide a rolling programme of training, develop resources, provide regular advice and consultation, and facilitate sessions for frontline practitioners to become mental health champions as part of the pre-CAMHS offer in Lincolnshire

6.15.5 Work in partnership with children, young people and families

- Work in partnership with children, young people and their parents/ carers, in co-designing and reviewing care pathways and services that meet their needs
- Ensure that the participation of children, young people and their parents/ carers is embedded within the service and that provision is made to ensure that regular participation is part of the service model
- Offer services as locally as possible to the child or young person, and/ or their family home/ place of residence that includes consideration of appropriate and creative ways of engaging children and their families, in venues where they feel able to participate fully in their care
- Ensure that children, young people and their parents/ carers are treated with compassion, respect and dignity, without stigma, discrimination or judgement
- Ensure that services are provided in an appropriate setting, which creates a safe physical environment, and supports the therapeutic needs of the child or young person. This should take into account issues that may prevent children and young people accessing the service, such as stigma.

6.15.6 Provision of information

- Ensure accessible information about the service and any assessment or treatments/ interventions is available in a variety of formats, including electronically and written, and that it is developed in partnership with children, young people and their parents/ carers.
- Ensure that all information is clear, and jargon free, and is accessible to those where English isn't the first language and where possible developed in partnership with children, young people and parents/ carers

- Provide information at all stages of the pathway about treatment/ intervention/ ineligibility/ options to enable children, young people and parents/ carers to make informed decisions about their care appropriate to their competence and capacity, and to empower them to develop the necessary skills to cope with some of their own mental health needs
- Provide written information that is shared with the child, young person and parent/ carer about their assessment, and any subsequent intervention or care plan, and how to access or contact the service routinely and if in a crisis

6.15.7

Delivery of Care

- Ensure that the service is easily accessible, and that referrals can be made through a single referral point, and that self-referral for children, young people and families is available
- Ensure that children and young people who access the service are seen within agreed timescales
- Operate a capacity and demand model of provision that ensures flexibility of the workforce to meet the needs of the children and young people requiring a service, across Lincolnshire
- Ensure that care is provided by an appropriately skilled and qualified workforce, with protocols in place that ensures regular supervision and appraisal, regular Continuing Professional Development (CPD), and a clear workforce plan that reflects the current and changing needs of the population of Lincolnshire
- Provide a range of direct care, through defined care clusters (packages of care) that is based on evidence or on best available practice.
- Provide direct care packages that promote recovery, and are meaningful and planned according to the needs of the individual
- Develop a transparent pathway into and out of specialist and targeted services that has knowledge of alternative provision available to support emotional wellbeing and mental health
- Participate in multi-agency pathways, where such an approach will ensure that children and young people with complex, severe and persistent behavioural and mental health needs are met. For example, pathways for those children who self-harm, and the multi-agency behavioural pathway and any others that are required
- Ensure that the service has clear access and exit points, and offers a step-down model for children and young people who have been an in-patient and/ or have been supported by the crisis support service to facilitate their return to independence
- Ensure that children and young people referred to the service are seen in a timely manner and within agreed timescales
- Ensure that services for children or young people who are experiencing an emergency or are in crisis, including out of hours care on a 24/7 basis, are provided within agreed timescales
- Ensure that services are provided that allow a child or young person to avoid unnecessary admission, where possible, and to facilitate safe and speedy discharge should in-patient care be necessary
- Provide initial and follow-up assessments that are undertaken in partnership with the child, young person and or parent and carer
- Ensure that children, young people and their parents/ carers are offered a choice of treatments or interventions that are appropriate to their needs, and they are given relevant and appropriate information at all stages of their care pathway that will assist them to make informed decisions about their care
- Agree the aims and goals of treatment or intervention with the child, young person and/or parent and carer, as early as possible within their care, and monitor the changes to agreed and shared goals, and to symptoms, amending interventions as a result to ensure responsive care and the best possible outcome is delivered
- Ensure that children or young people leaving the service have a written and agreed discharge plan that supports self-management, where possible, and explains how to access help should this become necessary
- Provide CAMH services to specific groups of children and young people who have the potential to be marginalised because of their additional needs that:
- provide services for Looked After Children, as well as supporting social care to enable children to remain within their placements

- provide services for children with an Adoption plan or Adopted children to include:
 - provide advice and support to Adoption Social Workers from Adoption Planning through too and including Post Adoption stage and to prospective adopters regarding children and young people's needs and placement requirements
 - provide advice and strategies post adoption to parents and Social Workers who request support in managing children and young people's needs and behaviours
 - provide direct work with adopted children and young people from Adoption Planning through too and including Post Adoption stage
- ensure that children and young people with both a Learning Disability and a mental health problem have access to appropriate specialist mental health support
- ensure that children and young people within Youth Offending Services receive direct access to a comprehensive range of mental health services appropriate to their needs
- support other specialist groups that may have an increased likelihood of developing a mental health issue, such as children and young people with life changing or life limiting health conditions,
- through therapeutic interventions, support children and young people who have experienced abuse or trauma
- through therapeutic interventions, support children and young people who have engaged in sexually harmful behaviour
- Provide a range of mediums to access and use/ support services and ensure that technology is in place to support practice, whether this is online, app based and/ or face to face. This should be based on the needs and wants of the children and young people accessing it.

6.15.8 **Data and Sharing Information**

- Ensure clear and robust workable information sharing protocols are in place that work across services/ organisational boundaries to support individual care planning for vulnerable young people
- Identify ways that will reduce the number of times children, young people and their parents/carers need to relay their story
- Ensure the collection of appropriate data to inform care planning, to evidence performance and to support future commissioning
- Ensure that appropriate IT systems are in place to aid in the collection and reporting of the data required both to inform progress in individual's care and the development of a responsive service

6.15.9 **User Outcomes**

The Supplier is expected to work with key stakeholders to achieve these outcomes for children and young people. This should include, but is not restricted to: schools, health services, parents/carers, voluntary organisations, social services, children's centres, adult mental health services and youth and community services.

- 6.15.10 The Service will contribute to improved mental health outcomes for children, young people and their parents/carers, and for the population as a whole by supporting the achievement of the following outcomes:

- ***More children and young people will have good mental health***

More children and young people of *all* ages and backgrounds will have better emotional wellbeing and good mental health.

A specific focus on improving the mental health of vulnerable children and those that have specific needs due to their circumstances, will be delivered, especially for young offenders, looked after children, children with learning disabilities, children with life changing or long term physical needs, and those who have experienced sexual abuse.

- 6.15.11 Fewer children and young people will develop mental health problems by starting well, developing well, learning well, working and living well.

- **More children and young people with mental health problems will recover**

More children and young people who develop mental health problems will have a good quality of life – with a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live as they reach adulthood. More parents and carers will feel supported with managing their child’s mental health needs.

6.15.12 Children and young people are cared for close to home, within their local community and receive as little disruption to their lives as possible.

- **More children and young people with mental health problems will have good physical health, and more children and young people with physical ill-health will have better mental health**

6.15.13 Fewer children and young people with mental health problems will be at risk of premature illness and mortality in adult life. There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term and life changing conditions.

- **More children and young people will have a positive experience of care and support**

Care and support, wherever it takes place, will offer access to timely, evidence-based interventions and approaches that give children and young people and their families the greatest choice and control over their own lives and a positive experience of care. Children, young people and their parents/ carers will feel in control of how and where they access support, and in turn this will improve their engagement and partnership in their care. They will also have a greater understanding of their own mental health needs and where and when to seek support. Where in-patient care is required this should be in an age appropriate setting and in the least restrictive environment, and they should be supported when they no longer require this level of care to maintain good mental health in the community.

- **Fewer children and young people will suffer avoidable harm**

6.15.15 Children and young people and their families should have confidence that care is safe and of the highest quality.

- **Fewer children and young people and families will experience stigma and discrimination**

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to children and young people with mental health problems will decrease.

Service Outcomes

6.15.17 The service should support the delivery of the following outcomes:

- Provision of local, flexible, responsive and outcomes focused services that put the needs of children, young people and their parents/ carers at the centre of their care, and that are delivered as part of integrated, interagency provision.
- Access to the service will be easier, more effective and timely for both partner and referring agencies, as well as children, young people and their parents/carers.
- Reduction in inappropriate referrals to the service, with children and young people receiving the most appropriate level and type of support for their mental health needs.
- Increased confidence and capability amongst frontline staff in Universal services, to address the emotional and mental health needs of children and young people within the context of their role and the services that are available, with an ability to intervene or refer on as required.
- Children, young people and their parents/ carers will be seen more quickly and at a more appropriate level of support, therefore reducing waiting times for the service.

