Public Document Pack

Blackpool Council

13 October 2015

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 21 October 2015 at 3.00 pm
in Solaris Centre

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 2ND SEPTEMBER 2015 (Pages 1 - 6)

To agree the minutes of the last meeting held on 2nd September 2015 as a true and correct record.

3 STRATEGIC COMMISSIONING GROUP UPDATE (Pages 7 - 12)

To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

4 CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP UPDATE (Pages 13 - 20)

To propose that the Children and Young People's Partnership becomes a sub-group of the Health and Wellbeing Board and present the terms of reference for the Partnership, which have been revised to reflect this relationship. The report also informs the Board of the activity of the Children and Young People's Partnership over

the last twelve months.

5 TRANSFORMING CARE - LEARNING DISABILITIES FASTRACK PLAN (Pages 21 - 92)

To provide an update on work to accelerate service change for people with learning disabilities as part of a national transformation (fastrack) programme and to present the transformation (fastrack) plan for Lancashire.

6 LANCASHIRE CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH, EMOTIONAL WELLBEING AND RESILIENCE TRANSFORMATIONAL PLAN (Pages 93 - 170)

To provide the Board with an overview and background to the development of the Children and Young People's Emotional Health and Wellbeing Transformational Plan 2015 – 20.

7 BLACKPOOL, WYRE AND FYLDE COUNCIL FOR VOLUNTARY SERVICES (Pages 171 - 174)

To inform the Board of the objectives, purpose and value of a Third Sector Infrastructure Organisation (Blackpool, Wyre and Fylde Council for Voluntary Service) and to request that fund holders consider funding to enable the Council for Voluntary Services to continue the work it has been undertaking.

8 SPECIAL EDUCATIONAL NEEDS AND DISABILITIES UPDATE (Pages 175 - 180)

To update the Board on the progress of the implementation of the 2014 Children and Families' Act across agencies and the new OFSTED/ Care Quality Commission inspection framework for Special Education Needs (0-25 year olds and their families) in a local area.

9 NEW MODELS OF CARE VALUE PROPOSITION (Pages 181 - 234)

To inform the Board of the Value Proposition for New Models of Care on the Fylde Coast that was submitted to NHS England for their Investment Board meeting week beginning 28th September.

10 SECTION 75 POOLED BUDGET AGREEMENT (Pages 235 - 274)

To inform the Board of the Section 75 Pooled Budget Agreement that has been developed by Blackpool Council and Blackpool Clinical Commissioning Group.

11 DRAFT FORWARD PLAN (Pages 275 - 280)

To inform members that a draft Forward Plan has been developed for the Board.

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact, Bernadette Jarvis, Tel: 01253 477212, e-mail bernadette.jarvis@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

This page is intentionally left blank

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 2 SEPTEMBER 2015

Present:

Councillor Cain, Cabinet Secretary (Resilient Communities), Blackpool Council (in the Chair)

Councillor Collett, Cabinet Member for Reducing Health Inequalities and Adult Safeguarding

Councillor Jones, Cabinet Member for School Improvement and Children's Safeguarding

Councillor Clapham, Opposition Group Representative

Simon Bone, Lancashire Fire and Rescue Service

Delyth Curtis, Director of People, Blackpool Council

Gary Doherty, Chief Executive, Blackpool Victoria Hospital NHS Trust

Roy Fisher, Chairman, Blackpool Clinical Commissioning Group

Dr Arif Rajpura, Director of Public Health, Blackpool Council

Joan Rose, Healthwatch

Karen Smith, Director of Director of Adult Services, Blackpool Council

In Attendance:

Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
Scott Butterfield, Corporate Development Manager, Blackpool Council
Ms L Donkin, Public Health Specialist, Blackpool Council
Jeannie Harrop, Senior Commissioning Manager, Blackpool Council
Neil Jack, Chief Executive, Blackpool Council
Bernadette Jarvis, Senior Democratic Governance Adviser
Simon Lawton, Voluntary Sector
Carmel McKeogh, Deputy Chief Executive, Blackpool Council
Liz Petch, Public Health Specialist, Blackpool Council
Val Raynor, Head of Commissioning, Blackpool Council
Emma Savage, Public Health Registrar, Blackpool Council
Ian Sewart, Lancashire Police
Beverly Wood, Police and Crime Commissioner's Office
Simon Lawton, Voluntary Sector
Chief Inspector Ian Sewart, Lancashire Constabulary
Beverly Wood, Police and Crime Commissioner's Office

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 2 SEPTEMBER 2015

Apologies:

David Bonson, Doyle, Higgs, Noble, Rudnick and Tierney-Moore, Lancashire Care NHS Trust

Ian Johnson and Wendy Swift, Blackpool Victoria Hospitals NHS Trust

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 15TH JULY 2015

Resolved: That the minutes of the meeting held on 15th July 2015 be approved as a correct record, subject to Item 5, second paragraph being amended to read 'She emphasised the links between the key objectives of the programme and the priorities of the Health and Wellbeing Board and it was noted that the key objectives were centred around three areas: Prevent, Pursue and Protect.'

3 STRATEGIC COMMISSIONING GROUP UPDATE

The Board received an update on the activity of the Strategic Commissioning Group which included discussions from its last meeting in August. It noted that that a section 75 agreement to enable Better Care funding to be paid through a pooled budget would be submitted to the Health and Wellbeing Board for ratification at its meeting in October. The Group was also advised on progress on the Vanguard New Models of Care which included the Value Proposition which was due to be submitted to NHS England and Ms Curtis, Director of People, Blackpool Council advised that a report on this would be provided to the Health and Wellbeing Board for consideration at a future meeting.

The Board considered the Strategic Commissioning Group's revised terms of reference and the changes to its membership.

Resolved:

1. To note the update from the last meeting of the Strategic Commissioning Group

2. To approve the new terms of reference for the Strategic Commissioning Group.

4 HEALTH PROTECTION ARRANGEMENTS

Ms Donkin, Public Health Specialist, Blackpool Council reported on the purpose of Health Protection in protecting the public from harm from infectious diseases and environmental hazards. She advised Members of the responsibility for providing good health care and reported on the many organisations that contributed to this, which included Public Health England and the Council's Public Protection and Public Health departments, along with a diverse range of providers.

The Board was advised that the Department of Health had recommended that a Health Protection Forum be established with a link from the Forum to the Health and Wellbeing Board. Ms Donkin acknowledged that this was already the case in Blackpool but suggested that it should be on a more formal basis with bi-annual reports to the Health and Wellbeing Board plus additional reports submitted as and when required.

The Board held a lengthy discussion on the recent water restrictions that had affected a large part of Lancashire due to the presence of cryptosporidium in the water treatment works. Members raised concerns relating to the poor communication of the water restrictions and were provided with assurances that this was being pursued with the relevant organisations. Dr Rajpura, Director of Public Health, Blackpool Council provided the Board with information on how the situation had been dealt with by the Local Authority and other organisations and updated Members on the current situation. The Board was also advised of the measures that had been put in place for schools and vulnerable people.

Resolved:

1. That the existing Health Protection Forum becomes part of the formal governance structure reporting into the Health and Wellbeing Board in the first instance and the Strategic Commissioning Group as required.

2. To receive regular reports and updates from the Health Protection Forum.

3. That a formal set of terms of reference be drawn up by the Director of Governance and Regulatory Services and the Director of Public Health and be submitted to the next meeting for approval.

5 BLACKPOOL INTERMEDIATE CARE REVIEW (2015)

Ms Harrop, Senior Commissioning Manager, Blackpool Council and Ms Raynor, Head of Commissioning, Blackpool Council presented with the Board with an overview of Blackpool's Intermediate Care Review that had been undertaken jointly by Blackpool Clinical Commissioning Group and the Council. Its purpose had been to review existing health and social care services with the aim of contributing to timely hospital discharges and prevention of avoidable hospital admissions by providing intermediate support in the appropriate care setting.

Ms Raynor reported on the proposed new model for a single local integrated Intermediate Care Service which included a robust management and governance structure with appropriate care being determined by a multi-disciplinary team. The new model proposed a move from bed based support towards the provision of intermediate care at home. Ms Raynor reported on the aims of the review which included a reduction in the cost of acute care, managing the projected increase in demand through a much more co-ordinated approach and increasing people's potential to remain independent.

The Board was advised that the next steps would be to seek agreement to progress the findings of the commissioning review with a proposed implementation date for the proposed model at the end of March 2016.

Responding to a question, Ms Raynor confirmed that the voluntary sector was included in the proposed Intermediate Care pathway.

Resolved:

1. To agree to progress the findings of the work to date in relation to delivering intermediate care closer to home through improved joint working and development of the care pathway.

2. To receive a progress report at its meeting in December and further reports at quarterly intervals.

6 PUBLIC HEALTH ANNUAL REPORT 2014

Dr Rajpura, Director of Public Health, Blackpool Council presented his Annual Report 2014 to the Board. He explained that the main theme of the Annual report was a response to the Due North report that had been published by Public Health England and which had demonstrated the inequalities between the North and South of the Country including recommendations to address this. The Board was presented with statistical information on the differences in life expectancy for men and women within Blackpool and nationally. Dr Rajpura reported on the wider determinates of health inequalities, the majority of which, in his view, were outside of the health service.

Dr Rajpura reported on of the four recommendations from the Due North report, which were:

1. Tackle poverty and economic inequality
2. Promote healthy development in early childhood
3. Share power over resources and increase influence of public
4. Strengthen role of health sector in promoting health equity

Dr Rajpura went on to explain the actions already being taken locally to address the issues and advised on further actions that still needed to be taken.

Dr Rajpura concluded his presentation by advising the Board that the single recommendation of the Public Health Annual Report 2014 was to ensure that the recommendations for local action as set out in the Due North report were implemented without delay.

Responding to questions from the Board regarding support from the Health and Wellbeing Board, Dr Rajpura informed Members that an action plan on the implementation of the recommendations for local action in the Due North report was being produced and suggested that the Board should monitor progress on the action plan.

During a lengthy discussion, it was generally accepted that there had been a lot of success in tackling health inequalities in Blackpool but more was needed to be done.

Resolved:

1. To note the Public Health Annual Report 2014 and endorse the recommendation.

2. To add an item on the Health and Wellbeing Board's Forward Plan to monitor progress on the action plan on the implementation of the recommendation.

7 PUBLIC HEALTH RING-FENCED FUNDING REDUCTION

Dr Rajpura updated the Board on the proposed reduction in the ring-fenced funding for Public Health. He advised Members that the deadline for consultation had passed and that a robust response had been provided to the consultation which had included the Council's view that it was against any cut in the Public Health budget.

The Group noted that a response from the Minister of Public Health had been received and circulated to Members of the Board.

The Group noted that a response to the proposed reduction had also been provided by 38 Degrees Blackpool, Fylde and Wyre NHS Support Group and it was requested that this be forwarded to Members. Dr Rajpura expressed concerns at the potential loss of £1.3million from the budget and suggested that any cuts should be on a pro-rata basis due to the length of time that would have elapsed before the extent of the proposed cuts was known.

Resolved: To note the verbal update.

8 DRAFT FORWARD PLAN

The Board considered the Forward Plan.

The Board was advised that individual Members had the opportunity to request appropriate items to be included in the Plan.

Resolved: To note the Forward Plan.

9 DATE OF FUTURE MEETINGS

Members noted the date of future meetings as follows:

21st October 2015
2nd December 2015
27th January 2016
2nd March 2016
20th April 2016

Chairman

(The meeting ended 4.45 pm)

Any queries regarding these minutes, please contact:
Bernadette Jarvis Senior Democratic Services Adviser
Tel: 01253 477212
E-mail: bernadette.jarvis@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People
Relevant Cabinet Member:	Councillor Cain, Cabinet Secretary (Resilient Communities)
Date of Decision/ Meeting:	21 October 2015

STRATEGIC COMMISSIONING GROUP UPDATE

1.0 Purpose of the report:

1.1 To update the Board on the activity of the Strategic Commissioning Group (SCG)since the last meeting. In addition, the Board is advised that the SCG terms of reference have been updated to include representation from Lancashire Constabulary with regards to enabling the SCG to have strategic oversight of the Early Action work that they lead on, in line with the Board's recommendation.

2.0 Recommendation(s):

2.1 It is recommended that the Board note the action points from the SCG's August meeting and a verbal update from the last meeting on 7 October 2015.

3.0 Reasons for recommendation(s):

3.1 The SCG is a sub-group of the Board, which is responsible for overseeing the integration and alignment of commissioning across the CCG and Council. It has a duty to update the Board on activity against its work programme and future planned activity.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

No alternative options.

4.0 Council Priority:

4.1 The relevant Council Priority is 'Improve health and well-being especially for the most disadvantaged'

5.0 Background Information

5.1 The action points and notes from August's SCG meeting are attached at Appendix 3(a). Items include:

- Section 75 agreement
- The Intermediate Care Commissioning Review
- Vanguard New Models of Care
- Public Health consultation on in year budget reductions
- Commissioning mapping ongoing work
- The updated terms of reference

5.2 The last meeting took place on 7 October, the minutes of this meeting are not yet available therefore a verbal update will be given. Items covered at the meeting include:

- An update on the Intermediate Care Commissioning Review
- A discussion on the Emotional Health and Wellbeing Transformation Plan
- A presentation on the Learning Disability Transformation Plan
- A discussion on the Vanguard Value Proposition
- An update on the Early Action work led be Lancashire Constabulary
- A discussion of the review of public health in secondary care services

Does the information submitted include any exempt information? No

5.3 **List of Appendices:**

Appendix 3(a) – Notes from August meeting

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

This page is intentionally left blank

Strategic Commissioning Group notes from meeting 13 August

Section 75 – Hilary Shaw

The finer detail of the agreement is being drafted; **this will be brought to the HWB for ratification in October.**

Intermediate Care Commissioning Review

The report was discussed and agreed that the group who led the review will lead the service redesign. The next steps will be brought to future meetings for further discussion as the plan is implemented.

New models of care

CCG advised that the Value Proposition has been submitted in draft to NHS England and feedback received.

NHSE asked for the submission to focus on describing the outcomes of the new vanguard; how much will health outcomes improve? How will it relate to activity in 3-4 years? Need to demonstrate impact and improvement.

Looked at cost and how much it will impact on urgent care activity and how to pump prime new service to shift away from acute need and redesign workforce to suit.

Agreed that work needs to be done around workforce issues, look at where roles can be merged, some redesign of services and roles; needs to dovetail with the Public Sector Reform Board work around workforce.

The final proposition is due to be signed off on 14 September and submitted to NHSE on 4 October.

The Vanguard Value Proposition will be brought to HWB in October for discussion.

Public health consultation

Discussed the implications of the proposed cuts, a meeting is planned to look at options and a response would be drafted and submitted.

Most likely £1.2m cut, carries influence across health economy, it will impact on 0-5 transfer budget, and other frontline health services.

Commissioning mapping

Contracts have been divided according to themes; these are mainly managed by one particular service area, with not much room to share further.

The CCG are supported by the CSU and there are contracts in place around this due for renewal – some work may be able to be done elsewhere – CCG to look at these areas (David).

Further work will be done to look at some lower risk contracts (Val).

Update to come to next SCG

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People
Relevant Cabinet Member	Cllr John Jones, Cabinet Member for Children's Safeguarding and School Improvement and Chair of Children and Young People's Partnership
Date of Decision/ Meeting	21 October 2015

CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP UPDATE

1.0 Purpose of the report:

1.1 To propose that the Children and Young People's Partnership becomes a sub-group of the Health and Wellbeing Board and present the terms of reference for the Partnership, which have been revised to reflect this relationship. The report also informs the Board of the activity of the Children and Young People's Partnership over the last twelve months.

2.0 Recommendation(s):

2.1 To agree that the Children and Young People's Partnership becomes a sub-group of the Board, to approve the terms of reference and note the areas of work that the Partnership has strategic oversight of.

3.0 Reasons for recommendation(s):

3.1 From 31 October 2010, the Department for Education (DfE, 2012) withdrew statutory guidance on Children's Trusts, however the requirement for local authorities and partners to have a Children's Trust Board and the wider duty to cooperate to improve children's wellbeing, as set out in section 10 of the Children Act 2004, remains in force.

3.2 The withdrawal of statutory guidance means that local authorities have the flexibility to ensure that their Children's Trust Board fits with local Health and Wellbeing Board arrangements to suit their local context. Following discussions that have taken place with members of the Board and Partnership; it is widely agreed that the proposed arrangement would best suit the needs of Blackpool and fit in with current governance structures.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:
An alternative option would be for the Partnership to not become a sub-group of the Board.