- Partnerships with other agencies will be strengthened and the support systems around children and young people will ensure an individualised response to their mental health needs.
- By operating a flexible, capacity and demand model, the service will demonstrate reduced demands and pressures across the whole health system.
- Children and young people will be seen within agreed timescales according to the defined level of urgency and severity of their mental health needs.
- The service will support more efficient and appropriate use of resources and demonstrate cost effective, best value provision within the allocated budget, where possible reducing the level of spend in certain areas, such as reduced admissions to A&E, and into Tier 4 services.
- Multi-agency and multi-disciplinary working will be more effective and streamlined along an agreed, integrated CAMHS care pathway.
- Children and young people will receive the best available support for their needs through care clusters that offer planned packages of care, with an effective range of treatment options that are responsive to individual needs.
- Evidence of high levels of service and user outcomes, and service user satisfaction with the service.
- Increase in the skills and capacity of the workforce to identify and meet the emotional and mental health needs of children and young people in Lincolnshire, ensuring support occurs at the earliest opportunity, reducing the demand on more specialist services.
- Routinely collect appropriate data that enables the identification of trends in the population of Lincolnshire, and ensures that the local services are configured and equipped to meet these needs.
- Employ a process of continuous improvement to ensure that the service offers the best practice and the best value for children and young people with mental health needs in Lincolnshire.

6.16 Concurrent Local Authority Reviews

6.16.1 Outside of the revised CAMHS model, Lincolnshire intends to meet the Transformation Planning requirements through several additional work streams. These areas include;

Health Visiting & School Nursing Review

6.16.2 The Council is undertaking a review of its Public Health offer to children and young people.

6.16.3 Alongside this the Council is reviewing the services it already commissions for children aged 0-5 mainly through Children's Centres, given the extensive crossover with these health services

6.16.4 By 1st October 2015, Local Authorities will commission the following Public Health services:

- Health Visiting and Family Nurse Partnership (via the Healthy Child Programme)
- Antenatal Weight Management
- School Nursing including the National Child Measurement Programme

6.16.5 The current annual contract value of these services is c£11.3m

Healthy Child Programme

6.16.6 The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The current programme for 0-5 year-olds is based on the evidence available at the time of the last update of the HCP 0-5 years in 2009. As local authorities take on the commissioning of the HCP 0-5 years and its delivery via the universal health visiting service, it is important that it is underpinned by the latest evidence.

- 6.16.6 A rapid review is being undertaken to update the evidence. Specifically, the aim is to synthesise relevant systematic review level evidence about 'what works' in key areas: parental mental health; smoking; alcohol/drug misuse; intimate partner violence; preparation and support for childbirth and the transition to parenthood; attachment; parenting support; unintentional injury in the home; safety from abuse and neglect; nutrition and obesity prevention; and speech, language and communication. In addition, the review seeks to draw out key messages in relation to:
- identifying families in need of additional support; the delivery/effective implementation of interventions at the programme/service level and individual practitioner level
 - workforce skills and training

Raising awareness of Mental Health & reducing stigma

- 6.16.7 A fundamental part of the 2015/2016 priorities for the Lincolnshire Youth Cabinet is Mental Health; our commissioned online counselling Provider is supporting with this priority, including planning pilot work in one Lincolnshire secondary School.
- The lead of the Youth Cabinet met with Council Leader Martin Hill to discuss UK Youth Parliament campaigns The Living Wage and Mental Health Services for Young People and raised Cabinet concerns about further spending cuts impacting on vulnerable teens with mental health issues. Councillor Hill maintained safeguarding is a priority and was interested in hearing Cabinet ideas about promoting the online counselling service Kooth which has a high profile on teeninfoincs.
- 6.16.8 Some of the recent events undertaken to raise awareness of Mental Health include;
- The First young people mental health public information event, organised by Lost Luggage, a group of young people who have experienced mental health difficulties and Lincolnshire Partnership NHS Foundation Trust. The event, held in July 2015, challenged preconceptions about young people's mental health. Members of Lost Luggage and supported service users to share their stories of what helped them on their road to recovery
 - Development of peer to peer support including sharing stories, online chatting forums and podcasts through Xenzone (Online Counselling service)
 - There is a Teen Information section within the Lincolnshire County Council website; this includes support on Mental Health and Emotional Wellbeing
 - As part of the new model, it is intended that there will be a directory of universal services that Children and Young People (as well as their families) can access to help them understand what services are available to them

School Approaches to promoting Mental Health and Well Being

- 6.16.9 Lincolnshire County Council has established a role, Chief Commissioning Officer with responsibility for Learning. This role will be pivotal in maintaining links with our 359 Schools and supporting on key themes such as Mental Health. Please see further detail on links with Schools in Section 2.

6.17 Broader work Lincolnshire is undertaking in response to the five themes identified within Future In Mind includes;

6.17.1

Resilience, prevention and early intervention

- Support is in place for early intervention through a Portage service
- Lincolnshire is undertaking a review of School Nursing services
- The training element within the new model will assist front line staff in identifying and tackling mental health stigma
- The new service model includes Attachment work to enhance attachment between parent and child, avoid early trauma and help build resilience and improve behaviour

Improving access to effective support

6.17.2

Our revised CAMHS model will respond to many of these points of action, including;

- Moving away from a tiered system and implementing integrated service delivery
- Enabling a single point of referral
- Establishing a clear and web based directory of a wide range of local universal services
- Developing an algorithm through the Single Point of Referral that will incorporate an initial risk assessment to ensure high risk C&YP are seen as a priority (including development of KPI that requires a 4 hour telephone response for emergency cases)
- Helping C&YP to self-refer
- Working closely with the voluntary and community sector in establishing need within the local area by supporting their role within the JSNA development
- Providing a named point of contact in CAMHS for Schools
- We have already ensured Lincolnshire Schools are on the pathway but we will continue to engage with Schools closely
- Over 170 days annually of training, guidance and support for Schools and Universal Services have been included within the contract
- We have strengthened the links between Mental Health and Learning Disabilities by providing specific support to vulnerable groups and ensuring onward referral to SEND is part of the Single Point of Referral algorithm with a robust gateway process
- Lincolnshire has fully implemented an SEND team and robust SEND process to support Children with additional needs
- Our model includes support out of hours for C&YP in crisis
- Our proposed T3+ model includes dedicated home treatment teams and provides a swift and comprehensive assessment
- Our model includes the recommended timescales for liaison psychiatry services
- Our model utilises clear, evidence based pathways, based on NICE guidance with community based care being key from universal services through to Tier 3+
- Our financial commitment to establishing T3+ services demonstrates our belief in reducing admission rates for Lincolnshire. In 2014/2015, Lincolnshire only admitted 19 children to inpatient services at T4
- We have supported the development of a series of pathways including Self Harm, Behaviour and Transitions. The Transitions pathway includes some flexibility around arbitrary cut off dates for ages

- Our model includes a comprehensive set of access and wait times
- Lincolnshire has chaired multi agency meetings looking to reduce the use of Section 136 beds

Caring for the most vulnerable

- 6.17.3
- Our services already monitor attendance and actively follow up on families and young people who miss appointments
 - Our proposed single point of referral and new model includes specified support for vulnerable groups including LAC (and adopted children) children with disabilities and children with learning difficulties
 - Reducing inequality is identified as a priority within the Health and Wellbeing Strategy
 - Our services already include sensitive enquiry about the possibility of neglect, violence and abuse
 - Our current CAMHS contract includes therapeutic services for those who have suffered trauma including sexual harm or those exhibiting harmful behaviours

To be accountable and transparent

- 6.17.4
- We are an ambitious and future focused
 - A Section 75 Agreement between the Local Authority and the four Clinical Commissioning Groups is in place and has been in place for several years, delegating the commissioning responsibility to the Local Authority and allowing for the pooling of budgets
 - The CAMHS review has taken on board the Lincolnshire JSNA, which includes a focus on C&YP's Mental Health
 - The Local Transformation Plan is being presented to the Health and Well Being Board for authorisation and implementation
 - Lincolnshire already collate a significant amount of contract performance data and the indicative performance indicators included within this plan evidence the intention to ensure that the performance of the service and the end to end experience for the service user is captured. This includes monitoring access and wait measurement and measurement of outcomes
 - The model meets the waiting time standards for psychosis

Developing the workforce

- 6.17.5
- Part of the new CAMHS model is training, support and guidance to universal services. This will include targeting training of health and social care professionals as part of their continuous professional development
 - This training will include supporting Social Workers during adoption and fostering processes and supporting the step down transition of Looked After Children from any inpatient settings
 - The model also includes a Professional Advice Line, which will support professionals who need to seek guidance on particular issues
 - The training and consulting work will include identification of mental health problems early on in C&YP

- The model will include support to Foster Carers and Adopters
- As part of the gap analysis that will be undertaken by the Provider, the skill set of the staff delivering the contract will be addressed and any requirements will be captured and progressed accordingly. The gap analysis will include a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix

Making Change Happen

6.17.6

- The Local Transformation clearly articulates the local offer within Lincolnshire
- This plan includes the full spectrum of services available for C&YP
- Lincolnshire has robust governance arrangements in place
- Lincolnshire is committed to accelerating service transformation
- The contract management process of any service (in-house or otherwise) requires a thorough examination of the evidence base that shows the impact of the service on C&YP

6.17.7 As part of our action plan for the five themes we will be improving our commitment to;

- Extend use of peer support
- Improving disengagement rates
- Consider how we can reach teams such as youth clubs and hostels to support those C&YP who may not even recognise they have Mental Health problems
- Improve our presence in web based tools
- Undertake further work to improve our understanding of how mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment
- Counsellors working in Schools and in the community being able to access further training to improve evidence based care
- Work with Schools to implement the recommendations of the Carter Review
- Continue to engage with regional working and national commissioning training, continuous professional development and the sharing of best practice

7. Financial Commitment

7.1 Please see Table 1 below for the financial breakdown of Section 75 funding for Lincolnshire CAMHS.

Existing CAMHS Service Budget		
	2015/16	2016/17
<i>Tier 2 Contribution</i>		
LCC	£724,589	£724,589
Lincolnshire East CCG	£136,670	£136,670
Lincolnshire West CCG	£114,003	£114,003
South Lincolnshire CCG	£78,021	£78,021
South West Lincolnshire CCG	£64,714	£64,714
	£1,117,998	£1,117,998
<i>Tier 3 Contribution</i>		
Lincolnshire East CCG	£1,504,934	£1,504,934
Lincolnshire West CCG	£1,255,334	£1,255,334
South Lincolnshire CCG	£859,122	£859,122
South West Lincolnshire CCG	£712,599	£712,599
	£4,331,989	£4,331,989
<i>CQUIN Contribution</i>		
Lincolnshire East CCG	£41,040	£41,040
Lincolnshire West CCG	£34,233	£34,233
South Lincolnshire CCG	£23,429	£23,429
South West Lincolnshire CCG	£19,433	£19,433
	£118,135	£118,135
Sub-Total	£5,568,122	£5,568,122
CAMHS BCF	£350,000	£356,000
Total CAMHS Pooled Fund	£5,918,122	£5,924,122

7.1.1 Implementation of the new model in line with the requirements from Future In Mind would result in a financial shortfall. Full support for all elements of the model have been agreed by all key stakeholders and the Local Transformation Planning monies would be used to plug this gap, enabling the Lincolnshire model to meet the recommended service innovations and improve outcomes for young people.

7.1.2 Table 2 shows the costs identified to deliver the revised model.

Please note, no uplifts have been applied.

Table 2

Revised Model Costs	2015/16 Year 1	2016/17 Year 2	2018/19 Year 3
Core Clinical Provision	£2,416,533	£2,416,533	£2,416,533
LD Provision	£252,065	£252,065	£252,065
LAC Provision	£284,415	£284,415	£284,415
Behaviour/Prescribing Support	£93,113	£93,113	£93,113
Tier 3 +	£1,448,102	£1,448,102	£1,448,102
Eating Disorder Service	£624,222	£624,222	£624,222
Medical Input	£997,686	£997,686	£997,686
Management & Admin Support	£765,800	£765,800	£765,800
Out of Hours	£31,118	£31,118	£31,118
LCC Single Point of Access	£127,510	£96,110	£96,110
Sub Total	£7,040,564	£7,009,164	£7,009,164
Training / Set up	£442,882	£356,000	
Project Review & Management	£131,718		
Total Expenditure	£7,615,164	£7,365,164	£7,009,164
Contract Income	£5,568,122	£5,568,122	£5,568,122
BCF	£350,000	£356,000	
PoE	£256,000		
Sub total Income	£6,174,122	£5,924,122	£5,568,122
Transformation Plan Funding	£1,441,042	£1,441,042	£1,441,042
Total Income	£7,615,164	£7,365,164	£7,009,164

8. Collaborative Regional Working

8.1 Collaborative Regional Working

- 8.1.1 Lincolnshire is always keen to support Regional Working and is a member of the East Midlands Regional Commissioning Champions Networking Group, Maternity & Children's Commissioning Champions Group, Regional SEND Group, Strategic Clinical Network Mental Health Group, Children's Clinical Reference Group, Paediatrics Surgery Network and Children's Alliance Group.
- 8.1.2 Lincolnshire participated in the Associate Development Solutions review of readiness to implement Future In Mind review. This was a self-assessment toolkit, completed by 7 areas in the East Midlands, commissioned by members of the East Midlands Clinical Network, as a response to concerns around gaps in services and increasing demands. The project explored the current demand on Community CAMH provision, the pathway into these services, and crisis care support, as well as plans to transform CAMHS across the region. It has also supported key stakeholders to assess their current plans and future direction in relation to the Children and Young Peoples' Mental Health Taskforce report.
- 8.1.3 The aim of the project was to:
- Help to establish key areas that stakeholders have concerns about
 - Consider where any gaps and shortfalls lie
 - Help partnerships assess their readiness to implement the *Future in Mind* action points
 - Share promising practice and innovation
 - Identify what is needed to provide a mental health improvement pathway for children and young people within the East Midlands region
- 8.1.4 The Associate Development Solutions Report on Readiness for Implementation showed that Lincolnshire (Area 4) has considered a number of elements in the Future In Mind report in our new service specification. We have developed an action plan following on from this work and are working closely with other key agencies to implement some of these actions.



Table 1.

8.1.5 Table 1. shows the progress of each Local Authority in addressing the needs identified within Future In Mind. The colour key is shown below the table. Lincolnshire is Area 4. This table shows us that Lincolnshire is in a strong position. All of the required changes under "Making Change Happen" have been agreed, a significant number under "Developing the Workforce" have been agreed and a large number of changes under "Care for the Most Vulnerable," "Accountability and Transparency" and "Improving Access to Effective Support" have already been implemented. There are few areas where requirements are noted as "Not Ready/Anticipate Some Barriers to Change" and these have been identified under Section 11, next steps. The table shows that Lincolnshire is forward thinking and has welcomed the opportunity to develop our services in line with best practice.

8.1.6

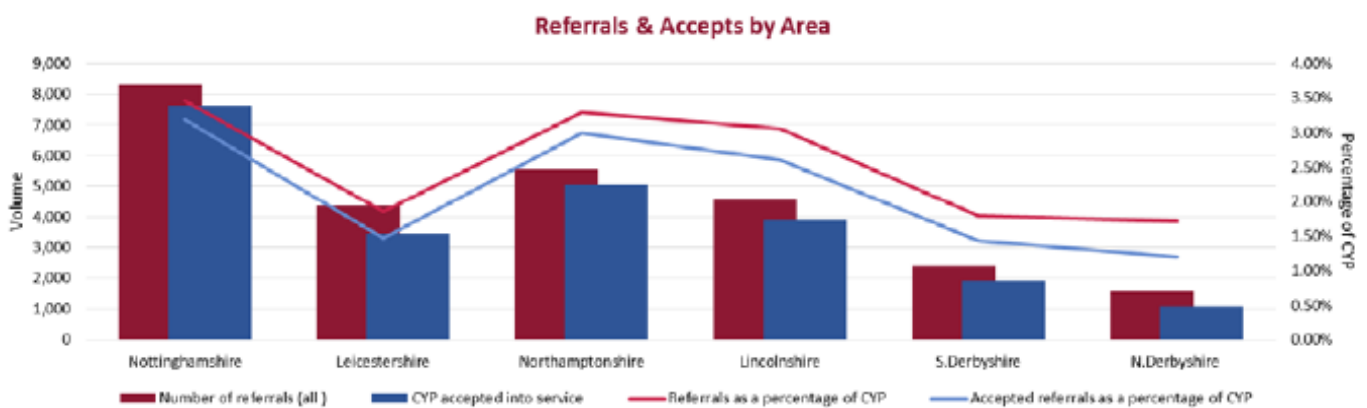


Table 2.

8.1.7 The table above shows the Referral and Accepts by Area, including;

- the number of referrals
- the number accepted into the service
- the referrals as a percentage of C&YP and
- the accepted referrals as a percentage of C&YP

8.1.8 Table 2 shows us that Lincolnshire CAMHS receives a similar number of referrals to Leicestershire and a significantly higher number of referrals than North or South Derbyshire. Lincolnshire falls in line with its East Midlands peers with the review of "Total Number of Referrals" versus "Children accepted into the Service."