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Tackle child poverty, raise aspirations and improve educational achievement
- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

Children and Young People's Partnership Terms of Reference

5.1 In Summer 2014, Blackpool reviewed its Children's Trust to create the Children and Young People's Partnership, with refreshed purpose, roles and responsibilities and membership, which are set out in Appendix 4(a) – draft Terms of Reference.

5.2 The relationship between the Children's Partnership and the Health and Wellbeing Board is key in improving children's outcomes and has been constructed in a way that fits in with wider governance structures of Blackpool. To facilitate co-ordination on children's health issues, it is proposed that the Partnership will function as a sub-group of the Health and Wellbeing Board, reporting back to the Board with its recommendations, as appropriate.

5.3 Its purpose is to operate as the key strategic group with responsibility for overseeing and shaping the delivery of the children's health and wellbeing agenda on behalf of the Health and Wellbeing Board and to influence relevant strategies to address wider issues around children's outcomes.

5.4 At a practical level and to ensure openness, transparency, clear lines of communication and accountability between the Partnership and Board, it is proposed that regular update reports are brought to the Board. The report will summarise key points of discussion and will request that the Board supports, endorses or agrees the decisions made by the Partnership. Minutes from the

meeting and /or relevant papers will be included as appendices for background information.

Children and Young People's Partnership activity

5.5 Since the Children's Trust was reviewed in Summer 2014 and became the Children and Young People's Partnership, it has had a strategic oversight of a number of important areas of work:

- 0 – 5 years public health commissioning transfer – a number of updates and reports have been discussed regarding the transfer of commissioning responsibility for children aged 0-5 years to the local authority and the implications for future commissioning and service delivery.
- Strategic oversight of the Children's Improvement Plan; developed in response to the 'requires improvement' judgement in the July 2014 Ofsted inspection of children's social care and safeguarding services. The Partnership had responsibility for overseeing and scrutinising the implementation of actions related to children's emotional health and wellbeing and early help services.
- Considered and gave feedback on the Lancashire Child Death Overview Panel Annual Report 2014, proposing that Blackpool should consider having its own specific Child Death Overview Panel to consider the issues within Blackpool's context.
- The Partnership has oversight of and has discussed and contributed towards the Head Start bid and input into the governance structure.
- Considered the draft Commissioning Strategy and fed into the consultation process, approving the finalised document.
- Considered the updated Children's Strategic Needs Assessment and Schools and Student Health Education Unit (SHEU) survey, which will be used to inform the priorities in Partnership's forthcoming strategy.
- Discussed and fed back on the Lancashire Children and Young People Emotional Health and Wellbeing Transformation Plan, positively supporting its development and raising concerns regarding the scope of the document and timescales for its development.
- Received presentations on and discussed Better Start, contributing to shaping the strategic direction.
- Supported the development of the Blackpool Challenge Partnership to raise attainment levels for children and young people.

Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Appendix 4(a) – Draft Children and Young People Partnership terms of reference

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

Children and Young People's Partnership

1. PURPOSE, REPORTING LINES, LIMITATIONS AND REVIEW

*This section should set out in no more than a couple of sentences the specific **PURPOSE** of this group (**WHY** it was established). It should state **WHO** established this group (usually a parent body), its reporting and accountability lines to its parent body and whether it has any limitations placed on its work, or whether it is a group of influence/ advisory body to others. If it does have any delegated powers (e.g. spend) then to state **HOW** it has been given those powers (do not state what those powers are in this section).*

Regarding reporting back to the parent group then this section should state how this is done and if relevant by whom. It should also state how often the group will review the relevance and value of its work and its terms of reference. The terms of reference can only be changed by the body which set this group up.

The Blackpool Children's Trust was created in 2006 as part of the Children and Young People's Plan (Decision EX2/2006 refers). The Plan had at the heart of its delivery mechanism, the Children's Trust, with the intention to promote the integrated delivery of services by all relevant agencies, to fulfil the requirements of Section 10 of the Children Act 2004. This Partnership has developed from the Children's Trust. From 31 October 2010 the Department for Education withdrew statutory guidance on Children's Trusts, however the requirement for local authorities and partners to co-operate to improve children's wellbeing, as set out in section 10 of the Children Act 2004, remains in force and this Partnership is the body which would co-ordinate that.

It is proposed that the Partnership will function as a sub-group of the Health and Wellbeing Board, reporting back to the Board with its recommendations, as appropriate.

Its purpose is to operate as the key strategic group with responsibility for overseeing and shaping the delivery of the children's health and wellbeing agenda on behalf of the Health and Wellbeing Board and to influence relevant strategies to address wider issues around children's outcomes.

2. KEY ROLES, RESPONSIBILITIES AND DUTIES

This section should state its key roles (in brief), responsibilities and the duties assigned to it from the parent body. These key roles and duties should specifically relate back to the purpose of the group and not deviate away from it.

To provide strategic leadership with responsibility for overseeing the delivery of the children's health and wellbeing agenda on behalf of the Health and Wellbeing Board

The Partnership is responsible for developing and overseeing delivery of a strategy for improving outcomes for children (Children and Young People's Partnership Strategy 2016-19), taking account of priorities of the Health and Wellbeing Board and evidence in the Joint Strategic Needs Assessment.

The Strategy will address the root causes of poor outcomes through an upstream approach to population change. This will primarily focus on cross-cutting factors which address the health, wellbeing and life chances of children, including poor dental health, factors leading to poor health outcomes, e.g. nutrition, exercise; child and adolescent mental health; poor educational attainment and the primary/secondary school transition; and development in the early years.

Influence relevant strategies to address wider issues around children's outcomes

In delivering the Children and Young People's Partnership Strategy, the role of the Partnership will be to:

- Align partner budgets towards work delivering the priorities;
- Influence the commissioning process;
- Reshape existing plans and services relating to children's outcomes to deliver the transition from downstream to upstream services;
- Ensure services are delivered in a more integrated and effective way.

There are a number of strategies which are planned or being implemented which the Children and Young People's Partnership will need to shape to bring in line with the CYPP Strategy; these are included in its review plan for 2014-16.

The Partnership will assess the scale and nature of impact on children of emerging strategies and bids and ensure that it has the opportunity to influence and make recommendations on these at the earliest stage.

Act as the strategic board for multi-agency co-ordination of partnership bids and projects around children

In order to deliver effectively, the Partnership will act as the strategic board for any national initiatives, projects or funding bids which have improving children's outcomes at their core. This initially includes Head Start and Better Start. Other multi-agency partnership projects will be added as they are developed.

Ensuring evidence-based decision-making and evaluation on children's projects and initiatives

The Children's Strategic Needs Assessment provides the evidence base for the selection of priorities and the Partnership has responsibility for ensuring that it is updated and used to inform priority setting and decision making. A public health approach requires that the actions implemented are proven, or where this is not possible, which have a scientific rationale.

Direct the transition to upstream services

The shift from resource intensive downstream services towards population-level upstream services needs careful oversight of the projects being delivered and the performance indicators identified as being relevant. The Partnership needs to shape the movement of investment between downstream and upstream interventions. Equally, it needs to be able to identify significant gaps in downstream service delivery which may need to be plugged pending the upstream approaches starting to make an impact.

Develop and oversee commissioning arrangements

The Partnership will develop an integrated commissioners' view of the change needed which will include looking at aligned or pooled budget arrangements, and ensuring that funding streams are targeted at initiatives which make the biggest long term impact on improving children's health and wellbeing and life chances.

3. MEMBERSHIP, APPOINTMENTS AND INTERESTS

This section should state who can be a member, how and when and by whom they are they appointed and the duration of the appointment. It should state if the membership of the group is open to anyone else and what the restriction on numbers are. There should be balanced representation from interested organisations and a nominated deputy to attend in the representative's place. If this is not set down then a reason should be stated for this difference.

Cabinet Member, Cabinet Member for School Improvement and Children's Safeguarding (Chairman)
Opposition Member, Vice-Chairman Resilient Communities Scrutiny Committee
Chairman, Safeguarding Children's Board
Director of Public Health, Blackpool Council
Deputy Chief Executive, Blackpool Council
Director of Children's Services, Blackpool Council
Chairman, Clinical Commissioning Group
Chief Operating Officer, Clinical Commissioning Group
Deputy Chief Executive, Blackpool Teaching Hospitals, NHS Foundation Trust
Chief Superintendent, Blackpool Police, Lancashire Constabulary
Director, Better Start
Primary School representative(or Chairman of Schools Forum)
Secondary School representative (or Chairman of Schools Forum)

4. CHAIRING ARRANGEMENTS, FREQUENCY OF AND PROCEDURES FOR THE MEETING AND GOVERNANCE SUPPORT

*This section should set down **WHO** the chairman is and whether they were pre-appointed by the parent body or whether this group appoints them. It should also set down their term of office, if this is set.*

*It should state the frequency of meetings, **HOW MANY** meetings will be held each year and **WHERE** will they be held . It should state brief arrangements for how reports for the agenda are co-ordinated and when the meeting papers will be circulated in advance of the meeting.*

Regarding the format of the meetings, then this section should state any rules of debate and voting arrangements (members or nominated deputies to vote) and whether the chairman has a casting vote. It should also state who will provide secretariat for the group.

The Chairman it is proposed will be the Cabinet Member for School Improvement and Children's Safeguarding by virtue of the Cabinet role. The term of office is not limited – the Chairman will always be the relevant Cabinet Member.

The Partnership meets approximately every two months, usually at the City Learning Centre, Bathurst Avenue, Blackpool, FY3 7RW.

Agenda setting meetings are usually held four weeks before a meeting with the Chairman, Director of People, Corporate Development, Policy and Research Manager and Senior Democratic Governance Adviser. The agenda is then sent out a week before the meeting by the Senior Democratic Services Adviser. There are no formal rules of debate, with the Partnership seeking to seek consensus on issues discussed. If any vote is required it would be by a simple majority vote, with the chairman having a casting vote.

Development of the Children and Young People's Partnership Strategy and Partnership work plan will be led by the Council's Corporate Development Team.

5. SHARING OF INFORMATION, CONFIDENTIALITY ISSUES

This section should state whether the meeting will be held in private or whether it will be open to the public to attend. It should state how group members will share information and resources (and any limitations on these). It should also state whether the papers are confidential and for what reason.

Meetings are not held in public. Papers are confidential, due to the nature of the issues discussed and consideration is also given to strategies in very early draft stage, presented for the Partnership's input before they are formally approved.

6. CONTEXT AND RELATIONSHIP TO OTHER GROUPS

This section will explain the environment to which the group belongs and it will also explain the links and relationships between associated groups and the reason for those relationships.

It is proposed that the Partnership will function as a sub-group of the Health and Wellbeing Board, with recommendations to the Health and Well Being Board.

In addition, Partnership members will take responsibility **within their organisations** for the following aspects of delivering the strategy:

- Provide strategic leadership on children's issues at an organisational and partnership level;
- Promote integrated working on children's initiatives through joined up commissioning plans;
- Ensure that the delivery of positive outcomes for children are considered and wherever appropriate built into the plans and strategies of their organisations;
- Work to ensure the support of their organisations for joint commissioning and pooled budget arrangements

Terms of reference last updated (date):	24 October 2012 (as the Children's Trust – EX37/ 2012)
Quality assured by:	Director of Governance and Regulatory Services
Terms of reference last updated (name of establishing body:	tbc

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Helen Lammond Smith, Head of Commissioning, NHS Blackpool CCG and Traci Lloyd-Moore, Commissioning Manager, Blackpool Council
Relevant Cabinet Member	Councillor Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	21 October 2015

Transforming Care – Learning Disabilities Fastrack Plan

1.0 Purpose of the report:

1.1 To provide an update on work to accelerate service change for people with learning disabilities as part of a national transformation (fastrack) programme.

1.2 To present the transformation (fastrack) plan for Lancashire.

2.0 Recommendation(s):

2.1 To approve the plan, agreeing the principles within it to develop the required transformation programme and create an integrated community approach for the Learning Disability population.

2.2 To support the financial bid and the Clinical Commissioning Groups (CCG) share of match funding (for the Discharge Co-ordinator and PMO elements) required to progress the work.

3.0 Reasons for recommendation(s):

3.1 Blackpool Health and Well-Being Board has a key leadership role to play in ensuring that the ambitions of the transforming care agenda are achieved.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is:

'Improve health and well-being especially for the most disadvantaged'

5.0 Background Information

5.1 Lancashire and Greater Manchester have been chosen as one of five Fast Track sites by NHS England. A £10 million fund has been identified by NHS England and the Fast Track sites were supported to develop a bid for the funds by producing a transformation plan. The plans were required to identify how funding will be spent prior to March 2016 and how the funding would be matched by CCG local spend during the financial years 2015/16 and 2016/17.

5.2 The plan submission date was Monday 7 September 2015. This date was achieved and the plan submitted with an accompanying letter indicating that Lancashire CCGs had not had the opportunity to request sign off by their Governing Bodies due to the timescales imposed. Whilst Lancashire and Greater Manchester have been chosen as one Fast Track site each area has developed their own plan and submitted them separately.

5.3 **Summary of Lancashire Plan**

The national directive following the Winterbourne View Concordat, supported by the Bubb report, is to transform long term in-patient care for patients with a learning disability to a more community based service model.

5.4 It is recognised that some in-patient facilities will be required for the population in Lancashire; however a new integrated model has been outlined within the plan. This would be delivered by integrated community teams, offering a core service to all patients from hubs with a regional service providing opportunity to purchase any required additional support to develop individualised packages of care.

5.5 Development of community support services will be required to transform care for those with learning disabilities who present challenging behaviour, from a reactionary approach to a proactive and preventative approach. Positive Behaviour Support services, Assessment, Treatment and Discharge facilities, Crisis support teams and Respite care are included in the plan, to deliver the required transformation. This work will be led by a transformation programme management

office team over a 12 month period in the first instance.

5.6 In addition to transforming the service model for new patients, or those currently cared for in the community, there is also the requirement to transfer as many of the current in-patient cohort as possible into community care packages. This process is often complex for a variety of reasons such as restrictions in place by the Ministry of Justice, identifying suitable accommodation or sufficient appropriately skilled staff to deliver the required care.

5.7 Across Lancashire there are 47 patients in CCG cohorts and 46 patients in the specialised commissioned cohorts. **Of these patients there are two in the CCG cohorts and five in the specialised commissioned cohorts for Blackpool**. In order to discharge the patients it has been identified that discharge co-ordinators are required who will be responsible for ensuring that progress is made at pace, and to commence a discharge plan on admission process for in-patients going forward. The plan identified these roles to be in place as a 12 month solution in the first instance.

5.8 Achieving these transformational changes has the potential to destabilise the main local provider of learning disability in-patient services in Lancashire and in order to manage the transition the Lancashire CCG Chief Finance Officers are working with the management team at Calderstones Partnership NHS Foundation Trust to establish financial stability.

5.9 The plans are going through a quality assurance process with NHS England. The bids for resources will be assessed on the level of ambition to close in-patient beds which has been set over a five year period for Lancashire and will need to be managed along with Specialised Commissioning plans.

5.10 Development of the plan has been led by a regional steering group with attendance from CCGs, Local Authorities, Specialised Commissioning, NHS England, Health Education England and Providers. The vision and new model of care has been operationally developed by the LD Commissioners Network for Lancashire and informed by stakeholder's events and workshops.

5.11 In Blackpool a transforming care project group is in place and working to localise the fastrack plan to take account of variations in workforce arrangements and commissioned services. The project group acts as the interface with the LD Commissioners Network and is represented by the Head of Commissioning, NHS Blackpool CCG, the Integrated Community Learning Disability Team Manager and Commissioning Manager for Learning Disabilities, Blackpool Council.

Does the information submitted include any exempt information? No

List of Appendices:

Appendix 5(a) - Fastrack plan for Lancashire

6.0 Legal considerations:

6.1 To meet the requirements of the Concordat and Transforming Care agenda, the Council and CCG must work within the legal requirements of the Mental Health Act 1983 and the Mental Capacity Act 2005.

7.0 Human Resources considerations:

7.1 The Integrated Community Learning Disability Team, (comprising of health and social care professionals from the Council's Adults Social Care Team, Psychology services, Blackpool Teaching Hospitals Community Health and Blackpool CCG) is responsible for co-ordinating and reviewing care plans of people with learning disabilities in social care and health placements. The Contracting and Commissioning Team within the Local Authority are responsible for coordinating contract monitoring arrangements including quality monitoring of Council and NHS contracted services respectively. Work will be undertaken as part of implementation of the fastrack plan to review workforce arrangements and commissioning intentions to ensure they meet the requirements of the plan.