8.1.9 Table 3 shows the budget of each Area, including the Spend per C&YP population, the number of referrals, the spend per discharge and the spend per referral. Lincolnshire is Area 4. Table 3 shows us that the average spend in the East Midlands per CYP Population is £36.60 compared to Lincolnshire spend of £40.13. The average number of referrals is 4468, with Lincolnshire referrals slightly higher at 4584. Lincolnshire spends less in comparison to the average spend per referral by £264 and has 55 more referrals on average each year than its East Midlands peers. Lincolnshire also has a lower spend per accepted referral at an average of £1540 per year versus £1945, Lincolnshire does however have a higher spend per face to face appointment offered by £70.

8.1.10 Table 3.

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Budget	£2,300,000	£7,417,352	£6,300,000	£6,005,882	£5,860,208	£8,991,990
2014 (forecast) Population (0 - 18)	91,463	133,762	235,620	149,667	168,864	240,241
Spend per CYP Population	£25.15	£55.45	£26.74	£40.13	£34.70	£37.43
Number of referrals (all)	1,568	2,397	4,386	4,584	5,552	8,320
Spend per Referral	£1,467	£3,094	£1,436	£1,310	£1,056	£1,081
CYP accepted into service	1,097	1,913	3,461	3,900	5,052	7,646
Spend per Accepted Referral	£2,097	£3,877	£1,820	£1,540	£1,160	£1,176
Total Number of face to face appointments offered	13,347	23,466	37,724	22,089	59,570	48,011
Spend per Face to Face Appointment Offered	£172	£316	£167	£272	£98	£187
Number of discharges		2,004	2,662	3,088	4,070	4,738
Spend per Discharge		£3,701	£2,367	£1,945	£1,440	£1,898

8.1.11 Within the Report, Lincolnshire is benchmarked as an example of good working practice for the CAMHS support to Looked After Children;

Practice Example – Vulnerable Children and Young People

Lincolnshire specialist CAMHS have a specific team for Looked After Children. They provide support and training to all Local Authority Staff, and have dedicated links to children’s homes, and also provide support to foster carers and post-adoption support. They also have a dedicated post for leaving care. The role of the team, as well as offering fast track support around mental health issues, is also to support placement stability.

9. Measurable Metrics – Accountability and Transparency

9.1 Contract Management

- 9.1.1 Contract management meetings are designed to share and exchange information that will support continuous improvement of service provision and ensure the placement is meeting its contractual obligations and providing positive outcomes for C&YP. The contract management process leads to integrative and collaborative partnership learning and offers opportunities to share good practice with the wider providers of placements. Contract management is undertaken utilising Children’s Services Joint Evaluation Toolkit (JET) system. The JET adopts a balanced scorecard approach to manage the performance and risks of contracted services delivered; evaluating the quality of service provided against the associated costs to assist Children’s Services in determining if the service provides value for money and improves outcomes for children and young people. As part of the balanced scorecard approach to contract management, all contracts within Children’s Services are performance graded as risk rated each month to provide an overview of the success of the contract and to inform areas for development.
- 9.1.2 Contract management is carried out jointly between the Commissioning team, the Provider and a service area representative(s) from Children’s Services in-house support services. In addition to reviewing the quality of the provision and progression of C&YP, there is proactive dialogue regarding future market development intentions and requirements and discussion concerning existing constraints in the system which may unsettle placements. Key points and matters are subsequently fed back to senior management to help influence and shape future placement strategies.
- 9.1.3 The table below identifies the scoring mechanism used:

Grade	Score	Descriptor	Guidance on Strengths/Weaknesses	KPI's
Outstanding	9	Exceptional	Exceptionally strong with essentially no weaknesses	All are above target
	8	Outstanding	Extremely strong with negligible weaknesses	Most are above target and are at least on target
Good	7	Excellent	Very strong with only some minor weaknesses	All are at least on target
	6	Good	Strong but with numerous minor weaknesses	Majority are on target with plans in place for all others to improve
Requires Improvement	5	Effective	Strong but with at least one moderate weakness	Some are under target, but showing signs of improvement
	4	Satisfactory	Some strengths but also some moderate weaknesses	Some are under target and provider has action plan in place to improve
Inadequate	3	Fair	Some strengths but with at least one major weakness	Majority are under target but provider can evidence action plans are in place to improve
	2	Marginal	A few strengths and a few major weaknesses	Majority are under target but provider has desire to improve
	1	Poor	Very few strengths and numerous major	All are under target and no plans in place to improve

			weaknesses	
<ul style="list-style-type: none"> ▪ Minor Weakness: An easily addressable weakness that does not substantially lessen impact • Moderate Weakness: A weakness that lessens impact ▪ Major Weakness: A weakness that severely limits impact 				

9.2 Strategic Commissioning Research

- 9.2.1 A number of reviews have been commissioned which looks at existing provision with a view to making recommendations which will improve and enhance the services on offer. These recent reviews include:
- A series of four reviews of specific aspects of SEN provision in Lincolnshire:
 - enhanced resource provision in mainstream schools;
 - residential SEN provision;
 - portage services;
 - Autism – A review of the way in which agencies in Lincolnshire respond to children and young people who have Autism, and an evaluation of the existing support being provided in the county including that available through universal as well as specialist services.
 - Outreach Support Service – a review of the existing services, including a desktop analysis profiling the current financial, performance and service delivery expectations of the various existing agreements under Outreach Support and to consider the role of Outreach within the wider context of holistic support packages. The review will conclude with the recommendation of how the service should be commissioned.
- 9.2.2 As part of the ongoing commissioning cycle Lincolnshire regularly undertakes reviews. These reviews ensure that commissioned services deliver required outcomes. The outcomes are the direct results or benefits for individuals, groups, communities or families and can be short, medium or long term and can effect positive, negative, neutral, unintended or intended change. Strategic Commissioning research will have a range of impacts, including inputting to effective service specification and contract documents, directing stakeholder engagement, understanding needs, priorities and risks and planning services to deliver identified outcomes.

9.3 Measures and Metrics

- 9.3.1 Utilising the Contract management process identified above, CAMHS will have specific, measurable, achievable, realistic and time focused targets. We have listed the metrics that will be measured as part of the CAMHS contract; **please note at this stage, the metrics are indicative and could be subject to change.**
- 9.3.2 These targets come under four areas;
- Outcomes and Stakeholder Focus
 - Inputs and Outputs
 - Continuous Improvement
 - Finance and Productivity

Measure	Target	Reporting Frequency
OUTCOMES & STAKEHOLDER FOCUS		
NHS Outcomes Framework	<p>The supplier can evidence conformance with, and improvement aligned with the CAMHS relevant objectives set out within the NHS Outcomes Framework. The NHS Outcomes Framework for Children and Young People will be referred to throughout the KPIs where another KPI relates to them.</p> <p>NHS1) More children and young people will have good mental health</p> <p>NHS2) More children and young people with mental health problems will recover</p> <p>NHS3) More children and young people with mental health problems will have good physical health, and more children and young people with physical ill-health will have better mental health</p> <p>NHS4) More children and young people will have a positive experience of care and support</p> <p>NHS5) Fewer children and young people will suffer avoidable harm</p> <p>NHS6) Fewer children and young people and families will experience stigma and discrimination</p>	
Timely Complaints Resolution (NHS4, NHS5)	<ul style="list-style-type: none"> • Widely disseminated complaints policy available to professionals and service users and is written in such a way that it is appropriate and accessible for all children, young people and their families • 100% complaints resolved in line with the supplier's Complaints Policy timelines • Areas for improvement are identified and acted upon • Year on year reduction in complaints (as a percentage of service users) • Complaints are reported monthly, grouped into themes with tracking of improvement and actions taken 	Quarterly