8.0 Equalities considerations:

8.1 A Lancashire wide JSNA report highlighted that people with learning disabilities are one of the most excluded groups in the community and experience much poorer health outcomes across a range of conditions including respiratory diseases, sensory impairment, gastrointestinal cancer, depression, dementia and challenging behaviour. Additionally the housing needs of people with learning disabilities are considerable and will increase; whilst prevalence and need is increasing available budgets have been decreasing and are likely to continue to decrease. This has major implications for how services are delivered and will require a different approach to commissioning and developing co-produced services.

8.2 The fastrack plan seeks to address these issues and will be a key mechanism to improve outcomes and ensure a better quality of life which is one of the underpinning aims of the transforming care agenda.

9.0 Financial considerations:

9.1 The new packages of care that are required for the discharged patients are a cost pressure to CCGs and have been included in the fast track bid for funding until March 2016 and identified as match funding in 2016/17.

9.2 The plan has outlined that proposals for service development in Lancashire will need business cases going forward, prior to funding being agreed. The finance section of the plan has described the funding requested and outlined the match funding requirements. Every effort has been made to minimise any additional financial impact to CCGs, as agreed with the Chief Finance Officer, prior to submission of the plan. Full details are within the finance section along with activity reduction proposals.

Fast Track Funding for Lancashire	Fast Track Funding 15/16 £000's	Match Funding 15/16 £000's	Match Funding 16/17 £000's
New Care Packages	680	0	875
Discharge Co-ordinators	150	0	150
Social Worker Support	60	0	120
National Capital Costs	200	0	0
PMO	111	0	111
Training & Engagement	180	0	0
PBS pilot in 2 areas	150	0	300
Total	1531	0	1556

10.0 Risk management considerations:

10.1 The requirements of the Winterbourne Concordat and ambitions laid out in transforming care fastrack programme are a 'must do', national expectation requires CCGs and local authorities to work together with NHS England to repatriate patients from hospital settings to local communities. The Health and Wellbeing Board therefore has a key leadership role in ensuring that the appropriate co-commissioning arrangements are put in place locally in order for these ambitions to be realised.

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 Service users, families and stakeholders have been engaged in the development of the plan via a stakeholders visioning event held on the 18th August 2015.The event consisted of a morning workshop session that was attended by patients with Learning Disabilities (LD), carers, families (including a number of parents) as well as Third Sector representatives. CCG managers from the area also attended to support and facilitate discussions. In particular the Stakeholder Day looked at:

- Values and Principles
- What is currently working well
- What is currently not working well
- What would good care look like

12.2 The outcomes and intelligence from this day, along with other consultations and engagement findings such as that from the LD Self-Assessment Framework carried out in 2014, are incorporated throughout this Plan and will continue to be used as a check and balance as the Plan is implemented.

12.3 Clinicians from across Lancashire attended the stakeholder's event on the afternoon of the 18th August to provide a broad spectrum of clinical input from what is currently in place and what is required for future service development and improvement. Clinical engagement has also been sought from the Greater Manchester, Lancashire and South Cumbria, Strategic Clinical Networks and Senate LD Advisory Group and from Calderstones and LCFT provider leads via the steering group.

13.0 Background papers:

13.1
- Transforming Care Next Steps July 2015
- Bubb Report Time to Change/Time is Running Out

The Right Track

Transforming Care in Lancashire

For individuals with Learning Disability and Autism

2015

1. Introduction

Lancashire has a strong history of working in partnership to improve care for people with learning disabilities – it is one of the few areas in the country to have a Strategic Clinical Network for Learning Disability Commissioners and there are robust collaborative arrangements for the annual Self-Assessment Framework.

There is a recognition that improvement is required and a Case for Change and a new model of care was in progress, with an agreed programme signed off by the Lancashire Collaborative Commissioning Board, which the Fast track has accelerated and enhanced.

This plan outlines the Pan Lancashire change programme that has been developed as a result of this accelerated focus and leadership. The Plan aims to deliver safe, sustainable services to the local population with Learning Disabilities and/or Autism, in accordance with National Directives and Local Drivers. The plan starts with those individuals who we know as the 'Winterbourne' or 'Transforming Care' group – people who are in hospital based provision or at risk of needing admission – before moving on to include all people with learning disability and/or autism in our communities.

The Lancashire Collaborative Programme is framed around a new model of care that is aligned to the recommendations in the recent 'Bubb report' (Winterbourne View – Time for Change, November 2014) and its predecessor mandates for change, drawing on the learning, principles and models still relevant from 'Valuing People', 'Six Lives' and the 'Mansell report'. The recent Winterbourne focus reinforces and expedites previous policy drivers. It shines a spotlight on those areas where progress has been slower and failed to meet national and local expectations.

The Transforming Care Programme nationally is more directive about the requirement for system change and sustained progress, embedded in new models of care and written into new specifications, with a strong emphasis on greater health and care integration. The Bubb report framed this as having 'one shared plan' 'one lead commissioner' and 'one pooled budget'. The NHS 5 Year Forward View and associated Planning Guidance released in December 2014 also referenced the requirements.

Being selected as one of the five Fast Track areas chosen by NHS England in 2015 has given a renewed pace and vigour to local efforts. The existing Strategic Clinical Network of commissioners has been bolstered by the creation of a Leadership Group to steer the Fast track, creating a link between the practical knowledge and experience of those working on the model and those responsible for system governance and resources.

This is an unprecedented opportunity for Lancashire to harness the knowledge and build on progress already made, producing an agreed plan across health and care; commissioners and providers; users and carers – that will reshape resources, contracts and the delivery of care from 2016. The Plan includes the necessary steps to ensure safe delivery of a new model, mitigation of potential risks and management of the necessary pathway and market changes that will be needed as the system re-design is implemented.

It will finally and definitively move services away from a bed based model of care to a community based model a system that not only enables but insists upon person centred care, for people with learning disabilities and/or Autism – including those whose behaviour is often described as challenging – but where often it is the service infrastructure that has, up to now, created a challenge to the users themselves.

Pan-Lancashire

CCGs:
Blackburn with Darwen
Chorley, South Ribble
Greater Preston
East Lancashire
Fylde and Wyre
Blackpool
West Lancashire
Lancashire North

Councils:

Blackburn with Darwen Unitary Authority
Blackpool Unitary Authority
Lancashire County Council

2. Background

Winterbourne / Transforming Care

Incidents that occurred at Winterbourne View, a residential care setting for people with learning disabilities, were publicised by a Panorama documentary in 2011 and subject to a review and inquiry by the Department of Health and CQC. A subsequent Serious Case Review was published after criminal proceedings had reached their outcome with 11 individuals prosecuted and sentenced http://hosted.southglos.gov.uk/wv/report.pdf.

In December 2012 the Department of Health published 'Transforming Care, A National Response to Winterbourne View Hospital: Final Review Report'. (An interim report also published in June 2012).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

The above report set out "a programme of action to transform services so that people no longer live inappropriately in hospitals, but are cared for in line with best practice based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care". The programme covered quality and appropriacy of care, governance and accountability, corporate responsibility, regulation, inspection and monitoring.
Follow up and progress reports have been published since 'Transforming Care One Year On', 'Transforming Care Two Years On'.

In 2014 NHS England asked Sir Stephen Bubb, ACEVO, to Chair a Steering Group and produce recommendations to accelerate the changes required, given the initial deadline of June 2014 had

passed without the corresponding transfers out of hospital care being achieved. A publication known as the 'Bubb report' was produced: 'Winterbourne View - A time for change'. www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

This was followed in July 2015 by an Independent Progress Review published by ACEVO 'Winterbourne View – Time is running out' with a further call to address the inpatient reduction requirement. Other criticisms in this report included the lack of dialogue with social care providers. Some progress was noted in Care and Treatment Reviews and the NHS England programme of work. https://www.acevo.org.uk/sites/default/files/Time%20Is%20Running%20Out%20FINAL%20WEB_0.pdf

Transforming Care is now overseen by a **Transforming Care Delivery Board,** which brings together the six national partners: NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH). The focus remains on the five key areas of: empowering individuals; right care, right place; workforce; regulation; and data. The most recent Progress Report can be found on NHS England webpages for Transforming Care.

Bringing the chronology up to the current point – where Five Transforming Care Fast Track areas have been identified as; Greater Manchester and Lancashire; Cumbria; North East, Arden, Herefordshire and Worcestershire, Nottinghamshire and Hertfordshire. This aims to bring together, health and care to accelerate service re-design and transformation, with access to a £10 million Transformation Fund. Plans must outline a bid identifying

3. Governance

The requirement to produce a fast track plan was discussed at the Collaborative Commissioning Board on 09/06/15, where Jan Ledward, Chief Officer for NHS Chorley and South Ribble CCG & NHS Greater Preston CCG, was appointed as the Senior Responsible officer and it was agreed that a dedicated Steering Group would be responsible for the Lancashire plan development.

The plan is to be taken back to the Collaborative Commissioning Board on the 08/09/15. Sign off from Health & Wellbeing boards and CCG Governing Bodies will be required thereafter.

Governing Body Meetings

West Lancashire CCG	24 November 2015
Blackburn with Darwen CCG	04 November 2015
Blackpool CCG	03 November 2015
Lancashire North CCG	20 October 2015
East Lancashire CCG	23 November 2015
Fylde & Wyre CCG	17 November 2015
Chorley and South Ribble CCG	23 September 2015
Greater Preston CCG	24 September 2015

Health & Wellbeing Boards

Blackpool Borough Council	22 October

Blackburn with Darwen Borough Council 22 September
Lancashire County Council 29 October

The scope of this fast track work programme has aimed for a whole system inclusive approach, organisations included in this plan:

Local Authorities:
Blackburn with Darwen Council
Blackpool Council
Lancashire County Council

Commissioning Groups:
Blackburn with Darwin CCG
Blackpool CCG
Chorley & South Ribble CCG
Greater Preston CCG
East Lancashire CCG
Fylde & Wyre CCG
Lancashire North CCG
West Lancashire CCG
NW Specialised Commissioning

The two main providers in Lancashire are:
Lancashire Care NHS Foundation Trust
Calderstones Partnership NHS Foundation Trust
Service users, families and stakeholders:

Service users, families and stakeholders have been engaged in the development of this plan via a stakeholders visioning event held on the 18th August 2015.

The event consisted of a morning workshop session that was attended by patients with Learning Disabilities (LD), carers, families (including a number of parents) as well as Third Sector representatives. CCG managers from the area also attended to support and facilitate discussions.

In particular the Stakeholder Day looked at:

- Values and Principles
- What is currently working well
- What is currently not working well
- What would good care look like

The outcomes and intelligence from this day, along with other consultations and engagement findings such as that from the LD Self-Assessment Framework carried out in 2014, are incorporated throughout this Plan and will continue to be used as a check and balance as the Plan is implemented.

"We want the right track, at the right pace" Healthwatch Representative

We must acknowledge however that there has been less engagement with people who have autism but do not have a learning disability. We will ensure that this is addressed and plans are in place to utilise the locality Autism Partnership Boards to involve people and their families in this work.

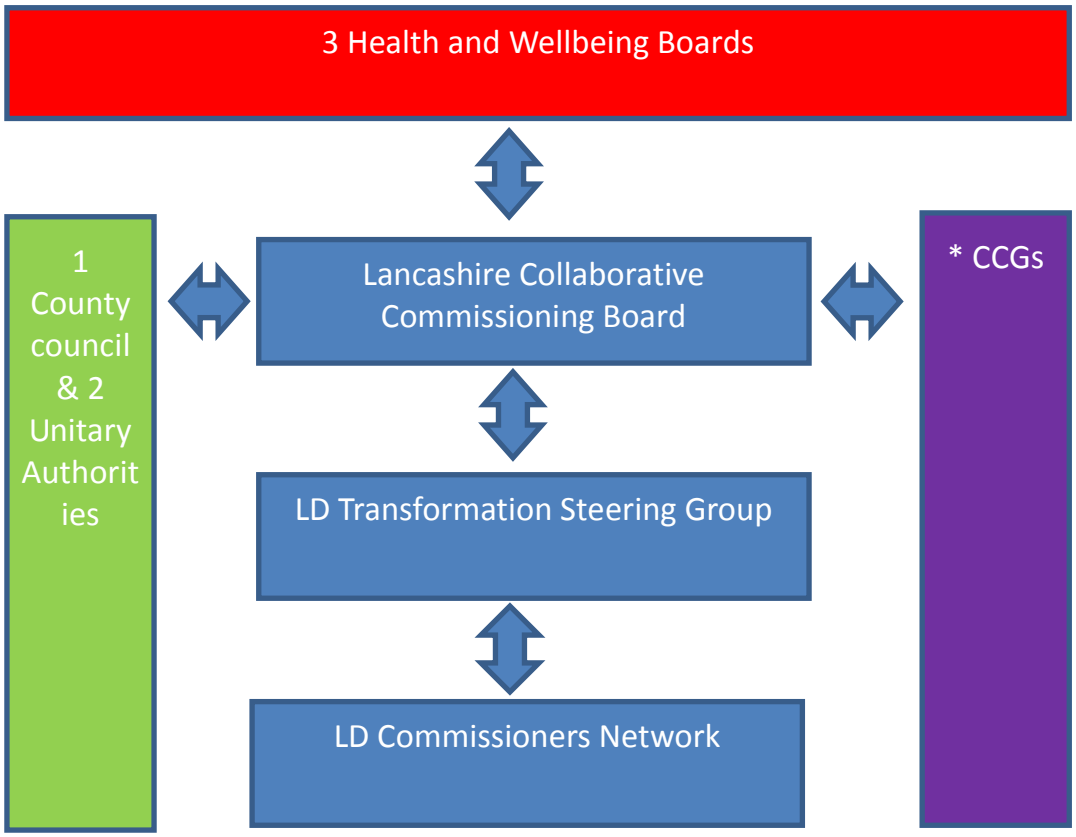
Clinical Engagement

Clinicians from across Lancashire attended the stakeholder's event on the afternoon of the 18th August to provide a broad spectrum of clinical input from what is currently in place and what is required for future service development and improvement.

Clinical engagement has also been sought from the Greater Manchester, Lancashire and South Cumbria, Strategic Clinical Networks and Senate LD Advisory Group and from Calderstones and LCFT provider leads via the steering group.

Steering Group:

Development of this plan has been led by a steering group with attendance from CCGs, Local Authority, Specialised Commissioner, NHS E, Health Education England and Providers. The vision and new model of care have been operationally developed by the LD Commissioners Network informed by the stakeholder's events and via a series of workshops. The governance structure as per the diagram has been agreed along with Terms of Reference for the steering group.



Values and Principles

"Be the best I can be"

These are the themes that emerged from the Stakeholder Day and these will inform the implementation of the Plan:

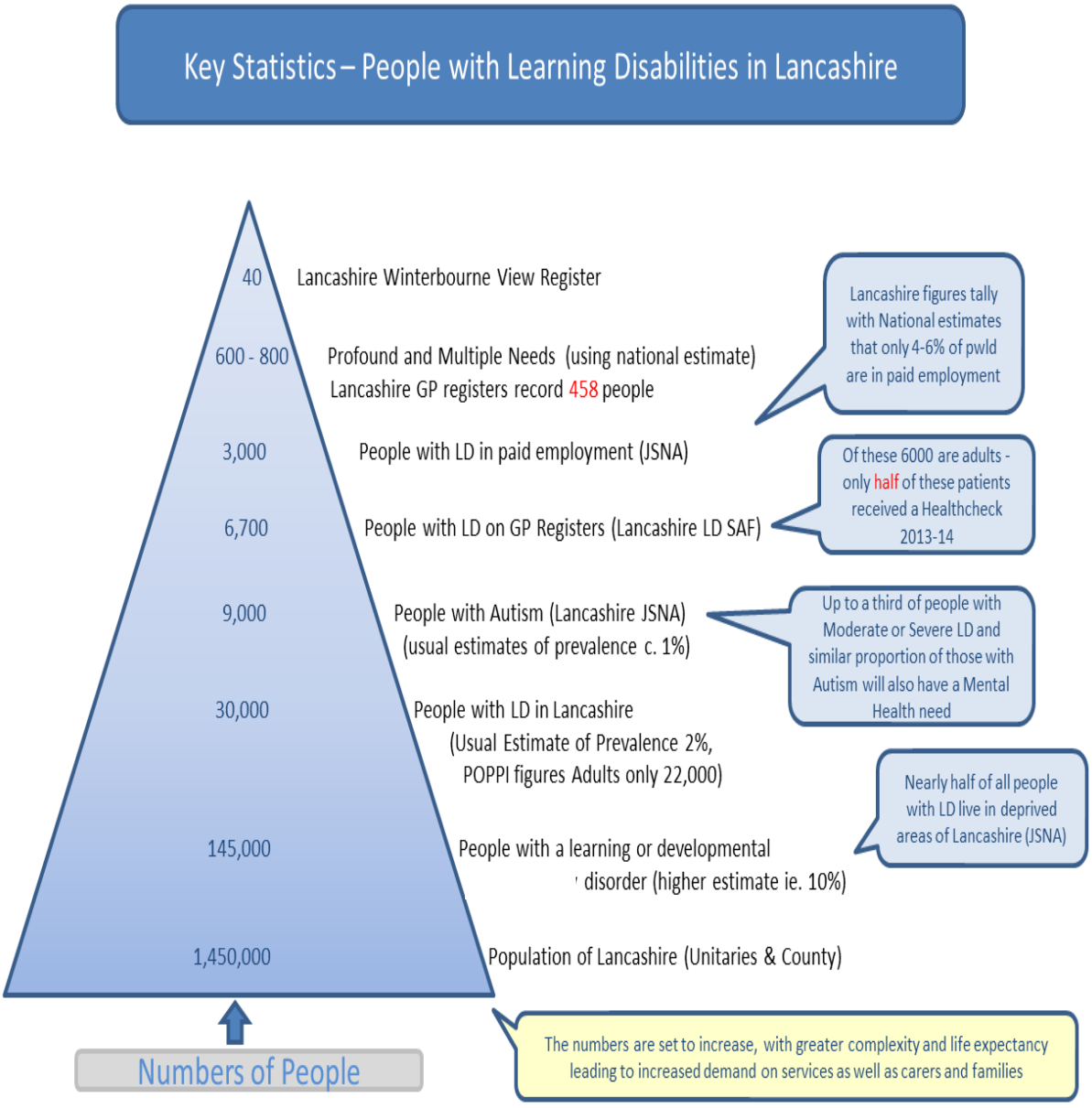
- Putting a high value on prevention and early intervention
- Person centred care as a default and a non-negotiable
- Recognition of personal value to improve health and wellbeing
- Fair and equal access to all services; education/ awareness and responsiveness
- High standards of care and improved experience for users, carers and support workers
- Working better together at all levels across the system to manage transitions and conflicts
- Taking the right risks, empowering people to do the right thing not forced to be expedient
- Really focusing on outcomes; the right kind of metrics, the best use of evidence bases
- Setting the bar high across the professional network and holding each other to account
- Creating an environment for candour and compassion
- Putting the system's money where its mouth is…

4. Baseline Assessment

The Population

There are a number of data sources that can be used for population and cohort counts for people with learning disabilities / autism. The numbers that follow provide figures taken from different sources such as GP registers, prevalence estimates, needs assessments. These figures will therefore not 'tally up' with each other exactly as they are recording particular groups or aspects or making projections – but together they paint an important picture of this population in Lancashire.

The figure below is a useful starting point and provides 'ball park' figures. These are not meant to be exact but were rounded for this use, from a snapshot taken at the time (January 2015). It helpfully makes visual the relationship between complexity and size of cohorts:



The Population Data

There are 1,519,892 registered people Pan Lancashire with 6056 registered as having a Learning Disability Quality and Outcome Framework (QOF) 2013/14

CCG	Blackpool	Blackburn and Darwen	East Lancashire	Fylde and Wyre	North Lancashire	West Lancashire	Chorley and South Ribble	Greater Preston
Registered Population 1,519,892	172,202	170,828	373,000	150,650	160,000	111,946	176,023	207,390
Adult LD Population 6056	763	717	1489	477	721	452	755	682
Children's 5-19yrs LD Population 5110	475	615	1315	460	555	395	575	720

Predicted Population Changes

Whilst the total numbers with Learning Disabilities are predicted to increase the split is not evenly distributed across all age ranges. Predicted changes will vary across the pan-Lancs footprint due to the uneven distribution of local services and deprivation indices. Deployment of resources in each area will be tailored appropriately.

Lancashire-14 - LD - Baseline estimates				
Age Group	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a learning disability	3,605	3,276	3,214	3,469
People aged 25-34 predicted to have a learning disability	4,440	4,512	4,358	4,084
People aged 35-44 predicted to have a learning disability	4,320	4,200	4,445	4,550
People aged 45-54 predicted to have a learning disability	4,948	4,667	4,146	4,057
People aged 55-64 predicted to have a learning disability	4,013	4,415	4,654	4,384
People aged 65-74 predicted to have a learning disability	3,414	3,564	3,478	3,851
People aged 75-84 predicted to have a learning disability	1,841	2,083	2,520	2,630
People aged 85 and over predicted to have a learning disability	701	825	1006	1,243
Lancashire-14 Total	**27,282**	**27,542**	**27,821**	**28,268**
Source POPPI & PANSI data extracts September 2015				

CeDR Centre for Disability Research Report 2008:6 Lancaster University

These predictions are based on prevalence rates detailed in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

A study by CeDR focuses on future adult social care needs for people with LD and it suggests that there are three things that will drive an increase in LD prevalence

- Decreasing mortality among people with learning disabilities, especially in older age ranges and among children with severe and complex needs; - This fits in with the LD life expectancy levels increases
- The impact of changes in fertility over the past two decades in the general population; - This is a reference to the decreasing birth rates in England
- The ageing of the 'baby boomers', among whom, there appears to be an increased incidence

of learning disabilities.

Estimated total number of children with a learning disability-

People with learning disabilities are more likely to experience mental health problems (Emerson, E. et al, 2008). Emerson et al (2004) calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years: 0.97%; 10 to 14 years: 2.26%; and 15 to 19 years: 2.67%. Estimation of the population prevalence of learning disability is problematic and should be treated with caution.

The following table applies these prevalence rates to Lancashire and the 8 CCGs.

CCG	Children aged 5-9 yrs with a learning disability (2014)	Children aged 10-14 yrs with a learning disability (2014)	Children aged 15-19 yrs with a learning disability (2014)
NHS Blackburn with Darwen	110	230	275
NHS Blackpool	80	170	225
NHS East Lancashire	230	490	595
NHS Fylde and Wyre	75	170	215
NHS Greater Preston	125	255	340
NHS Lancashire North	80	175	300
NHS West Lancashire	65	140	190
Pan Lancashire	**865**	**1855**	**2430**

Source: Office for National Statistics mid year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Emerson E. at al (2004).

These rates for different age groups reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with learning disability, with higher rates for those with severe learning disabilities. The following table shows how many children with learning disabilities who also experience mental health problems might be expected in Lancashire and the 8 CCGs.

Children with a learning disability with mental health problems (2014)

CCG	5-9 yrs	10-14 yrs	15-19 yrs
NHS Blackburn with Darwen	45	95	110
NHS Blackpool	35	70	90
NHS Chorley & South Ribble	40	85	105
NHS East Lancashire	95	200	240
NHS Fylde and Wyre	30	70	90
NHS Greater Preston	50	105	140
NHS Lancashire North	35	70	120
NHS West Lancashire	25	55	80
Pan Lancashire	**350**	**750**	**975**

Source: Office for National Statistics mid year population estimates for 2014. CCG population estimates aggregated from GP

registered populations (Oct 2014). The Foundation for People with Learning Disabilities (2002).

School Population

Schools are very aware of children who have particular difficulties in learning. Every term they report to the Department for Education about all children who have special educational needs. They say what sort of needs the children have. There are four levels of learning difficulties: specific difficulties (like dyslexia), moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties. The indicator shows the number of children in every thousand who have moderate learning difficulty. These children have difficulty in all areas of learning. They may have speech and language delay. The school census covers all pupils enrolled in state-funded primary, secondary or special schools. A formal medical diagnosis is not required; as such these numbers may not reflect those seen in data from medical sources.

Terminology differences regarding Learning Difficulties and Learning Disability are acknowledged. Cohorts do not match exactly although the majority of children and young people considered to have a severe learning difficulty are likely, as an adult, to be considered to have a learning disability.

Indicator	Lancashire	
	2012/13	2013/14
Children with Moderate Learning Difficulties known to schools	**3422**	**2927**
Children with Severe Learning Difficulties known to schools per 1,000 pupils	**723**	**669**
Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	**270**	**47**
Children with Autism known to schools per 1,000 pupils	**1687**	**1766**
Children with learning disabilities known to schools per 1,000 pupils	**3821**	**478**

Source: PHE Learning Disability Profiles

Health of the LD Population

Proportion of eligible adults having a GP Health Check

Authority	Lancashire	Blackburn and Darwen	Blackpool
Count	1985	292	313
Value	43.4	40.7	41
North West	50	50	50
England	44.2	44.2	44.2

Source: Public Health Outcomes Framework 2013/14 data

Secondary Care Admissions

Between April 1st 2009 and March 31th 2015, there were 248 admissions between secondary care

and patients with a learning disability.

These 248 admissions were generated by 184 patients.
There are 74 planned admissions and 174 emergency admissions.

Source: SUS

Planned / Unplanned	POD	Count	Total
Elective and Day Case admissions	DC	29	74
	EL	45	
Emergency Admissions	NEL	165	174
	NELNE	4	
	NELST	5	
Grand Total		**248**	

The average length of stay across the 45 elective admissions was 198 days, with six patients recording length of stays in excess of 1,000 days. In total the 45 elective admissions resulted in 14,682 bed days.

The majority of these admissions came from patients aged 15-24 (31%)

Age band	Total	%
05-14	7	9%
15-24	23	31%
25-34	17	23%
35-44	12	16%
45-54	11	15%
55-64	1	1%
65-74	2	3%
75-84	1	1%
Grand Total	**74**	**-**

59% (44) of these patients were male, with 41% (30) female

The most commonly used primary diagnoses for planned admissions was F70.1: Mild Mental Retardation, accounting for 14% (10) of all planned admissions.

Meeting the needs of the Learning Disability Population

The extract below is taken for the Lancashire Learning Disability JSNA
http://www3.lancashire.gov.uk/corporate/web/?siteid=6167&pageid=35899&e=e

The analysis of learning disabilities in adults in Lancashire has highlighted a number of key issues:

- Nearly half of people experiencing a learning disability live in the most deprived areas of Lancashire.
- People with learning disabilities are much less likely to be in paid employment.
- People with learning disabilities are over-represented in prison populations.
- The changes to benefit allocation will also affect people with learning disabilities disproportionately.
- Housing needs of people with learning disabilities are considerable and will increase.
- People with learning disabilities experience much poorer health outcomes across a range of

conditions.

- Prevalence and need is increasing whilst available budgets have been decreasing and are likely to continue to decrease.
- This has major implications for how services are delivered and will require a different approach to commissioning and developing co-produced services.

Experiential Evidence

We know from engaging with users, carers, support workers and stakeholders that there are things in the system that work well and things that don't work well currently.

At the stakeholder event on 18th August 2015 the key themes were:

Working Well	Not Working Well
• Supporting people who use services is critical to maintaining their care / wellbeing • Independent support such as advocacy is highly valued by users and carers • People also find support in other ways such as community groups, voluntary organisations, friends and social groups • Social connections and a sense of belonging is important to wellbeing and coping • Fulfilling activities are important as part of regular routines and opportunities for development – one person told us about the importance of his morning visit to the gym in Preston for example • The role of the support worker is vital – when there is a good 'match' between the user and their support worker it helps promote independence and wellbeing • Staff can be caring and compassionate, basing their care around the person's needs as much as they can in the restrictions that they work in • Hospital / bed based care does work for some people; it is often very much like a house or flat not like a ward – it is home for some people and should be recognised • Visits to doctors are helped if the doctor or nurse knows the individual and their history and has time to listen carefully • Hospital Passport highly praised, where it	• Not getting diagnosed early enough- underlying conditions or co-morbidities not being addressed in a holistic way • Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another) • Too much focus on risk and not enough thought given to independence • Lack of understanding of MHA / Consent, some people noted that Sections are being used or managed inappropriately • Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family • Staffing is inconsistent – leading to breakdowns in key care relationships and difficult transitions / poor experiences • Professional workloads / processes are not well designed to meet needs for this group – e.g. GP appointments too short, LD Community teams have too broad a remit, support workers are isolated/ low wage based, specialist providers are few • Care plans are often not complete or up to date or well followed; reviews are often infrequent or not robust; health action plans in primary care not being used • There is a lack of networking across the system to wrap care around people – reports of arguments between agencies

is in use and embedded in practice • Person centred planning also described as 'fantastic' where it works well: *'everything has to fit around my son, not the other way round, that's the beauty of it'*	and refusals to accept cases e.g. Autism • When communications are poor, people with learning disabilities feel they are not listened to and not understood – their views are not taken into account and changes in care are being made 'to them' • Professionals noted the lack of integration in systems, partnerships and funding leading to delayed decisions, particularly in relation to judicial requirements: "people are getting stuck in the system" • Market issues and lack of responsiveness and resilience also raised by partners

Personal budgets - 1,022 people with learning disabilities in the county of Lancashire received a personal budget in 2009/10, and this increased to 1,825 in 2010/11 (Central, East and North Lancashire Learning Disability Partnership Board annual reports, 2011). 67 people with autism in the county of Lancashire receive a personal budget or direct pay. A focus of the plan needs to be increasing access to Personal Health Budgets as application is currently not consistent.

Poverty and deprivation - People with learning disabilities and autism are more likely to be living in poverty than the general population, partially because they are less likely to be in paid employment. Poverty is defined as having less than 60% of the median national income (currently the median income is £406.40 per week so those living in poverty are earning less than £243.84 a week).

When people's resources are significantly below average, they are in effect excluded from normal living patterns, customs and activities. They are precluded from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantages through unemployment, low income and limited employment, poor housing, low educational attainment and health care issues. They can become marginalised and excluded from participating in activities (economic, social and cultural) that are the norm for other people.

Many people with moderate to severe learning disabilities receive benefits to support or supplement their income, such as disability living allowance and housing benefits and, for young people, employment support allowance in youth.

Many of these benefits are changing or being replaced altogether following the reforms to the benefits system. In particular, disability living allowance and many other benefits are being replaced with universal credit. It is anticipated that the additional payments for disability under universal credit will be lower than under the previous system, affecting individuals with disabilities, including learning disabilities. Additionally, housing benefits changes may adversely affect many people with learning disabilities who rely on this income. It is expected that £360million will be saved benefits and tax credits spending in Lancashire.

Some technological as well as process changes, for example the move to more electronic benefit systems could also inadvertently create difficulties in accessing essential finance for people with a learning disability.

Employment - Fewer than 15% of people with a learning disability across Lancashire are in employment. All areas have an employment strategy for people with learning disabilities in line with Valuing People Now: Real Jobs for People with Learning Disabilities.

Data about the number of adults with autism in employment is not currently recorded. A subgroup of the Lancashire Autism Partnership Board is working to develop measures for the number of adults with autism in employment.

Crime, prison population and secure mental health services - Lancashire Probation Trust regularly assesses the education, training and employability status of offenders subject to supervision through completion of the offender assessment system (OASys). Data from a 'snapshot' of these assessments provides evidence that 4% of offenders in Lancashire have severe learning difficulties, with particular issues in the districts of West Lancashire and Lancaster (7%) and Burnley (5%). In such cases, offenders will have attended a special school for either behavioural or learning difficulties, or may have received a statement of educational needs. 10% of offenders assessed may have had problems at school or present evidence of difficulties coping in everyday situations. 23% of offenders under the supervision of Lancashire Probation Trust have no educational qualifications, with particular issues in Blackpool (29%), Lancaster (26%) and Preston and Burnley (24%) (Figures quoted above will also include people who do not have LD and/or autism).

People with learning disability and autism in secure services (both LD & MH Secure Services) and prison may not have been known previously to services, and those that are known may have demonstrated signs of pre-offending behaviour when they were younger.

Resources are needed to ensure that information about potential pre-offending behaviour is recorded and passed onto Adult Services through transitions, which would then enable earlier intervention. Also, factors that affect whether a person subsequently is admitted to secure provision or not need to be scoped, so that people at risk can be targeted and preventative strategies identified and developed.

Housing - Across the Lancashire county area over 1,800 people with a learning disability are estimated to have a housing need. It should be noted however that the methodology used to determine these estimates has been controversial, so are intended as indicative only.