Formal Compliments Received (NHS4)	<ul style="list-style-type: none"> The supplier can evidence a cumulative year on year increase in the number of formal compliments received during a contract year (as a percentage of service users) Compliments are reported monthly, grouped into themes 	Quarterly
Annual Stakeholder Survey	<ul style="list-style-type: none"> The Supplier completes an annual stakeholder survey (to be included within the annual Supplier Performance Report) The supplier conducts a regular, planned programme of service evaluation The supplier provides evidence of systematic and continuing process of consultation with a broad range of stakeholders, including service users Areas for improvement are identified and acted upon "you said, we did" approach 	Annually
Voice of the Service User (NHS4)	<ul style="list-style-type: none"> The supplier provides evidence of systematic and continuing process of involvement with children & young people regarding areas for service improvement & adding value (including a cross section of all key service use groups e.g. LLDD, LAC etc.) The supplier is to demonstrate how key stakeholder feedback from children and young people has been utilised in improving the service delivered The supplier is to empower young people to provide feedback on their experiences through suitable language and mediums, such as child and young person friendly versions of key documentation Parent and Carer and Children and Young People questionnaire results to be presented along with Performance Information. Results should be tracked to enable identification of trends Questionnaires should show 100% of service users have received a copy of their care plan 	Quarterly
Demonstrable Commitment to the Participation Charter (NHS4)	<p>The supplier is to demonstrate commitment to the four key principles of the Participation Charter:</p> <ol style="list-style-type: none"> Children have equal opportunity to be involved Children are valued The involvement of children is a visible commitment which is properly resourced The involvement of children is monitored, evaluated, reported and improved 	Quarterly
Standards for the Service (NHS4)	<p>The service will establish reporting processes for feedback to commissioners on achievement of appropriate service standards. These will include:</p> <ul style="list-style-type: none"> You're Welcome QNCC 	Quarterly

<p>The Supplier has a model in place to measure how users outcomes have been achieved</p> <p>(NHS2, NHS4)</p>	<ul style="list-style-type: none"> • Model to measure progression of outcome is in place, which includes recording of outcome measures for each child/young person • Desired outcome is identified at start of engagement and evaluated at point of transition – and recorded at both points • Routine use of Patient Rated Outcome Measures (PROMS). These should include, as a minimum Goal Based Outcomes; session by session monitoring and symptom trackers. • Results of outcomes measures will be shared with children, young people and their families (where appropriate) to involve them in understanding their progress, to empower the service users and to help service users and their families understand and decide what further intervention they need • Symptom trackers will be linked to the Care Clusters to enable effectiveness of care clusters to be monitored 	<p>Quarterly</p>
<p>Average aggregated improvement in service user mental health outcomes from start of provision to discharge</p> <p>(NHS1, NHS2, NHS4)</p>	<ul style="list-style-type: none"> • 100% of service users outcomes reported on at first appointment, discharge and any measure-specific time-intervals • Aggregated score shows improvement in outcomes for service users • CHI-ESQ Report action plan is agreed with commissioners and recommendations are implemented (bi-annual reporting) 	<p>Quarterly</p>
<p>Outcome measures evidence improvement in mental health risk</p> <p>(NHS1, NHS2)</p>	<p>The supplier will use an accepted risk assessment scoring tool.</p> <p>The supplier can evidence that mental health risk scores are being captured for 100% of individuals at assessment, 1st contact and discharge (excluding discharges due to service user disengagement) as a minimum.</p> <p>80% of risk scores show a measurable improvement in the mental health of the service users at the point of discharge.</p> <p>The supplier can evidence that staff are trained and have the required competencies to undertake risk assessments.</p>	<p>Quarterly</p>
<p>INPUTS & OUTPUTS</p>		
<p>Contract Performance Monitoring System Effectiveness</p>	<p>There is a performance monitoring system in place for recording and reporting contract related management information.</p> <ul style="list-style-type: none"> • Monitoring information is provided in line with the measures agreed and is to schedule • 100% of Performance Reports are accurate & are provided within 15 working days of the contract management meeting* • Significant over or under-achievement of measures required are to be highlighted 	<p>Quarterly</p>

	<i>*excluding significant changes or requests made by the Commissioner – alternative timescales will be agreed where this occurs</i>	
Delivery of Service Specification	<p>Prior to the signing of the new contract, the supplier shall conduct a gap analysis on current services versus the requirements detailed within this service specification. The supplier shall develop an action plan with key dates, milestones and acceptable tolerances for the transition of services to the required specification that is agreeable to the commissioner.</p> <p>The supplier shall ensure 100% of agreed actions are completed within the agreed timescales and to the required quality.</p> <p>The progress of change against this agreed action plan shall be reviewed on a monthly basis with the commissioner.</p>	Quarterly
2nd Screening Response Speed (NHS2, NHS5)	<p>The supplier shall deliver high quality consistent prioritisation of children and young people’s mental health needs during the 2nd screening process for new referrals.</p> <p>95% of all CAMHS led 2nd screenings are conducted and an accept/reject response given within 4 hours of initial referral where before 1pm that day</p>	Monthly
Booking onto 1st Appointment	95% of service users are booked onto their 1st appointment during the 2nd screening process, if the 2nd screening process assesses the user as requiring CAMHS	Monthly
<p>Response Rates (Urgency)</p> <p>NB: There are two response rate targets (<i>Service and Presentation Type, and Urgency</i>). The service user should always be subject to the quicker of the two response targets, based on their individual need.</p> <p>(NHS2, NHS5)</p>	<p>95% of service users (assessed as requiring CAMHS) receive the following response within the target timescales (below) based on the urgency of their need:</p> <p>Emergency</p> <ul style="list-style-type: none"> ■ CAMHS telephone response within 4 hours ■ Face-to-face emergency response within 13 hours (24/7) <p>Urgent</p> <ul style="list-style-type: none"> ■ Face to face within 72 hours <p>Routine</p> <ul style="list-style-type: none"> ■ Face to face within 6 weeks <p>Although a target of 95% has been set for whole service response rates, it is the view of the commissioner that 100% of service users should receive a response within the targets set. Therefore all waits for a response that exceed</p>	Monthly in first 12 months, then moving to quarterly

	target should be reported as an exception, regardless of whether they push the overall service response rate below 95%	
<p>Response Rates (service & presentation type)</p> <p>NB: There are two response rate targets (<i>Service and Presentation Type</i>, and <i>Urgency</i>). The service user should always be subject to the quicker of the two response targets, based on their individual need.</p> <p>(NHS2, NHS5)</p>	<p>95% of service users (assessed as requiring CAMHS) receive an appointment within the following timescales:</p> <p>24 hours</p> <ul style="list-style-type: none"> Self-Harm Assessment and Intervention Service <p>3 weeks</p> <ul style="list-style-type: none"> Youth Offending/CAMHS Nurse Specialist Service <p>4 Weeks</p> <ul style="list-style-type: none"> Specialist CAMHS Support to LAC <p>6 Weeks</p> <ul style="list-style-type: none"> Targeted CAMHS Support to Universal Services and Local Integrated Teams Therapeutic Services Post Abuse Therapeutic Services Harmful Behaviours Targeted CAMHS Support to Universal Services and Local Integrated Teams (GP referral) Specialist CAMHS Community Forensic Psychology Service Specialist CAMHS Learning Disability Service Input to Diabetes Service 	Monthly
Booking 1st 'Core' appointment	95% of service users who are booked onto a 1 st 'Core' intervention appointment, are booked onto it during their 1 st 'Assessment' appointment	Monthly
Care Pathways (NHS2, NHS3, NHS4, NHS5)	<p>The supplier shall support the development, creation and maintenance of effective key multi-agency pathways based on best evidence by agreeing the CAMHS part of the pathway and ensuring adherence to this is monitored and reported to commissioners.</p> <p>The supplier will establish pathways, in partnership with other agencies, for the following presentations within 3 months of the contract start date: Self-Harm and Transitions to Adult Services; Children and young people with dual diagnosis (substance misuse and mental health concerns). The CAMHS element of the pathway will be reflected in their 'care clusters'.</p> <p>The supplier shall play a key role as highlighted in the Behaviour Pathway (included at Appendix A)</p> <p>The supplier will report any issues with these developments in the contract review meeting.</p>	Quarterly
DNA Rates	The supplier will actively manage DNA rates for all subsets of its services and service users (including YOS DNA rates) and deliver a	Monthly

	<p>cumulative year on year reduction in DNAs rates (towards a target of less than 2% within the life of the contract):</p> <p>Year 1: less than 5%</p> <p>Year 2: less than 4%</p> <p>Year 3: less than 3%</p> <p>Year 4: less than 2%</p> <p>Where DNA rates are high (whole service or subset of service and service users) the supplier will seek to understand the root cause and initiate an appropriate solution.</p>	
Inappropriate Referrals	The supplier works with referrers into the service to achieve a year on year reduction in inappropriate referrals and referrals that do not ultimately receive an intervention (as a percentage of total annual referrals)	Quarterly
Re-admission Rates	Less than 15% of all admissions are re-admissions from children and young people previously discharged from CAMHS within the previous 6 months	Quarterly
Open cases	<p>95% of all open cases (excluding medication-only cases) should receive a face-to-face contact each month (as a minimum). This is to avoid non-active caseloads remaining open and drives focus on effective discharge.</p> <p>NB: The once a month measure is used in this KPI to distinguish between active and inactive open cases, and is in no way a target for intervention frequency</p>	Monthly
Disengagement Rate (NHS4)	Less than 15% of all discharges are as a result of the service user becoming 'disengaged'.	Quarterly
CAMH Young Offender Service discharges (NHS4)	<p>All disengaged YOS cases where discharge has been agreed by YOS Service are to be reported by exception</p> <p>All YOS cases transitioned to AMHS are to be reported by exception</p>	Quarterly
Wide Access to Services (NHS1)	<p>The supplier can demonstrate improvements to access to service for children with additional needs by virtue of their circumstances (e.g. children and young people with LD & or from deprived areas etc.) and for children from traditionally hard to engage cultures and ethnicity.</p> <p>Ethnicity is recorded for 100% of children and young people who access the service.</p> <p>All CAMHS staff are trained in cultural competence.</p>	Quarterly
Average Core Sessions	Average (mean) number of 'core' face-to-face sessions is less than 10 per service user	Quarterly