Lancashire County Council currently support approximately 2,000 people committing £79 million within a range of 24 hour domically support services, with each person having a tenancy agreement with a housing provider and support commissioned through the pooled budget . The schemes are referred to as 'supported living'.

Blackpool Council currently support approximately 115 people committing around £9 million within a range of 24 hour domiciliary support services, with each person having a tenancy agreement with *Learning disabilities in adults in Lancashire – a* housing provider and support commissioned through the social care budget . The schemes are referred to as 'supported living'.

Blackburn with Darwen Council also have supported living, domiciliary care and adult placement services across the borough. These services are provided to over 200 people and commit circa £10 million per year from the adult social care budget.

As at August 2011 there were 81 people with learning disabilities across the county of Lancashire who were in residential placements out of area as there is no suitable housing available in the area: 20 of these were in North Lancashire, 41 in Central Lancashire and 20 in East Lancashire. This

information only relates to Lancashire County Council - Scoping is underway to develop more up to date intelligence around out of area placements and treatments across the whole life course for people with LD and/or autism.

Health outcomes - People with learning disabilities are at increased risk of early death and generally have a shorter life expectancy than the general population. Estimates at quantifying this additional risk suggest the all-cause mortality rate for people with learning disabilities is three times higher. However, life expectancy among people with learning disabilities is gradually increasing, which will likely lead to increased demand for social care and health services, as people with learning disabilities will begin to outlive their parents, who currently provide the bulk of informal care.

Since 2009 Primary Care Trusts, followed by NHS England who took over the primary care commissioning in 2013, have been required to fund GP practices to carry out annual health checks for adults with learning disabilities through direct enhanced service (DES). The health check includes an assessment of physical and mental health; health promotion; review of chronic illness; a physical examination; review of epilepsy; review of behaviour and mental health; a syndrome specific check; review of prescribed medications; a review of co-ordination arrangements with secondary care; and a review of transition arrangements where appropriate.

Around 60% of people in Lancashire with a learning disability received a health check in 2010-11; this varied from 45% in East Lancashire and Blackburn with Darwen to 79% in North Lancashire. Data suggests that the cumulative percentage take–up of AHC's across pan-Lancashire has decreased since 2011. This is partly due to the changes made to the LD ES in 2014 (eligibility criteria expanded to include people 14yrs upwards) which enlarged the patient cohort however addressing this decrease is a strategic priority for all partners to this plan – AHC's are seen to be a key tool in reducing health inequalities for people with learning disabilities.

People with learning disabilities are at increased risk of many health conditions compared to the general population. Common problems include:

- **Respiratory disease** - the leading cause of death for people with learning disabilities (46%-52%) and is much higher than for the general population (15-17%).
- **Gastrointestinal cancer** - people with learning disabilities have proportionally higher rates compared to the general population (48%-58.5% vs 25% of cancer deaths)
- **Long term conditions** - up to a third of people with a learning disability also have a physical disability, most often cerebral palsy which puts them at greater risk of associated health problems. The increased prevalence of **epilepsy** ranges from 10 - 20% in people with a mild learning disability up to 50% in those with profound learning disabilities. This is compared to 1% in the general population. Epilepsy is of a more complex nature with higher levels of poly pharmacy, complex seizure types and sudden unexplained death as a result of seizures12.
- **Anxiety and depression** - particularly common among people with Downs' syndrome.
- **Schizophrenia** - limited evidence suggests prevalence is three times higher among people with learning disabilities than the general population (3% versus 1%)
- **Challenging behaviours** - such as aggression, destruction and self-injury are present in 10-15% of people with learning disabilities. This can result from pain associated with untreated medical disorders.
- **Dementia** - prevalence is higher amongst older people with learning disabilities (22%) compared to other older adults (6%). People with Downs' syndrome have a much higher risk of developing dementia than the general population, with onset often 30 to 40 years earlier.

Sensory impairment

People with a mild learning disability (aged under 50 years) have 21% prevalence of hearing impairment compared to 0.2-1.9% in the general population. The prevalence is higher in people with profound and multiple disability. People with a mild learning disability (aged under 50 years) experience 4% prevalence of visual Impairment 4 compared to 2-7% in the general population.

The results of an audit of people with learning disabilities in Preston showed that a third could not verbally communicate that they are in pain. Almost half use behaviour to communicate health needs and less than a fifth had access to Speech and Language Therapy.

Improving the baseline

The baseline can be improved by providing a consistent Lancashire wide approach to addressing the needs of the Learning Disability and Autistic population across the whole life course. Adopting early identification, integrated case management, individualised care planning, early interventions, positive behaviour therapy, community based support services, providing short term intensive community based support and respite care facilities.

Where inpatient treatment is required, small scale assessment, treatment and discharge services can be developed and in-patient low and medium secure treatments should be as short as possible with lifelong enhanced support services to meet individual needs, in the community available for those who need it.

The Provider Base

Each CCG currently commissions different services for patients with Learning Disability and Autism. The level of service input also varies. The providers market across Lancashire includes:

- Lancashire Care FT is the largest Provider of Acute and Community Mental Health and LD services. The Trust specialises in inpatient and community mental health services but also provides the Community LD Teams and where commissioned, Children's LD provision. Lancashire Care NHS Foundation Trust covers the whole of the county.

- Some inpatient services used for specialist LD are provided from Calderstones Partnership. Their core business is a forensic service although there are some legacy placements for people with complex non-forensic behaviours still in operation. They are commissioned to provide medium secure, low secure, secure step down unit and specialist NHS services to adult men and women with learning disabilities or other developmental disorders who present with extremes of serious offending behaviour. They also provide Enhanced Support Services (ESS) and Individual Packages of Care (IPC), for people who have stepped down from secure provision but who are not yet considered ready to be discharged into the community. The expectation is that a significant number of the clients from the ESS and IPC beds would be resettled as part of this work.

- Assessment and Treatment services are commissioned via Midlands and Lancashire CSU – these services ae mainly spot purchased from NHS and private providers.

- CCGs to varying levels commission services from the voluntary community and faith sector including but not limited to:
    - Supported Employment
    - Advocacy
    - Self-Advocacy
    - Peer support – Empowerment

- Independent health sector providers - There are multiple placements commissioned from Private Providers, in the main these are for individual packages of care. These placements are commissioned from providers which include but are not limited to
    - Lighthouse
    - The Priory
    - Partnerships in Care

Local Authorities commission supported living services and social care services from a range of domiciliary and residential based providers both inside and outside their own boundary areas and make use of direct payments and personal budgets. The Local Authorities will now be managing provider allocation and payment in accordance with Care Act requirements.

Placements can be funded jointly in even/uneven splits. The provider market across pan-lancs is diverse and has approximately 80 service providers commissioned to support people with learning disabilities and/or autism and their families. Commissioned organisations include those from the voluntary, charitable and private sectors.

Commissioning Arrangements

Learning Disability services are jointly funded through CCGs and Councils however pooled budget arrangements are not consistently used across Lancashire.

Overall services are commissioned by open tender with individual packages of care commissioned through a mini-selection process which is open to existing or new providers. LD Care at Home frameworks are in place in some localities. Work is ongoing to upskill the local market so that it is able to provide more specialist care and support but this is not consistent across Lancashire.

Block contracts are in place with Calderstones and Lancashire Care FT.

Patient Flows

Due to the size of Lancashire and number of boarders there are multiple cross boundary issues which complicate patient flows, notably:

- West Lancashire has significant patient flows into Merseyside (not in the Fast track area)
- Lancashire North has a shared health care economy with Cumbria (in another Fast track area)
- There are patients who are registered out of area but live in Lancashire and vice versa.

Due to the specialist Learning Disability Providers in Lancashire, we have historically been an importer of patients and had a higher number of local patients in inpatient beds than other areas.

There is not an integrated Health and Social Care Team managing the flow of patients across Lancashire and managing out of area placement. The health and social care teams are currently fragmented with both size and team make up varying between CCG / LA area.

Key Partners

This list isn't comprehensive but starts to demonstrate the complex interdependencies within the system and the key bodies that have a stake in the development of the Fast track Plan:

- CCGs (Fast track Commissioners but also boundary CCG Commissioners)
- Local Authorities (as above – within the Fast track primarily but also links to boundaries)
- NHSE Specialist Commissioning (and transitioning Primary Care leads)
- NHSE Transforming Care Teams and other Area / National leads on key area
- LD Providers – NHS; Independent Sector; Residential, Domiciliary, Third Sector
- Mental Health Providers in NHS and Independent / Third Sector
- Community Providers – NHS sector primarily as CLDT providers
- NHS Acute Trusts/ System Resilience & Crisis Concordat leads
- North West Ambulance Service / other patient transport providers
- Community Voluntary Sector; Faith Groups
- Police, Probation and other justice system leads
- Fire Service and other home support providers / telecare providers
- Advocacy and Peer Support organisations
- Oversight and Scrutiny Bodies; Healthwatch, Patient representative bodies
- Carer representatives

5. The Fast Track In-Patient Cohort

There is National drive and expectation to achieve at least a 10% reduction of the total in-patient cohort between 31/03/15 and 31/03/ 16.

The baseline figures for the North West in-patients - provided by NHS England Area Team :

Team / CCG	Baseline @31/3/15	Projected 10% @31/3/16
North of England	**909**	**818**
Greater Manchester	72	60
Lancashire	47	39
Specialised Commissioning	**495**	**470**
North West hub	205	195

Projected in year admissions from NHS England, based on the previous year admissions, for the 5 fast track areas are as below (these are straight-line calculations not including growth/ risks):

	Total inpatients	*Setting*		*10% Reduction*		*Setting*	*10% Reduction*	*Projection admissions#*	Discharges required	Transfer required	Transfer required
	Total	Non	Low	diff	all inpatients	Medium	transfer only	*15/16*	Non & Low	Low	Medium
North	**909**	**448**	**301**	**91**	**818**	**160**	**16**	**330**	**421**	**30**	**16**
Cheshire & Merseyside	**49**	**46**	**2**	**5**	**44**			**33**	**38**	**0**	
CWW	33	31	2	3	30			17	20	0	
Mersey	16	15	0	2	14			17	18	0	
Cumbria & North East	**131**	**130**	**1**	**13**	**118**			**57**	**70**	**0**	
CNTW	69	68	1	7	62			34	40	0	
DDT	62	62	0	6	56			23	29	0	
Lancs & GM	**119**	**112**	**7**	**12**	**107**			**23**	**34**	**1**	
GM	72	65	7	7	65			11	18	1	
Lancs	47	47	0	5	42			12	16	0	
Yorkshire & Humber	**115**	**112**	**3**	**12**	**104**			**52**	**64**	**0**	
NYH	40	40	0	4	36			27	31	0	
SYB	25	22	3	3	23			11	14	0	
WY	50	50	0	5	45			14	19	0	
Specialised Commissio	**495**	**48**	**288**	**50**	**446**	**159**	**16**	**166**	**215**	**29**	**16**
CWW SC	205	26	128	21	185	51	5	58	78	13	5
CNTW SC	140	12	93	14	126	35	4	56	70	9	4
SYB SC	150	10	67	15	135	73	7	53	68	7	7

NB .It must be noted that the projected admissions are new patients entering the system, and what must be understood is that many of the Specialised Commissioned patients transfer as part of their treatment pathway into the CCG figures. Therefore the CCG figures can increase above the projected figures due to movement within the existing cohort of patient journey.

Implications of the Fast Track Plan

The 5 fast track areas have been requested to create plans to exceed the 10% reductions supported by a £10 million transformation fund, to be distributed on the merit of the local plans developed and the confidence in reducing total numbers of in-patient beds.

The Current In-patient figures Provided by NHS England Area Team - August 15

CCG	Baseline 31/3/15	April	May	June	July
Lancashire	**47**	**43**	**42**	**38**	**39**
Blackburn with Darwen	7	6	6	5	6
Blackpool	2	2	2	3	2
Chorley & South Ribble	3	3	3	3	3
East Lancashire	11	10	9	9	8
Fylde & Wyre	3	3	2	2	2
Greater Preston	8	5	6	5	6
Lancashire North	9	10	10	7	7
West Lancashire	4	4	4	4	5

Provided by Specialised Commissioner for Lancashire

	Baseline Position at 31/03/2015				Position at 30/07/2015			
CCG	**Medium Security**	**Low Security**	**Rehab**	**Total**	**Medium Security**	**Low Security**	**Rehab**	**Total**
Blackpool	5	2	0	**7**	2	3	0	**5**
BWD	2	7	1	**10**	2	6	0	**8**
CH & SR	0	3	2	**5**	0	2	2	**4**
Grt Preston	1	3	3	**7**	1	1	4	**6**
East Lancs	7	4	4	**15**	4	10	1	**15**
West Lancs	1	2	1	**4**	1	1	1	**3**
Lancashire North	2	2	0	**4**	1	2	0	**3**
Fylde & Wyre	0	1	0	**1**	0	2	0	**2**
Totals	**18**	**24**	**11**	**53**	**11**	**27**	**8**	**46**

These figures will fluctuate as new patients are admitted to in-patient services and patients are discharged.

6. The Lancashire Vision

The Lancashire vision is consistent with the national service model and is that:

People with a Learning Disability and/or Autism, including people with complex and challenging behaviour, can lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support them and their needs in their local community, whenever possible.

The Principles of the transforming care programme in Lancashire are:

- People with a Learning Disability and/or Autism, including people with complex and challenging behaviour will sometimes have physical or mental health problems and will be supported to access mainstream health services that will make reasonable adjustments to the provision of their care.
- Lancashire< Blackburn with Darwen and Blackpool will become centres for excellence in supporting people with learning disabilities and/or autism in the community. We will develop and apply best practice and evidence based interventions to ensure we facilitate the most successful outcomes for people.
- We will ensure that population data is kept up to date and use this to better understand the needs of our population ensuring flexible and intelligent commissioning practices that make the right services available and at the right time.
- All generic health and social care services will be encouraged to extend the range and provision Learning Disability/Autism champions to improve the care experience.
- There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services. We will build community capacity to encourage co-production based choice and control.
- Where they need more specialist support, including specialist support arising from complex and challenging behaviour they will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support.
- Good quality learning disability services will have an approach based on strong community support services, planned around people in the environment that they are in, focussing on person-centred care, and looking at each individual's needs and where appropriate the family needs. This approach should be applied to all, including people with very complex needs. The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs.
- Services should ensure that those with learning disabilities and their carers are able to access the right level of information, advice and advocacy support. Carers should be provided with support in accordance with the national Carers Strategy and the Care Act, and services should ensure that appropriate attention is given to meeting the needs of older carers and people with learning disabilities and/or autism who are carers themselves.
- Over and above all of this framework is the vision to make person centred care the reality, whether it's in the delivery of the ordinary or the specialist care – system leaders have been brought together in an unprecedented way to do the Fast Track Plan and will continue to use

their leverage to create an environment in which person centred care is the norm and personalisation mechanisms become part and parcel of delivery.

7. The Model

The model is based on the premise that people with a learning disability or Autism, including people with complex and challenging behaviour, should lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support people with learning disabilities. They will sometimes have physical or mental health problems and should be supported to access mainstream health services. All generic health and social care services should be encouraged to extend the current number and range of Learning Disability/Autism champions to improve the care experience.

There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.

Where they need more specialist support, including specialist support arising from complex and challenging behaviour they will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support.

Lancashire will make person centred care the default, non-negotiable offer. The use of personalised budgets and the adoption of an all age approach will allow us to build on progress to date. Where plans exist already, the Fast track model will be used to expedite and accelerate these.

<u>Feedback from the Stakeholder Day on the emerging vision for Lancashire:</u>

"What do you think good care would look like?"