3rd Quartile Core Sessions	<p>No more than 25% of all service users should receive more than 8 ‘core’ face-to-face sessions before discharge.</p>	<p>Quarterly</p>
Mental Health Training Delivery (NHS1, NHS5, NHS6)	<p>The supplier can evidence the delivery of a rolling programme of training to universal services based on a training needs analysis.</p> <p>Training on how to make an effective and appropriate referred to CAMHS will be delivered to named staff, who will act as the named referral contact, within schools and colleges. These staff will also be training in low level interventions and how to monitor improvements using goals-based outcomes.</p> <p>Service who work with children and young people in targeted services who are at greatest risk of mental health services will receive training in mental health. The supplier will provide up to 177 training days per year to the LA’s social workers, fosters carers, residential care home staff, leaving care workers and adoptive parents (pre-adoption).</p> <p>This provision of training will include promoting mental health, recognising and supporting children and young people with mental health problems, referrals and priorities of the integrated CAMHS, including an introductory module, followed by access to more advanced training around specific mental health problems and support strategies that can be used in Universal/Targeted Services.</p> <p>Numbers of universal staff trained will be included in the monthly performance report.</p> <p>An audit will take place bi-annually (i.e. every two years) of a sample of universal staff to demonstrate evidence of ability to recognise and influence psychological well-being and early signs of distress.</p>	<p>Quarterly</p>
Care Cluster Development (NHS2, NHS4, NHS5)	<p>The supplier shall develop ways of working that support the creation, maintenance and on-going development of effective evidence-based Care Clusters.</p> <p>The supplier shall evidence that a minimum of 50% of its caseload is being supported using a care cluster approach within 6 months of the contract beginning.</p> <p>The supplier shall evidence that a minimum of 80% of its caseload is being supported using a care cluster approach within 12 month of the contract beginning.</p> <p>The use of which PROMS, particularly symptom trackers, and when, will be identified in the care</p>	<p>Quarterly</p>

	clusters in order to measure the effectiveness.	
The creation of an effective T3+ service (NHS2, NHS5)	<p>The supplier shall evidence the establishment of a T3+ service (described in section 3.0) within 3 months of the contract start date, which is to continue for the remaining duration of the contract.</p> <p>Reporting on the progress of this service will be in the contract review meetings. Reporting requirements, if different to those for the rest of the service, will be agreed between the supplier and commissioner.</p>	Monthly
T3+ Home Treatment Package response rates (NHS5)	95% of all 'intensive home treatment packages' are to commence within 24 hours of acceptance by the service.	Monthly
KPI Reporting	<p>100% of Performance Reports are accurate & are provided within 15 working days of the contract management meeting*</p> <p><i>*excluding significant changes or requests made by the Commissioner – alternative timescales will be agreed where this occurs</i></p>	Quarterly unless reporting by exception (which will be monthly) or as frequently as contract meetings
Effective granular reporting that enables effective data driven decision making	<p>As a minimum, the supplier will monitor, measure and report the following KPIs as part of the monthly Contract Management Review Meetings (taking remedial/improvement action where necessary):</p> <ul style="list-style-type: none"> • Number of referral received (1st screening) • Number of referrals accepted (1st Screening) • Number of referrals rejected (1st screening) • Number of CYP who were accepted onto a 2nd screening • Number of CYP whose referral was rejected in the month • Number of referrals accepted onto a service(2nd screening) • Number of referrals rejected (2nd screening) • Number of CYP whose referral was rejected in the month • Number of referrals by urgency • Total number of CYP who are on a waiting list (<i>snapshot</i>) • <i>Total number of CYP who have joined a waiting list in a given month</i> • <i>Total number of CYP who have left a waiting list in a given month</i> • <i>How many people joined a CAMHS service</i> • <i>How long have they been waiting</i> • <i>Caseload</i> • <i>F2F Contacts(CYP seen)</i> • <i>F2F Contacts (Appointments booked)</i> 	Monthly

	<ul style="list-style-type: none"> • <i>F2F Contacts (Total Conducted)</i> • <i>F2F Contacts (No presenting Problem recorded)</i> • DNAs (numbers & rates) • Total number of F2F contacts cancelled in a month by clinician or service • Case complexity • <i>Number of CYP whose cases were discussed/affected by an indirect contact in the month</i> • <i>Total number of indirect contacts conducted in the month</i> • Number of CYP discharged from a service within a month • Reason for discharge from service (other is not an acceptable category) • Average number of appointments received at time of discharge (to 1 decimal place) • Average time in service at point of discharge (in weeks to 1 decimal place) • Average number of F2F contacts for all individuals currently within the service (all individuals & all contacts – not just individuals who received a Face to Face contact in that month) • Average time (<i>in weeks to 1 decimal place</i>) of all individuals currently within the service– not just individuals who received a Face to Face contact in that month) (<i>Snapshot</i>) • <i>Total number of paid staff hours in a month (shown to one decimal place)</i> • <i>Total cost of staff in a month (shown to the nearest pound)</i> • Number of universal and targeted staff trained in the month <p><i>All of the above will be able to be broken down by: Whole Service; Locality; Service Specific; Source; Severity; Presentation type; Reason etc. where appropriate</i></p> <p>The Provider shall clarify the operational definition of terminology used in performance monitoring data.</p>	
CONTINUOUS IMPROVEMENT		
<p>Annual Self-Review of Safeguarding Arrangements in line with Section 11 of Children Act 1989. (NHS5)</p>	<ul style="list-style-type: none"> • The supplier is able to demonstrate and evidence compliance with Section 11 of Children Act 1989. • The supplier is able to evidence that where areas for improvement are identified they are acted upon in a timely and appropriate manner • The supplier shall complete a self-review of Safeguarding Arrangements annually • The supplier shall use either the Lincolnshire LSCB template or the 'Safe Network' website 	<p>Annually</p>

	<p>as a means to evidence compliance and best practice</p> <ul style="list-style-type: none"> The Supplier shall ensure 100% of staff have undertaken Safeguarding training 	
<p>Supplier actively manages delivery utilising an up to date risk register, to include a business continuity plan.</p> <p>(NHS4)</p>	<ul style="list-style-type: none"> Risk Report: Any risks identified are managed and actions to mitigate risk are identified and implemented Supplier to manage, maintain and report by exception on contracts risk register Business continuity plans are in place and available for review Business continuity arrangements are in place and are regularly reviewed to ensure they remain fit for purpose. These could include: <ul style="list-style-type: none"> Staff Shortage - illness, industrial action, severe weather Loss of premises - flood, fire, gas leaks Key Resources - loss of ICT, communications, data Supply Chain - loss of key supplier, service provider or partner The supplier is able to evidence when BC arrangements have been tested? The supplier can evidence that staff are aware of their roles and responsibilities during an incident or disruption? 	Quarterly
<p>The Supplier can demonstrate continuous improvement in the development of their workforce.</p>	<p>The supplier can evidence that the following systems are in place and are operational and effective:</p> <ul style="list-style-type: none"> Induction training is provided to all new starters All employees receive regular supervision All employees are subject to an annual appraisal with associated personal development plan Training, development and support standards are met and plans are in place and monitored to ensure that specific competencies for the various roles are achieved All employees are in receipt of all appropriate accreditation Teaching Agency requirements are met (previously referred to as the Children's Workforce Development Council) 	Quarterly
<p>Breadth of Skills Base</p> <p>(NHS2, NHS4, NHS5)</p>	<p>The supplier can evidence the provision of a clinical workforce that are trained, certified and able to offer a wide range of evidence based interventions in line with local need and NICE Guidance</p>	Bi-annually
<p>Friends and Family</p>	<p>The supplier is to gather Friends and Family Test scores from all service users at discharge from</p>	Quarterly