Service users, carers, support workers and patient representatives including Healthwatch emphasised the following points:

- Person Centred Care from the beginning that recognises that every person is different:
    - Individual care design, flexibility and choice
    - Caring staff who listen and understand
    - A "Plan B" in case of a break down in provision
- Early intervention including access to appropriate diagnostics with appropriate adjustments
- Starting in children's services and following the individual through their life
- Not waiting for a crisis to occur, pro-active risk management and access to the best in behavioural support as well as physical and cognitive support, with the least restrictions
- Emphasis on care that allows individuals to be safe, in a familiar environment, with consistent care and people they can trust and who know them
- When people to need to make changes to their care it is supported, with proper preparation, transition planning and discharge processes. To include reviewing social expectations, orientation and maintaining links to previous placement and peers to reduce risk of isolation
- Effective community services in place to identify triggers and able to act upon these, with strong support and professionals available the individual in the community
- Appropriate staff in place with bespoke training, mentoring, buddying and networking of professionals, enabling choice of key worker and appropriate skill / personality matching
- Eliminating blame culture and improving working conditions including pay
- Good access to universal services available when it's needed 24/7 and with reasonable adjustments that take into account people's differences e.g. those with autism
- Regular updates, explanations and meetings with the patient, family and/or carer and any other key individual, with independent support, underpinned by good processes and tools (e.g. hospital passport, LD Champions) to help people make informed decisions and take

control

- Movement away from solely medical models to social models which can be demonstrated by a person centred audit trail – going from good examples, to good practice for all

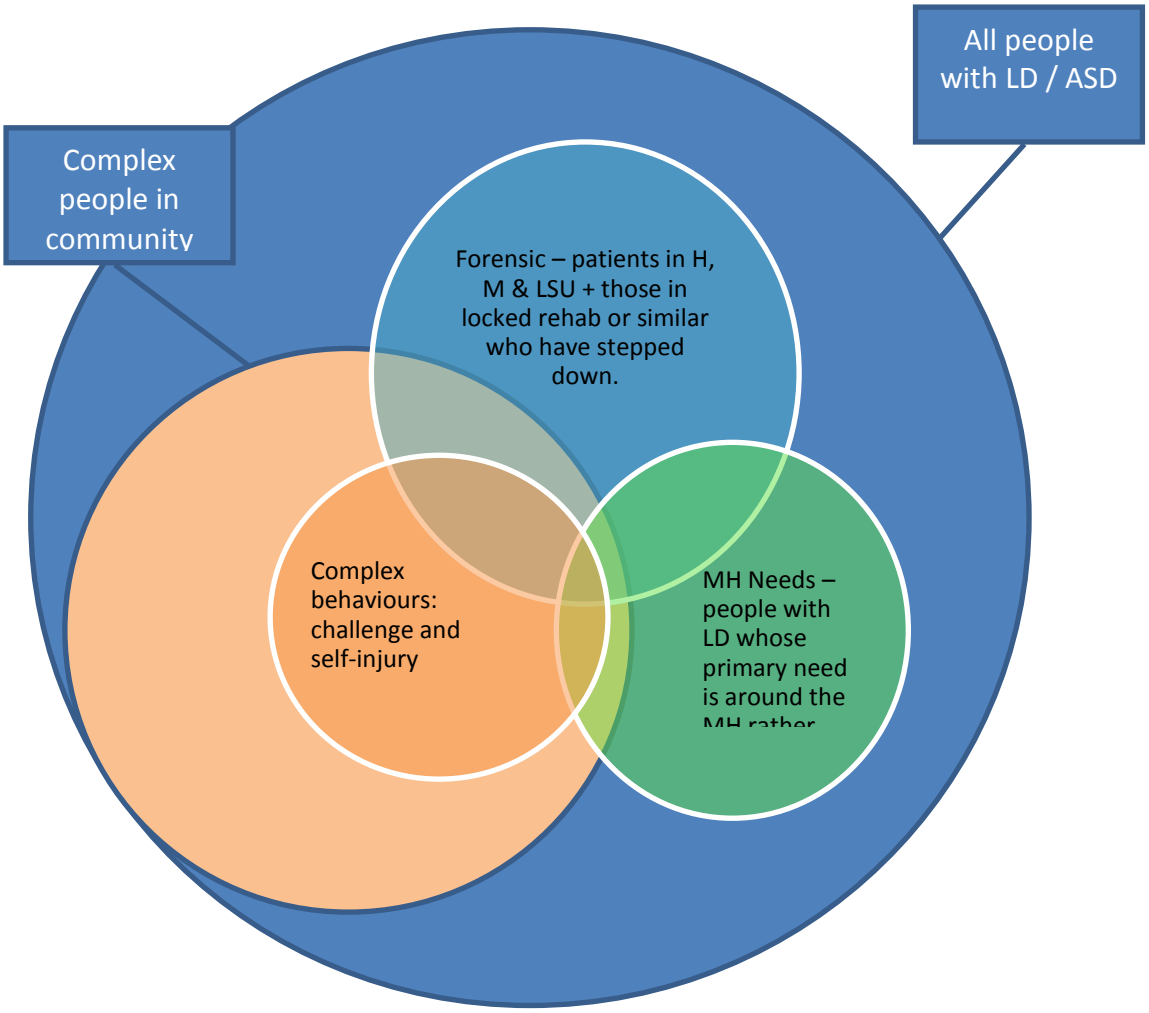
Professionals echoed the above points and had innovative ideas about delivering it! They suggested merging care packages to benefit from the skills and specialisms of more than one provider, networking support across different providers, sharing staff for infrequent but high skill responses such as crisis, clustering residential/ care home providers that are either geographically close or share specialisms such as care for those with autism, to increase resilience in the system. A shared approach to therapeutic approaches, risk assessment and management and legal requirements was suggested

Professionals also placed a high importance on values, candour, transparency and good working conditions to ensure people with appropriate skills and experience can be attracted and retained. As turnover is high it was suggested that innovative working models were adopted such as rotating staff between settings and providers, recognising the level of difficulty in some care types and the need to have breaks and time out, to recharge.

The need for two particular kinds of professional support was raised - confidential, supportive and empowering supervision, probably with a psychological / counselling emphasis. But also on a practical level – real mentors who know what it's like and can role model approaches and skills.

"This can be the most difficult, as well as the most rewarding care to work in – staff can burnout easily and need good support networks".

The Cohorts



Children's services

The Lancashire Collaborative Commissioning Board have agreed a Pan Lancashire programme of work to review and redesign the approach to children and young people's emotional health and wellbeing. A System Board has been set up and a Director position, resourced jointly between all CCGs and Local Authorities, is being recruited to lead this ambitious and important work.

The current priorities, to be developed into workstreams include whole system finance; shared records and IT; contracting models and operating principles.

This work will have an impact on service design at all Tiers of CAMHS provision, including the CAMHS LD Service. It is a transformational programme across 5 Years which encompasses the themes and principles in the 'Future in Mind' Taskforce document released in 2015 for children's mental health.

Transitions are a priority and the plan includes the intention to move to a 0-25 years approach with some elements of the service being all age where this is clinically appropriate.

As both the CAMHS programme and the Fast track programme mobilise their Plans, the interdependency will be tested and refined and any service models will include interdependent checks / impact analysis to ensure responsibilities are clear and new silos are not created.

Transition

"If we get the service right, we won't need to transition people anymore" – CCG Commissioner

The ultimate aim is to have an integrated pathway with networked providers managing service level changes in responsibility, service provision and case management so that they are not evident to the user or carer, other than when they have chosen to make changes.

A young person will not need to transition for age reasons in the all-age model – however there will still be times when they will have some care transitions in relation to services to meet emerging needs.

Also, it is recognised that until an improved system is fully up and running, there is a need for robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults.

Young people with behaviour that is complex and challenges should be the subject of focused attention and support. The arrangements will specify that no young person be placed in a distant residential school or other distant placements when their needs can be met effectively nearer to home. Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support is based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation. Transition planning should start at the age of 14 years and adult services should become increasingly involved from this age and remain involved during a planned and measured handover to adult services post 18th birthday.

Comprehensive Community Support

Effective community services should have at their core an integrated Community Learning Disabilities Team that is sufficiently and appropriately resourced to fulfil its role in meeting local needs including the capability to respond effectively to the needs of people with complex needs and challenging behaviour. It should have, or ensure access to; the necessary skills to manage all age provision from adolescents to old age and the diseases of old age in combination with LD such as dementia.

Effective CLDTs will lead to a greater level of admission avoidance and accelerated discharge from in patient's services. Evidence of the success of integration can be seen in other areas of the northwest including Salford. Funding will be based on the principles of supporting individuals to live independent, fulfilling lives; resources currently committed to in-patient services will migrate to community services as activity migrates.

The workloads of the CLDTs will be carefully monitored, so that the impact of any change in in-patient capacity and of any refocusing of the use of in-patient services (such as focusing solely on meeting acute mental health needs) can be identified at an early stage and effectively managed.

The Integrated CLDT will work to support Primary Care and Hospital services in delivering high

quality health services to promote and maintain good health and well-being for people with learning disabilities. Teams will support the needs of the people with whom they work holistically, ensuring that all health and social care needs are assessed and understood.

This includes access to mainstream health screening services and encouraging individuals to attend GP Health checks when offered.

Appropriately resourced Community Learning Disability Teams (CLDTs)

Comprehensive community support requires:

- Appropriately resourced Community Learning Disability Teams
- Accessible specialist professional support
- Education, work and day opportunities
- The capacity to respond to crises 24 x 7
- Accessible resources to facilitate effective support for people with complex and challenging behaviour
- Policies and protocols for the prevention of placement breakdown
- Respite / short breaks for carers of people with challenging behaviour
- Effective integration of the components of the service

Accessible specialist professional support

Where the CLDT is unable to meet all of the needs of an individual and requires additional specialist input this should be readily accessible.

The specialist service professionals such as psychiatrists, psychologists, Occupational Threapists and speech and language therapists need to have the capability to respond effectively to the needs of people with complex needs and challenging behaviour and to respond in a timely fashion in situations of crisis including potential placement breakdown. In most cases this will mean utilising the skills of the teams which already exist in mainstream services such as Mental Health to blend the skills of the CLDT and the specialist service.

The Specialist/Intensive Team professionals will work closely with other community colleagues in a programme to repatriate people from out of area placements, prevent admissions and support people and families in the community

The CLDT will work to support Primary Care and Hospital services in delivering high quality health services to promote and maintain good health and well-being for people with learning disabilities. This includes access to mainstream health screening services and encouraging individuals to attend GP Health checks when offered.

The various elements of community services for people with learning disabilities will operate more efficiently and effectively where there is good joint working, with a high level of co-operation and co-ordination, and where services share the same priorities. Integration means combining the strengths of both health care and social care through fully integrated teams.

<u>Model Aims, objectives and values of a Community Learning Disability service</u>

This service is a critical component in the delivery of the Lancashire Vision – to support people in both ordinary and specialist services; and to make person centred care our default position. Specifically, this service will:

- Support people with learning disabilities in all settings, providing specific and additional input as required responding to their health care needs.
- Provide health facilitation to support people with learning disabilities to improve their health, well-being and social inclusion, both directly via interventions and in-directly through their support and relationships with mainstream NHS and Service Providers.

The Service has an essential facilitation, clinical and therapeutic role, which will include support to people with learning disability, their families and carers, and service providers beyond the traditional 9.00-5.00 day:

- Facilitating access to mainstream health and social care services for those patients with learning disabilities whose needs could be more appropriately met by those services
- The provision of longer term support for patients who may have complex and continuing health needs
- Proactive care planning to de-escalate situations as they arise and planning for the emergency / crisis contingencies to manage without admission wherever possible
- Managing the transition from child and young person's services to adult services where necessary for education and other mainstream health services
- The teaching role; to enable a wide range of staff, to become more familiar with how to support people with learning disabilities to have their health needs met
- Developing behaviour strategies and interventions with the support of a Positive Behaviour Support Service where appropriate
- Health promotion role; working closely with local health promotion services
- Work with individuals and families to promote the use of Integrated Personal Budgets

Crisis response capacity

Part of the work of the community team should be about ensuring that patients have the necessary care plans, relapse prevention and contingencies in place so that crisis occur as rarely as possible. We will also build on current work to know who is at risk within the community and manage this group successfully. However, even best managed plans cannot avoid all crisis situations. The first point of contact for developing crisis should be the CLDT who will work though the care and contingency plan to try and avoid escalation and to de-escalate the situation.

However if a full crisis occurs in an unforeseen way or when the CLDT is not available it is essential that services can respond to their needs with appropriate and effective advice and support 24 hours a day, 7 days a week. As well as improving service accessibility and responsiveness this will positively impact on the number of out-of-hours admissions to in-patient units.

It would be consistent with current commissioning guidance to develop this service through investment in the existing mental health crisis response service with the caveat that it is also suitable for people with learning disability and/or autism who experience behavioural crises.

Linkage to services such as appropriate short break facilities and to the out of hours management system for local learning disability residential/supported living services could provide some flexible options to lessen immediate pressures and provide 'holding solutions' until the day-time services can resume responsibility. Where the person in crisis is in the 'core group' they should have in place a well thought out contingency plan, which should assist the effective management of the situation.

Community services in Lancashire generally operate on a traditional working day pattern, Monday to Friday 9.00-5.00. Outside these hours Social Services Emergency Duty Teams provide the principle crisis response. Those caring for somebody with a learning disability or autism often describe the challenges posed are when individuals get up preparing to leave for a day centre or in the early evening once they have returned to the family home. Services need to be flexible enough to offer some support during these periods. Each person in receipt of care should have a crisis plan, accessible to the individual and their carers outlining what actions they can take and who to contact.

Respite Care and Short Breaks

It is recognised by health and care commissioners that respite care and short breaks are an important part of the current provision available to users and carers. In many cases it is avoiding the need for admissions to bed based care or the escalation of difficulties that could lead to care breakdown.

Whilst it is accepted that it will be carried forward into the new model, there is also an opportunity to refresh the approach and leverage any new benefits that integrated working will bring. At the most basic level, respite can mean different things not only to different people using services but also to different commissioners. This plan recognises that respite may not be fully maximised at present because it will inevitably be bounded by where it is commissioned from and by whom.

Local Authority Commissioners have a lead role in the procurement and management of respite care currently and will be supported within the new system approach across health and care to make improvements and tailor this component of the care model in accordance with the emerging intelligence that will be produced, as the system moves from one state to a new model.

In particular the focus on personalisation will enable personal budgets as well as direct payments to be used for care that is designed and controlled by the users and carers – which will mean that respite provision can be more responsive, more innovative and fit with the individual's interpretation of what respite means to them and works for them.

Opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home. Providing carers with a break when they are under pressure will prevent crises developing and help to prevent placements from breaking down.

An Effective Response to Challenging Behaviour

Learning disability services should give priority to people with complex needs and challenging behaviour. They are the people with the greatest need for services and marked improvements can be achieved by the provision of quality services. The adoption of a challenging behaviour policy by all providers will underpin this and ensure that there is a consistent response across all services. It should commit staff to maintain input and contact with service users to resolve problems.

The group of people whose behaviour is complex and presents a serious challenge to services should

be identified, and the services that are assessed as necessary to meet their needs developed through a person centred planning process. The plans should be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back-up resources can be made available to sustain arrangements through difficult periods, and that services are put in place to support this.

Our model includes access to specialist staff that have the appropriate skills and knowledge about complex and challenging behaviour that can provide specific support to individuals and their carers and families, providing specialist assessment, supporting development of proactive support plans giving advice and information and provide training.

This requirement will be part of the CLDT Specification but we are also pursuing options for additional specialist behavioural inputs. We have visited the team delivering Positive Behaviour Support in Knowsley and will progress with further modelling using the evidence base available from this work which provides an invest to save basis for this aspect of the model.

Further modelling is required whilst the Programme is in implementation and cohorts are migrating to optimised care options, so that we can test and refine our assumptions on capacity and demand and match these with the quantity of staff and caseloads in the model.

The CLDT should have an adequate workforce with appropriately accredited training to equip them with the specialist knowledge and skills required to work with people with learning disabilities who have complex challenging behaviour. All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role. Services should use a competency framework to oversee staff training and competency based on Skills for Care Guidance for Employers (2013).

A Positive Behaviour service will need to be embedded within and alongside other services by establishing working protocols that are communicated and agreed with relevant stakeholders. Ensuring effective links with other key services are created by amenable working practices and appropriate formal arrangements.

Intensive Support Service

At times people with Learning disabilities may need access to short term residential care to provide a safe environment. This service should be utilised for the shortest time possible (from overnight up to 6 weeks). This facility would be used to support individuals that may require short term accommodation for times such as undertaking repairs to damaged property or during times of carer's illness, where lack of supported living may result in an otherwise avoidable crisis admission.

Again we will conduct further modelling during implementation to test and refine bed base and caseloads/ staffing quantities as the system shifts to new ways of working. Initial assumptions have been built in to this Plan and its associated resources which will need to be reviewed.

Learning Disability In-Patient Services

This is the part of our model that has the greatest national driver for change. There is a requirement for not only a significant reduction in bed numbers in inpatient settings but also, supporting this and inextricably linked with it, a sea-change in the delivery and clinical model within these settings.

Partners have agreed that some inpatient provision will continue to be needed, for intensive support, assessment and treatment that cannot be safely managed in another setting and where there is a clear, clinical need for a bed based period of care in an NHS staffed setting.

Discussions on this element of the model have been productive and lengthy and this plan is written at a snapshot point in time - whilst we have worked hard to agree a model that we believe is safe now and based on robust assumptions at this point in time, we know we need to review and modify in the light of changes as they are being made.

There are existing service providers in this market whose provision also needs to be taken into account so that any transition opportunities are fairly and openly made within the market.

This Plan will therefore use the wording 'inpatient services' as a general reference point for this component, acknowledging that this doesn't fit exactly with CQC licensing descriptors, with provider terminology or with all partners preferred frames of references.

Within this overall heading the term "Crisis Response" is favoured as it describes care that can be delivered in multiple settings – and it links with the ambition for fewer, shorter, more focused periods of assessment and/or treatment, leading to shorter lengths of stay and greater flow.

We will commission inpatient care based on the principles that:

1. People with learning disabilities have the same right of access to mainstream mental health services as the rest of the population
2. Mental health services that are commissioned need to have the appropriate skills and services to address the specific needs of people with learning disabilities who have or are suspected to have a mental illness
3. Psychiatric hospital care should be based on short-term, highly focused assessment and treatment of mental illness through a very specifically defined, time-limited service

The aim of an In Patient Service is to provide intensive inpatient assessment and treatment for adults with a learning disability, who require more intensive services than local services can provide, in order to enable them to return to live in their communities. The Service will work in partnership with community learning disability services and community mental health services to provide effective integrated care arrangements along an agreed pathway of care.

General Overview

The Inpatient Service fulfils an important role within the range of services locally available to meet the needs of adults with learning disabilities. Most people with learning disabilities will have their needs met in the community however a small number, in particular circumstances will present with needs that cannot be managed by local community based Intensive Support Services.

The Service will offer comprehensive, multidisciplinary, person-centred, inpatient assessment and treatment for people with complex needs who display challenging behaviour is not being managed by community services.

The Service will provide a 24-hour service and the full range of appropriate professional input. It will assist with the development of appropriate individual care packages and provide outreach provision to assist with rehabilitation back to the local community.

The Inpatient Service will adopt a whole system approach to the provision of service, and will actively support local partnership working. It will contribute to local service planning and development and support the improvement of local services by contributing to the provision of training and having both in-reach and outreach capability ensuring a consistency of approach between community and inpatient services.

Scope
The service will be funded for the registered population for the CCGs, which it serves providing evidence based inpatient assessment and treatment for adults aged 18 plus with learning disabilities and additional mental health issues.

The Service will meet the needs of people with learning disabilities including:

- People with learning disabilities who have severe challenging needs and present major risks to themselves and/or others
- People with learning disabilities and severe mental health problems who cannot be addressed by general psychiatric services
- People with learning disability and autistic spectrum disorder with severe challenging behaviour
- People with learning disability and autistic spectrum who have forensic needs.

Any such centre is predicated on short-term length of stays to enable assessment, treatment and discharge planning. It therefore requires effective management of admissions and discharges

- With effective monitoring and management of use of the available capacity
- Commissioners should ensure that only appropriate admissions take place and that they follow an agreed admission / discharge pathway with clear admission criteria
- The CLDT should ensure that people are moved on from the centre as soon as possible once they are considered appropriate for discharge
- Length of stay of patients should be formally monitored and if there appear to be impediments to a timely discharge resources should be identified as a priority to enable discharge to proceed
- Having access to appropriate accommodation is essential and a unit that includes a live in may be particularly helpful in this regard.
- Discharge planning should commence on the day of admission

Supported Accommodation

Decisions about where a person is to live need to be made on the basis of what is best for each individual. Where people need to be supported other than with their families, they should be supported in a home, (their own home or small residential home) near their family and friends. Each authority needs to ensure that it has a range of appropriate accommodation options available to meet local needs and to make best use of the opportunities provided by personalisation to build flexible individualised models of support

There may be particular complexities associated with the provision of appropriate local accommodation in relation to:

- People returning from out of area

- Transition support for young people approaching adulthood who are in - or being considered for – an out of area placement
- Move on from hospital
- Placement breakdown / crisis support
- Supported living from forensic settings

Wherever possible the accommodation needs of people in any of these circumstances should be met within the above framework. However, there may be some people who need a period of relatively intensive support, together with focused rehabilitative work to enable them to successfully manage in the family home or in local supported accommodation.

8. In-patient Commissioning Plans & Discharges

Specialised Commissioning Support for Lancashire CCG LD Fast Track Plans

Specialised services in the North West commission Low and Medium Secure care for people with a primary diagnosis of learning Disability with a forensic history or who are at risk of offending. In addition it commissions a small cohort of 'step down' beds, as part of a pathway into community based care.

The current commissioned in-patient bed provision is as follows:

	Medium secure	**Low secure**	**Step down**
Calderstones (GM & Lancs) and Cumbria	52 beds (inc 6 f)	86 beds (inc 24 f)	20 beds (inc 5 f)
5BP (primarily Cheshire/ Mersey service but can take GM & Lancs pts)		10 female beds	
CWP (primarily Cheshire/ Mersey service but can take GM & Lancs pts)		15 male beds	

The vision of NHS England Specialised Commissioning in the North West is to create a sustainable forensic service for people with learning disabilities/ASC, ensuring the availability of highly specialised services for the most vulnerable people. We will work with credible and competent providers to ensure that there is integration between forensic inpatient and community based services. This vision will apply equally across the geography of the North West.

NHS England is committed to the principles of least restrictive practice and the strengthening of both locally commissioned services and in patient and forensic out-reach services who will work to ensure only those admissions that are absolutely necessary and in the persons best interests will occur and that these will be for the shortest possible period.

Forensic outreach services will work with our partners in offender health, local learning disability / ASC services and education to ensure that the necessary support and treatment is available to the person preferably within their home environment. This works to ensure that pathways will be optimised to ensure that individuals are cared for in the least restrictive environment and for the appropriate length of time in that setting and according to their needs. Those pathways will be driven by care and treatment reviews embedded in both commissioner and provider arrangements. In-patient care will no longer be a replacement for home and this will be reflected in a significant reduction in the number of beds commissioned by NHS England.

The realisation of that vision and breaking the cycle of over reliance on inpatient services is

dependent on the success of the transforming care plans of the Lancashire and Greater Manchester CCGs to develop, grow and fund the transformation of community based services to better meet the needs of those patients no longer requiring the physical, relational and procedural levels of security offered by in-patient secure forensic services. Specialised commissioning is committed to working collaboratively to achieve these goals.

Special consideration needs to be given to the learning disability/ASC provision for CAMHs tier 4 in patient services. This will be considered further within the national procurement for CAMHs tier 4. Additional beds where facilitated across the country in 2014/15 for PICU and generic services to meet demand and whilst this has eased pressure it has identified the difficulties that this group experience in mainstream services. The availability of specialised services across the country is limited and often demand outweighs provision. It is expected that this will be addressed as part of the procurement work and the aim is to keep children as close to home, in the right service and for the least time as possible. Please note the figures provided relate to adults only.

The implementation of NHS England's plans to provide services in the community for people who do not need to be cared for in a hospital setting will, over time, remove or reduce the need for, or configuration of, some in-patient services that are currently provided in the North West. The services required to do this with be both specialised and local and will work together to strengthen care and treatment pathways for people.

Most recently there has been an agreement on the reduction of in-patient beds commissioned across the country by NHS England Specialised Services over the next five years and is detailed below.

	Current	**Future**	**Assumptions**
High secure	80	80	No change
Medium secure	460	360	25% reduction
Low secure	853	525	50% reduction plus 100 short term assessment beds

With regard to the Lancashire fast track area, below are the patient numbers;

Current Lancashire Population at Calderstones with expected discharges by April 2016

CCG	Medium Security	Low Security	Stepdown	Total	Should all expected discharges occur	Projected cohort by April 2016
Blackpool	2	3	0	5	1	4
BWD	2	6	0	8	3 – LSU, 1 - MSU	4
CH & SR	0	2	2	4	1	3
Gtr Preston	1	1	4	6	3	3
East Lancs	4	10	1	15	3 plus 1 other provider	12
W Lancs	1	1	1	3	2	1
Lancashire North	1	2	0	3	0	3
Fylde & Wyre	0	2	0	2	0	2
Totals	**11**	**27**	**8**	**46**	**14 (+1)**	**32**

Lancashire – other providers

Across the north west there are 13 people identified on the CTR Tracker who are placed in other secure services, 9 Low secure and 4 medium secure. (1 out of area – MSU).

In addition to this, work is underway nationally within specialised commissioning to address both the long term national vision for forensic secure services the financial implications of the transforming care agenda. There is a commitment to transferring the necessary funding from bed based specialised services to more appropriately commissioned local services for the population. However this work is not yet complete and there is no definite timetable for this work to be completed. We are unable at this time to be more definite about the resources and how these will be reused. What we can say with confidence is that there is a commitment to ensure the resources released from bed closures are redistributed between commissioners to ensure the new models of care delivery are

appropriately funded.
This will most significantly affect services provided by Calderstones FT Hospital. As a single specialty provider with a relatively small provision compared to other multi-specialty FT providers, it has already been vulnerable to the financial challenges placed on it by the NHS over recent years. The Transforming Care agenda will reduce the annual income of Calderstones and add to those financial challenges. In light of these developments it is inevitable that the Trust will not be viable as a standalone single speciality trust in the short to medium term.
With this uncertainty, staff morale has suffered and attrition and sickness rates have risen over recent times, bringing new challenges for managers in ensuring a capable, safe and sustainable workforce.
Specialised Commissioners have worked with Calderstones Hospital to identify potential solutions and have been involved in the identification of a neighbouring, multi-specialty Trust willing to acquire Calderstones and create a more resilient and effective centre of excellence for secure care for both learning disability and mental illness patients. Merseycare Trust is working with Calderstones to develop an outline business case for this acquisition. It is envisaged that this will take place in April 2016.
In the short term NHS England Specialised Services in the North West have worked with Calderstones to rationalise existing pathways and service configurations in the context of reducing patient numbers to use their staff more efficiently. They have also subsidised the Trust by £3m to ensure short term financial stability by agreeing not to withdraw committed income from beds where patients have been discharged already through the Transforming Care process.
NHS England Specialised Commissioners are supportive of the plans being put in place by both Greater Manchester and Lancashire CCGs in support of the Transforming Care agenda. We have been involved at both Board and Delivery group level and are engaged with them in their planning for alternative provision based closer to home and outside of a hospital setting. The plans fit well with the NHS England vision for future Specialised Services commissioned for secure forensic LD provision.
In addition to our commitment to continue to work with CCGs across the North West on delivering their transition plans, we have non-recurrently employed an additional 1.5 WTE case managers and 0.5 WTE administrative support to continue the CTR process across the North West and to act as key links for CCG Case Managers and Commissioners around individual patient pathways from in-patient into community based services. Commissioners are working with providers to embed these processes in normal business for both parties.
The risks associated with this process and mostly centre on the capacity of the specialised commissioning team to undertake the associated workload. Most specifically capacity issues lay with the current lack of commitment around the non-recurrent funding for CTR implementation after 31st March 2016 this will mean that the case management resource employed for the chairing of and following up of CTRs and actions will cease. The remaining team cannot pick up the work due to the effects on the rest of the system and this will result in the slowing down of pathways for people transferring out of secure care.
Another risk to be considered is that of the lack of capacity from supplier management on working with providers on contractual and reconfiguration of services. The team will require the commitment of an additional supplier manager to undertake this process. This will allow for the proper management of the contractual issues and changes that will be required.
Service reconfiguration across the North West will include the rationalisation of low secure services in non-fast track areas and will involve significant commissioning of new service models and units that will allow for the more appropriate delivery of care for the population going forward. Outreach services will require significant development to support people as described above.
Our aim is to achieve a service provision across the North West that is responsive, least restrictive and only accessible to those who meet the criteria after rigorous assessment and development of clear and time limited treatment plans.

Clinical Commissioning Group Support for Lancashire Fast Track Plans

Calderstones

Achieving a high level of discharges on a fast track programme has the potential to significantly destabilise this organisation. In order to manage the reductions in bed numbers is essential for transformation to be undertaken in a carefully planned and managed process. Lancashire & Greater Manchester CCGs have agreed to collaborate and work with the provider to design an approach to ensure stability. Staffing issues have been highlighted by the provider and all organisations are committed to ensuring that every opportunity to retain the scarce skilled LD workforce should be maximised. Therefore where possible redeployment and TUPE arrangements for staff will be explored. Ensuring staff are supported and informed during the transition will be a priority and a robust staff communication process will be crucial to minimise the disruption caused by uncertainty in the future for the Trust and its employees.

A two phased plan is identified:

Phase 1 - Transition

A co-produced investment and action programme has been produced, to ensure adequate and sufficient clinical leadership and management capacity, to deliver the required re-configuration of in-patient services at Calderstones, and thereby enable:

- A workforce development plan as the mechanism to equip workers with the education, skills, values, knowledge and behaviours they need to effectively deliver and improve services, both now and in the future – ensuring the service is supported in providing a range of professionals and workers with the right attitudes and skills
- Rationalise and merge ESS/Low Secure resources to enable speeding up of discharge care pathways over the next year to support transition placements
- Re-design of specialist and criminal justice systems/forensic support diversion care pathways - including expanding the Forensic Outreach Support Service
- Build on the Calderstones LDD NOMS national best practice work with Probation Trusts and Police Forces, including work to:
    - identify and improve outcomes for offenders who have a Learning Disability
    - better identify the prevalence of learning disability within offending cohorts reducing the discrepancy between the reported number of cases in GMPT and Lancashire Constabulary with a learning disability compared to the expected prevalence as identified in the research.
    - extend cross criminal justice service working parties including Probation Services, Police, HMP, the National Autistic Society, and partnership agencies such as the National Careers Service and Work Solutions – and targeting work, centred around identifying an offender's pathway through the criminal justice service and solving the 'roadblocks', gaps in provision and best practice, in the areas of screening, identification, information sharing, safeguarding and sentence planning.
    - continue use of the Communication Reflection Tool developed by Calderstones to gauge levels of communication skills within probation and prison cohorts
    - support offender managers to avoid misinterpreting the behaviour of offenders with a communication need as non-compliance, rather than that of an individual with a communication need and so improve the early identification of offenders who have

a learning disability.

- improve offender engagement through more effective use of existing workforce skills and competencies.
- enhance interventions through the development a range of practice tools.
- improve assessment and planning by a clear focus on presenting need and improved professional judgement.
- ensure that the new ways of working are embedded in business as usual models.
- promote more effective multi-agency responses to risk and vulnerability.

Phase 2 – Long term sustainability

Following the authorisation of Mersey Care as a foundation trust there is a proposal for Mersey Care to acquire Calderstones from April 2016.

Mersey Care has been working with Calderstones since April 2014. Both trusts care for service users with similar offending profiles. In September 2014 the two trusts agreed a joint strategy for clinical working which has led to several developments, including joint clinical appointment(s). Throughout this period, clinicians from both trusts have developed a good working relationship and have a shared clinical model for the future which will offer specialist, intense progressive care based on interventions that demonstrate the best outcome for people with learning disabilities and or mental health conditions. The current business case focuses on the opportunity to fully integrate forensic services with Calderstones, builds on the expertise of both trusts and is a natural progression of the work that has been developing between the two trusts during the past year.

In order to achieve reductions in the number of hospital in-patients the Lancashire Health and Care System's commissioning strategy is to commission community based packages of care where it is safe and effective to do so for patients who require Enhanced Support Services. We have already stopped admissions into the beds at Calderstones from the community and therefore reduced admissions. In addition, the direct pathway from LSU down to ESS beds has also been closed.

We will examine the referral gateway to inpatient beds so that all referrals for admission using the civil sections of the Mental Health Act will be via the lead health workers of the Integrated Learning Disability Teams.

Discharge Plans

CCG in-patients with projected discharge dates are identified by quarter in the tables below with the confidence levels of achieving the date set taken from the tracker on the 26th August 2015, these dates will fluctuate as individual circumstances change and are dependent on multiple organisation input such as social care, community health services, housing and the impact of medical conditions.

The colours in the table below are RAG ratings, indicating the confidence level of achieving the date, according to guidance provided by NHS England, during Care and Treatment Reviews. The initial date setting was done on clinical presentation at a point in time and without reference to contextual and external factors. Each responsible commissioner has mitigations in place for each case and a rationale for their confidence rating.