<p>Test</p> <p>(NHS4)</p>	<p>the service (in line with NHS England guidance) based on the following statement:</p> <p><i>'How likely are you to recommend our Child and Adolescent Mental Health Service to friends and family if they needed similar care or treatment?'</i></p> <p>Scores shall be reported monthly for both 'Recommended' and 'Not Recommended' rates.</p> <p>The supplier shall deliver a year-on-year improvement in '<i>recommended</i>' responses and a year-on-year decrease in '<i>not recommended</i>' rates.</p> <p>Low '<i>recommended</i>' response rates or high '<i>not recommended</i>' response rates at a service, location, or service user group level shall drive further investigation and inform the continuous improvement of the service.</p> <p>NB: A response of 'extremely unlikely' will be captured as the default for any service users that are discharged from the service without completing the 'Friends and Family Test'.</p>	
<p>Completed annual Contract Performance Report</p>	<p>The supplier is to provide the commissioner with an annual Contract Performance Report that includes the following:</p> <ul style="list-style-type: none"> • A review of the year's performance, including any centrally imposed targets/expectations • The annual stakeholder survey results and subsequent improvement actions taken • Evidence that objectives, actions, tasks within the plan have led to actual service improvements • The impact of the service outcomes is demonstrated and benchmarked against other services locally, regionally & nationally • A service user engagement plan for the forthcoming year • Evidence of the effective engagement of other services • Value for money is demonstrated • Areas for improvements that have been identified and acted upon • Findings from Quality Assurance audits have resulted in positive changes to services (where needed) • Demonstrable Outstanding delivery in line with Ofsted grade descriptors (where applicable) • A forward look at how to improve service delivery during the following year including acting upon suggestions from children/young people 	<p>Annually</p>
<p>Safeguarding Vulnerable Adults and Children 'Markers of Good</p>	<p>85% of staff are trained in safeguarding according to the levels and competencies set out by the LCSB.</p> <p>CAMHS are represented on the LCSB and attend</p>	<p>Annually</p>

<p>Practice' RAG rating</p> <p>(NHS5)</p>	<p>75% of meetings.</p> <p>85% of staff have received training in safeguarding vulnerable adults according to the levels set out in the Safeguarding Adults Board.</p> <p>85% of staff have received training in line with the Mental Capacity Act 2005/Deprivation of Liberty Safeguards.</p> <p>The supplier is able to provide the following:</p> <ul style="list-style-type: none"> • Written evidence of implementation of local policies and procedures are in place • Evidence that a designated Child Protection Nurse and a named Doctor are funded and in post • All DBS checks have been conducted and assurance received for all employees and volunteers • The process for flagging children who miss appointments • The system for flagging children for whom there are safeguarding concerns • Evidence that there is role clarity and sufficient time and support for named professionals • Safeguarding is led from Board & Executive level • The board review of safeguarding occurs annually • Robust and appropriate performance monitoring systems in place <p>NB: Reporting does not need to be completed in years when S11 Assessments are completed.</p>	
<p>Type of presenting problem</p>	<p>Type of presenting problems to be recorded in line with CAMHS minimum data set.</p> <p>The recording of a presenting problem as 'other' shall be addressed and rectified internally prior to reporting, or reported and discussed as an exception within the monthly meetings where the supplier deems 'other' to be the most appropriate category.</p>	<p>Monthly</p>
<p>FINANCE & PRODUCTIVITY</p>		
<p>Demonstrable Financial Stability</p>	<p>The Supplier can demonstrate financial stability and shall operate Open Book Accounting in relation to the Agreement and will provide as a minimum:</p> <ul style="list-style-type: none"> • Detailed financial information and reports that are submitted on time as per agreed schedule. • a breakdown of Direct, Indirect and Non-staffing costs <ul style="list-style-type: none"> - Direct staffing costs (e.g. number of 	<p>Monthly</p>

	<p>positions, vacancies, FTE status, NI/ Pension contributions, consultant costs etc.) including team and service managers</p> <ul style="list-style-type: none"> - Indirect staffing costs (e.g. travel, training, mobile phones etc.) - Non-staffing costs (e.g. premises costs, rates, utilities, corporate overheads, contribution to surplus etc.) <ul style="list-style-type: none"> • The name of the Identified Budget Holder • Details of any assets purchased with contract funding (identified and recorded) <p>The structured management and sharing of costing information between the supplier and the commissioner, will enable both parties to work together to jointly manage and ultimately reduce costs</p>	
Unit Costs	<p>The Supplier can demonstrate the unit cost of delivering the service and how it has worked with the LA to bring added value to the contract and improved value for money:</p> <ul style="list-style-type: none"> • Unit costs are established, in line with care clusters • Benchmarking data is established and comparisons are made and analysed against a relevant comparator group • Supplier can demonstrate delivering added value to the service • Efficient, Effective, Economic service is provided • Supplier can demonstrate delivering added value to the service 	Monthly
Vacant Posts	<p>The supplier provides the number of days that posts are vacant during the year (Cumulative) and percentage of full capacity workforce that is vacant on a month by month and annual basis.</p> <p>Details of each vacancy are to be provided through contact management.</p> <p>The supplier ensures vacancies are filled quickly to reduce the reliance on agency staff and to minimise the impact on service</p> <p>The supplier ensures any negative impact to the service user while a role is vacant is minimised</p>	Monthly
Clinical Staff as a percentage of Budget	<p>A minimum of 68% of the overall budget shall be spent on clinical staff</p>	Quarterly
Absence	<p>Number of Days and % of contract time lost to sickness kept to a minimum (Cumulative).</p> <ul style="list-style-type: none"> • The data shall be presented as a percentage and shall be contract specific, not overall sickness of the Trust • The % shall be tracked against target of the overall target of the Trust so that trends can be identified 	Quarterly

Out of area LAC provision	The supplier is to provide timely and accurate information in relation to provision of services to Looked After Children from other Local Authorities (monthly) to enable recharge to other services for this provision.	Quarterly
Risk Report	The supplier is to manage, maintain and report by exception on contract risks, including contingency plans.	Quarterly

10. Promotion and Publication

10.1

- 10.1.1 This is Lincolnshire's initial Local Transformation Plan which sets out our intentions for responding to the Local Transformation requirements. It is recognised by the Plan that the breadth of stakeholders involved in Children's mental health and emotional wellbeing is extensive and the Plan needs to be encompass these stakeholders views and is also likely to require actions of from those key agencies. In order to support this, it is anticipated that the Plan will be shared widely and updated accordingly to ensure it is reflective of multi-agency working with Schools, NHS England Specialist Commissioning, Public Health and Service Users.
- 10.1.2 The Lincolnshire Transformation Plan will be reviewed on an bi-annual basis with a commitment to further develop the Executive Action plan (currently sat under Section 1.4)
- 10.1.3 The Plan will link into broader strategic work including the Crisis Care Concordat, the JSNA, and the Health and Wellbeing Strategy. Lincolnshire County Council already host a web presence that includes an outline of the services available to Lincolnshire Children and their families. We will be publishing our Local Transformation on the site by November 2015.

10.2 Stakeholder Communication Engagement Plan

- 10.2.1 Please see overleaf the proposed engagement plan for the first tranche of engagement with our identified stakeholders. It is intended this time period will reflect the first few months after the Local Transformation Plan is published

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Stakeholder Group	Interest	Proposal
Schools	High	<ul style="list-style-type: none"> ■ Attendance at Headteacher Briefings ■ Distribution of promotional material
NHS England Specialist Commissioning	High	<ul style="list-style-type: none"> ■ Review of LTP ■ Distribution of promotional material
Provider	High	<ul style="list-style-type: none"> ■ Implementation Meetings ■ Contract Management Meetings ■ Staff Consultation
Young People	High	<ul style="list-style-type: none"> ■ Engagement with Young People Groups ■ Tailored Promotional Materials ■ Release a Young People friendly LTP
Parents, Carers and families	High	<ul style="list-style-type: none"> ■ Distribution of promotional material including website
Lincolnshire County Council	High	<ul style="list-style-type: none"> ■ Internal news bulletin ■ Corporate news links ■ Attendance at team meetings
Clinical Commissioning Groups	High	<ul style="list-style-type: none"> ■ Attendance at Executive Boards
United Lincolnshire Hospital Trust	Medium	<ul style="list-style-type: none"> ■ Distribution of promotional material
Public Health	Medium	<ul style="list-style-type: none"> ■ Distribution of promotional material
Third Sector / Private Sector	Medium	<ul style="list-style-type: none"> ■ Distribution of promotional material including website ■ Attendance at VSF
Probation & Youth Offending	High	<ul style="list-style-type: none"> ■ Distribution of promotional material ■ Attendance at Team Meetings
Engagement Forums	Medium	<ul style="list-style-type: none"> ■ Distribution of promotional material ■ Attendance at meetings
Lincolnshire Community Health Services	Medium	<ul style="list-style-type: none"> ■ Distribution of promotional material

11. Future Objectives

11.1 Aims & Objectives

- 11.1.1 Achieving the following commissioning objectives will help enable Lincolnshire Children's Services to realise the strategic outcomes identified within Future In Mind and will provide sufficient provision and support for C&YP with Mental Health and Emotional Well Being Needs.
- 11.1.2 A number of these objectives will be achieved as part of the development of the new CAMHS model including the ongoing development of Behaviour, Self-Harm and Transitions Pathways in conjunction with current reviews on wrap around services that work in conjunction with CAMHS and the Local Authority response to the Crisis Care Concordat.

11.2 Analysis

- Co-ordinate a plan following on from the ADS "Readiness for Implementation" Report to identify actions, such as working with Schools to implement the recommendations of the Carter Review
- Lincolnshire has already undertaken significant stakeholder engagement with our service users and used this information as part of the specification re-design process
- We will build appropriate metrics into the contract management process to monitor the performance of the contract
- Develop metrics for the Single Point of Referral to ensure it prioritises service users appropriately
- Undertaking a gap analysis to identify potential breaches between existing and new model of CAMHS delivery
- Gather stakeholder feedback on what training topics front line practitioners feel would be helpful

11.3 Plan

- Increased engagement with key agencies such as Schools, Health, Lincolnshire Police, Lincolnshire Community Health Service, Youth Offending Service, GP's
- Identify the key objectives for implementation of the new model so these can be actioned as a priority
- Co-ordinate an Implementation Plan for the new model
- Identify the clinical and non-clinical staff that will receive CYP IAPT Training to develop the workforce
- The Executive Action Plan in Section 1 shows the next steps, lead organisation and implementation date. The executive action plan will require input from several agencies on an ongoing basis
- Develop assessment process for Single Point of Referral with Provider (LPFT) and Customer Service Centre

11.4 Do

- Respond to the areas highlighted within the CAMHS gap analysis, identifying how these gaps will be met
- Ensure clinical staff are trained in the use of OO-CAMHS and CORC in order to comply with data capture requirements that feedback from the data collection system
- Develop the young people's forum, Lost Luggage group so they are more engaged in the performance monitoring process. This should be done through a variety of mechanisms, including seeking feedback at contract management, promoting the Lost Luggage group on the "teeninfoincs" site and developing the relationship between the Local Authority Participation Team and the Provider Membership & Involvement Team
- The development of young people's advisory boards/involvement group
- Focus groups on specific issues such involving the Young Inspectors in unannounced site visits to the Providers premises to feedback how the site could be made more young people friendly. These comments should then be tracked, implemented and monitored through contract management.
- Benchmarking and monitoring participation in the service using Hear by Right, You're Welcome, HASCAS and QNCC standards to provide steer on the quality of participation
- Identifying participation leads to drive the work forward, who are supported by the Trust's Membership & Involvement Team so governance arrangements are in place to support other participation actions
- Developing work with hard to reach groups by linking into Local Authority Participation Team for best practice, guidance and advice
- Investigate the practicality of involving young people in the training and/or recruitment of staff
- Monitor through robust contract management processes the performance of the service
- Link into additional work streams including School Nursing, Health Visiting, Healthy Child Agenda, Portage Review and Behaviour Outreach Review to ensure that the holistic package of support for young people is working in a joined up way
- Work with Schools to implement the recommendations of the Carter Review
- Undertaking the actions identified in the stakeholder communication engagement Plan including attending team meetings, distributing promotional material, attendance at Executive Boards and Headteacher briefings
- Continue to engage with regional working and national commissioning training, continuous professional development and the sharing of best practice
- Extend the use of peer to peer support utilising the Online Counselling service which already hosts blogs, forum chats, artwork and podcasts
- Implement a performance monitoring mechanism that measures disengagement rates with a stretching target to reduce disengagement year on year
- Consider how we can reach services such as youth clubs and supported accommodation to support those C&YP who may not even recognise they have Mental Health problems
- Improve our digital presence by updating the teeninfoincs site to include an overview of how the CAMH service will work, so service users and their families understand the service they can expect and making clear the universal services that are available and how to access them

- Undertake further work to identify the holistic flow of mental health funding across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment

11.5 Review

- Commit to reviewing the Local Transformation Plan on a bi-annual basis with a number of key agencies
- Develop the shared action plan under Section 1 so that all agencies can review, monitor and track improvements on, supported by appropriate governance structures.
- Utilise the opportunity to share and receive best practice with other Local Authorities through the publication of Local Transformation Plans

12. References

- 12.1
- The Children and Families Act 2014
 - The Children Act 1989 and 2004
 - The Adoption and Children Act 2002
 - Education Act 1996, 2002 and 2011
 - Health and Social Care Act 2001, 2008 and 2012
 - Safeguarding of Vulnerable Groups Act 2006
 - Mental Health Act 1983 and Code of Practice (Amended 2007)
 - Mental Capacity Act 2005
 - Care Act 2014
 - Working Together to Safeguard Children 2013
 - Social Value Act 2012
 - Human Medicines Regulations 2012
 - Housing Act 1996
 - The Equality Act 2010
 - National Health Service Act 2006
 - Sex Offenders Act 1997 as amended by part 2 of the Sexual Offences Act 2003
 - Police and Justice Act 2006

12.1.1 There are several national standards and relevant guidance that are applicable to children and young people's mental health and CAMHS. This includes, but is not limited to:

- Department of Health, No Health Without Mental Health, 2011
- Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) <http://www.cypiapt.org/children-and-young-peoples-project.php>
- CYP IAPT Principles in CAMHS Services: Values and Standards "Delivering With and Delivering Well", 2014
- Special Educational Needs and Disability (SEND) Code of Practice 2014
- The Care Quality Commission's Essential Standards of Quality and Safety
- Department of Health, You're Welcome Quality Criteria, 2011
- National Youth Agency, Hear By Right – Standards for young people's participation, 2006
- The National Service Framework for Children, Young People and Maternity Services (2004) – disabled children, young people and those with complex needs (Standard 8) and The Mental Health and Psychological Well-being of Children and Young People (Standard 9)
- The NHS Choice of Provider initiative
- Personal Budgets Guidance
- NHS England (2015) Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)
- NHSE National Specification for Transitions from CAMHS Guidance (2015)
- Recommendations from the House of Commons health Committee on Children's and Adolescent' mental health and CAMHS (2014)
- Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (2014)
- Achieving Better Access to Mental Health Services by 2020 (2014)
- Future in mind – Promoting, protecting and improving our children and young people's mental health and well being
- Promoting the health and welfare of looked-after children - Statutory guidance for local authorities, clinical commissioning groups and NHS England
- Lincolnshire All Age Autism Strategy 2015-2018
- NICE guidance relating to children and young people's emotional well-being and mental

health:

CG9 Eating Disorders 2004

CG16 Self-harm 2004

CG26 Post-traumatic stress disorder

CG28 Depression in Children and Young People 2005

CG31 Obsessive Compulsive Disorder and Body Dysmorphic Disorder 2005

CG38 Bipolar Disorder 2006

CG72 Attention Deficit Disorder 2009

CG77 Antisocial personality disorder 2009

CG78 Borderline personality disorder 2009

CG112 Anxiety 2011

CG128 Autism diagnosis in children and young people 2011

CG133 Self-harm: longer term management 2011

CG155 Psychosis and schizophrenia in children and young people 2013

CG158 Anti-social and conduct disorders in children and young people 2013

CG170 Autism 2013

PH4 Interventions to reduce substance misuse among vulnerable young people 2007

PH12 Social and emotional well-being for children and young people 2008

PH20 Social and emotional well-being in secondary schools 2009

PH28 Looked-after children and young people 2010

PH40 Social and emotional well-being: early years 2012

QS48 Depression in children and young people 2013

QS59 Anti-social behaviour and conduct disorders in children and young people pathway 2014

In development – Children’s attachment (2015); Sexually harmful behaviour in young people (2016)

12.1.2 Applicable standards set out in guidance and/or issued by a competent body:

- [Quality Network for Community CAMHS Standards](#)
- [Quality Network for Inpatient CAMHS Standards](#)
- [Youth Wellbeing Directory & ACE V Quality Standards](#)
- [Child Outcome Research Consortium \(CORC\)](#)
- [Choice and Partnership Approach \(CAPA\)](#)
- CYP IAPT Accreditation Council (NHS England) [values and standards](#) following a wide consultation with professionals, children / young people, parents and carers