Confidence in discharge:	High	Medium	Low	Unsure	Not given

CCG Projected Discharges

2015/2016							
Q2		Q3			Q4		
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
31/08/2015	01/09/2015	1/10/15*		15/12/2015	31/01/2016	28/02/2016	
	30/09/2015	06/10/2015		31/12/15*	31/01/2016	29/2/16*	
		09/10/2015		31/12/2015	31/01/2016		
		31/10/15*			31/01/2016		
		31/10/2015					
3		**8**			**6**		

17 CCG Patient Discharges expected by the end of March 2016
*Identify patients not in Calderstones

2016/2017					
Q1		Q2		Q3	Q4
Apr	Jun	Jul	Sep	Dec	Mar
30/04/2016	30/06/2016	30/07/2016	01/09/2016	15/12/2016	31/03/2017
	30/06/2016	30/07/2016			
3		**3**		**2**	

8 CCG Patient Discharge dates identified so for in 2016/17

2017
01/09/2017
01/09/2017
01/09/2017
3

3 Patient Discharge dates identified so far for 2017/18

Specialised Commissioning Projected Discharges

The dates may need to be altered as care reviews are undertaken as those indicated in the tables are from the initial reviews where dates were not to exceed a specified date by NHS England. The first section in the tables show the dates from the cohort expected to be discharged by end of March 2016, second section are those admitted after 31st March 2014.

Some of these patients have restrictions in place such as Ministry of Justice, which will have an impact on the options for discharge destinations and the length of stay of the patient.

Many of the discharges do not have a specified place of discharge, 16 not yet known, 4 have a community setting identified, 11 in-patient medium or low secure, 1 in-patient non-secure.

2015/16 Discharges

Q2	Q3			Q4		
Sep/2015	Oct/2015	Nov/2015	Dec/2015	Jan/2016	Feb/2016	Mar/2016
01/09/2015	09/10/2015	30/11/2015	30/12/2015	31/01/2016	01/02/2016	01/03/2016
	31/10/2015	30/11/2015	30/12/2015		28/02/2016	01/03/2016
	31/10/2015	30/11/2015	30/12/2015			30/03/2016
		30/11/2015	30/12/2015			30/03/2016
			31/12/2015			30/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
Admitted since March 2014						
30/09/2015	11/10/2015	05/11/2015	01/12/2015		19/02/2016	
30/09/2015			01/12/2015			
			31/12/2015			
3	**17**			**14**		

2016/17 Discharges

Q1			Q2		Q3	Q4
Apr/2016	May/2016	Jun/2016	Aug/2016	Sep/2016	Nov/2016	Dec/2016
30/04/2016	30/05/2016	30/06/2016	31/08/2016	30/09/2016		30/12/2016
		30/06/2016	31/08/2016	30/09/2016		
		30/06/2016	31/08/2016			

			31/08/2016			
Admitted since March 2014						
30/04/2016					24/11/2016	
6			**6**		**1**	**2**

9. Delivering the New Model of Care

Achieving safe discharges

Achieving discharges for those individuals currently in LD in-patient services is a complex process, encountering a variety of issues and difficulties. The Lancashire commissioner's network held a workshop to consider the best approach to managing discharges of the current LD in-patient cohorts and identify solutions to overcome the challenges that present.

Cohorts of patients identified fall into the following categories:

- Restrictions by Ministry of Justice
- Court of Protection and Deprivation of Liberty Safeguards (DoLS)
- Enhanced Support Services – Community type care packages delivered in accommodation where the person would choose to live
- Enhanced Support Services - Community type packages delivered where the person would NOT choose to live
- Unknown – as yet no person centred care plans are in place

All Patients need discharge co-ordinators to ensure the discharge process is progressed effectively and to agreed timelines. This role should be responsible for ensuring that all organisations are aware of the plan and that a holistic approach can be taken for all aspects of health and social care. These roles will be linked to the Dedicated Community Nurse and Dedicated Social Worker for each individual. 5 new posts will be recruited to enable these discharges and case manage all patients in in-patient beds.

The co-ordinators should work across all inpatient groups and have a complete understanding of the issues, restrictions and requirements of the identified cohorts in order to ensure robust case management to meet the needs of the individuals and achieve a safe and smooth transition of care delivery.

There must be a uniform process for case management to ensure that there is system wide support to meet the needs of each individual case and that all drivers and progress made is in the best interests of the patient.

Governance arrangements - any issues arising during the discharge process should be entered onto a log, with clear actions taken, and an escalation process should be developed, to ensure they are addressed quickly to minimise any disruption to the discharge timeline:

- Via the contract & performance meetings for Calderstones contract
- Via the LD steering group for other issues

Estates

Currently the care providers are responsible for arranging accommodation, which is undertaken case by case. A more planned and proactive system of management could help prevent some of the issues encountered.

There are currently no links to Housing Associations to enable proactive planning, to ensure demand can meet supply, through a deliberated process.

Issues encountered are:

- Market availability
- Suitability – requirement for alterations & timely completion
- Timescales for funding – Landlords let to other tenants, while approval is being sought.

Mapping of individuals to areas and earlier notification of requirements for accommodation would assist to prevent delays occurring.

Where individuals are currently living in accommodation that is community based, suitable for their needs and where they wish to reside long term, the accommodation should where possible be reclassified for their permanent use.

There should be exploration to consider alternative accommodation options and development of suitable housing solutions. Opportunity for Capital investments and optimising use of current property investments will need to be undertaken and continue to develop to meet demand.

Procurement

Partners have access to CSU and Local Authority support and expertise in legal requirements relating to market exercises. Whilst legal obligations are important to consider there are increasingly innovative procurement devices that can be used to promote more dynamic purchasing. All partners will be progressing with greater joint approaches to the market management and purchasing frameworks.

The Collaborative Commissioning Board have recently agreed the development of a Health and Care Strategy which is setting an overarching shared vision to care delivered in individual packages. This programme of work whilst separate to the Fast track will be linked in as a key interdependency and enabler.

The Community Offer

The aim in Lancashire is to create a truly integrated community service offer for the all age LD population. We need to ensure that there is an integrated approach to specialist support provision, determining packages of support that can be tailored to individual needs.

Community-based support will be delivered via a network of 8 LD centres covering each CCG area (this is the footprint of the existing locality teams and is considered as a starting point option however as the model evolves this will be reviewed so that opportunities for networking of specialisms can be maximised). The hubs will operate as drop-in centres, enabling self- and support-worker referrals. Typically they will be accessible between 12-7pm daily for core services (capacity / demand for extended access e.g. 8am-7pm will be explored during implementation planning).

The centres will all provide the same core service, incorporating duty workers, LD nurses and day services as a standard offer to ensure a consistent approach across Lancashire for the LD population. The service will operate across Lancashire providing a uniform process of case management incorporating, Person Centred Care Planning, Care & Treatment Reviews (CTRs), Blue Light CTRs and an ongoing programme of case reviews to ensure a culture of learning organisations is developed to maximise the impact of transformation. Understanding where system pressures and failures are encountered will allow services to adapt meet local needs.

Other specialist services, operating part-time, on the basis of local demand, will facilitate a flexible approach and enable services to be tailored to individual needs. Duty workers will function as the first point of contact within centres, undertaking initial assessments and directing individuals to appropriate support functions. Support workers must operate as part of the locality team provision, unblocking referral routes to centres (currently a disconnect in some areas)

Social activities must be considered on an individual basis as part of care plans. Capacity building / training required to progress this element, not only for carers but for parents and families too. A web portal either developed or purchased can enable brokerage of social activities there will need to be research into existing models being delivered elsewhere to identify the right solution for Lancashire.

In the long term a holistic view of support is needed but the initial focus will be LD individuals with behavioural issues and prevention of reoffending for those with forensic histories. The new model of care is to be community-based with provision to offer services currently provided as an in-patient such as Enhanced Support Services and Step Down services at Calderstones.

Stratification of individuals by their specific needs / issues must be assessed and regularly reviewed to reduce risk of harm to themselves or others.

In addition to the service offer provided by the hubs community services on a wider footprint will also be provided. These services will link into each of the hubs to provide individualised packages of care such as speech and language therapy, psychology, psychiatry and where mainstream services are not appropriate specialist occupational therapy and physiotherapy.

Personalisation and Personal Budgets

This is at the heart of the Lancashire vision and model – all services will be expected to deliver truly person centred care; supported and empowered to do so, by the league of leaders that will continue to oversee and review the Plan as it is implemented across the system.

Plans that already exist to use Personal Budgets are showing benefits and this Fast track opportunity will provide further impetus to enable progress to be accelerated.

Personal budgets will be embraced not just as a requirement and another device but as a fundamentally accepted part of the control and choice that allows people to get the care they really need – expediting discharges, preventing admissions and readmissions.

The Lancashire Plan includes the deployment of Discharge Facilitators to work with the initial priority cohort in inpatient settings – these facilitators will be encouraged to see personalisation and personal budgets in particular as tools in their toolkits, to work with families and users and their support professionals to design bespoke and tailored care.

Positive Behaviour Support (PBS)

As part of the Fast track planning process a Lancashire representative visited the PBS Service in Knowsley to understand the model employed by them specifically for behavioural support. There is strong evidence of benefits being realised, which offset investment in the service, notably in reductions in behavioural incidents and related admissions / lengths of stay etc.

The Lancashire LD Commissioners Network are keen to develop this feedback further and include this element in the model, further exploration is required particularly with clinicians and social care practitioners to understand how the model could be adapted to a large footprint in Lancashire and how it would be maximised alongside the existing and planned service model elements.

There are proposals in place to implement and pilot this in two CCGs initially, with a view to develop a full business cases for future roll out Lancashire wide.

PBS is recommended as best practice within professional practice documents (Royal College of Psychiatrists, British Psychological Society & Royal College of Speech & Language Therapists, 2007) and in national policy statements. In England, for example, this includes Meeting Needs and Reducing Stress (NHS Protect, 2013) Positive and Proactive Care (Department of Health, 2014), Ensuring Quality Services (Local Government Association and NHS England, 2014) and A Positive and Proactive Workforce (Department of Health, Skills for Health & Skills for Care, 2014), all of which champion the role of PBS in providing effective support to people who challenge.

Crisis Support

Wherever possible individuals should be supported by community crisis response services that work together with individuals and their carers to overcome issues within the home setting to minimise disruption to all involved. A community support in-reach service will be part of the wider support offer across all of the hubs. It should be the first line of offer for those in crisis to prevent disruption to home life as much as possible.

Local Intensive Support Units

The team supporting these units should be the same leadership that provide the wider support to the hub based community services, to ensure a consistent holistic approach to care. The principles and culture of this service should be for home based care whenever possible.

- Crisis Community Care Beds

  At times individuals need a safe place to stay during times of crisis but do not require hospital treatment. This may be at time such as; to cover unexpected illness of carers; for repairs to be carried out to damaged property or when seeking alternative accommodation. These beds do not need to be hospital registered, however will need to be staffed by appropriately skilled staff to support people with challenging behaviour. The length of stay should be as short as possible (a few hours or overnight to 6 weeks).

- Assessment, Treatment & Discharge Beds:

  Development of intensive support to be undertaken to provide assessment, treatment and discharge registered hospital beds. These facilities will be an alternative time limited (maximum 6 months) treatment offer, to current large scale hospital treatment services.

Optimally in order to ensure services are as local as possible, sustainable and financially viable, two 6 bedded units would be proposed for Lancashire with 3 beds for each types of need.

Forensic Outreach Teams

A highly specialised community forensic service (Tier 3) is a pivotal integrator to the future model of care. Forensic Outreach Teams will interface with health and social care services and criminal justice agencies to share specialist forensic skills and knowledge in order to provide appropriate support to individuals who are at risk of, or engage in offending. The main focus of the teams will be to help people to remain in the community, either by preventing admission to inpatient secure services or following their discharge from them.

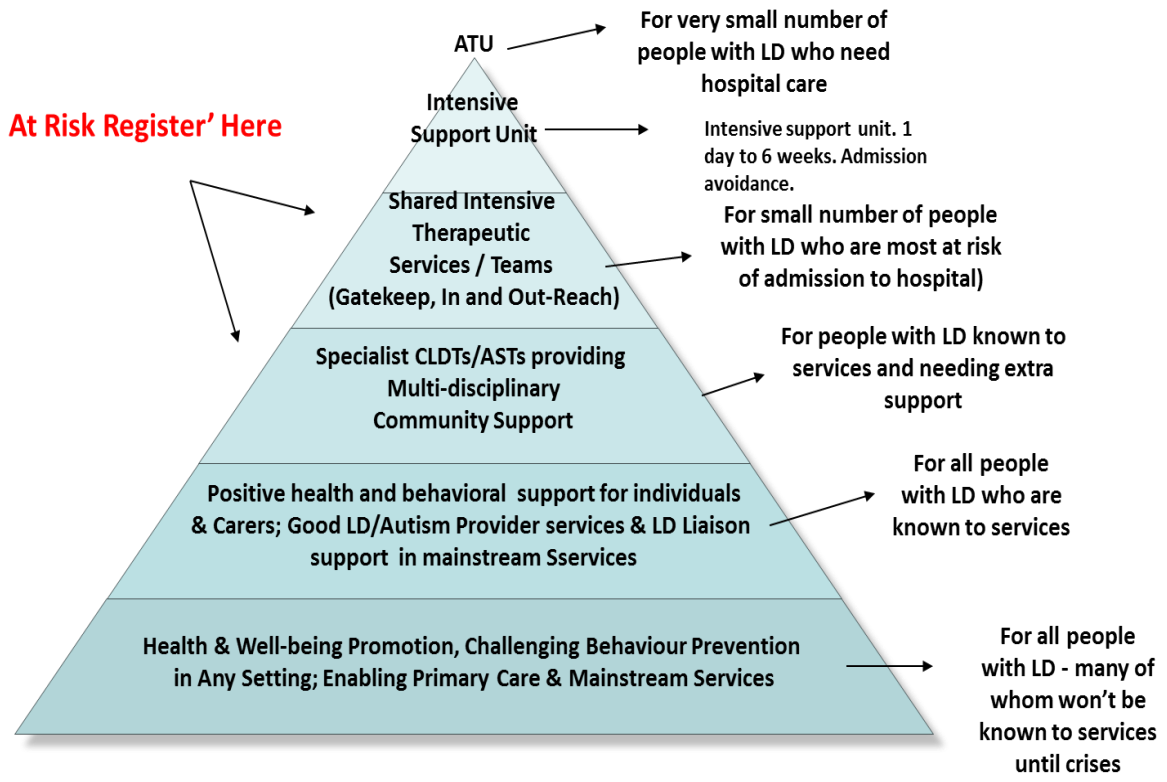
The decision to accept a patient for forensic outreach services will be based on a comprehensive risk assessment, including how the potential risk identified can be managed safely in the community. People accessing the service will be provided with a package of care which is developed with the individual and which:

- is sensitive to their personal needs;
- clearly defines responsibilities for services and individuals who use services;
- Is outcome focussed

The team would be a highly specialist resource working on a regional basis and their offer to local Community Learning Disability Teams and the Criminal Justice System would be clear. The Forensic Outreach Service will form an essential component of the pathway providing clear and continuous lines of sight of people with problems who present significant risk to themselves or others, enabling them to safely avoid admission to, or leave secure inpatient services and move back to the community or an alternative setting, when the time is right.

Enhanced Respite Care

As more of the learning Disability and Autistic population are cared for in community settings enhancement of respite services will need to be mapped to the growing community cohorts to ensure that family and carer support packages do not break down due to burn out.



Specialist Services

Inpatient admissions are required if the risk posed by the behaviour of an individual is of such a degree that it cannot safely be managed in the community. Individuals will require hospital treatment placements in low and medium secure settings and may have restrictions imposed such as from the ministry of justice or court of protection. The length of treatment however should be time limited based on an assessment of the person's needs and risks including the nature of their index offence and forensic history

Supported Living

Some individuals may require further support and may even have lifelong needs. This should be delivered within safe and secure high level supported living accommodation. Individuals should be supported by skilled staff to live in a community location that ensures safety of both the individual and the local community.

10. Workforce

Workforce development

The learning disability workforce needs to have the right skills, capability and capacity to deliver personalised, high quality care and outcomes for people with learning disabilities and their families. This includes the delivery of the ambitious transformation of services as set out in the Fast Track Transformational Plan. A key priority is the development of a comprehensive Workforce Strategy,

identifying needs from both, an at scale cross Lancashire and locality based workforce.

The development of competency based care requires a move beyond education or training targeted only at individual workers, to include a wider whole system remit which develops the capacity for a skills and culturally competent workforce. This training and development approach must then be supported with comprehensive continuous professional development, case management and skills based supervision.

Lancashire recognises the additional challenges of delivering an integrated model of care. Significant barriers can exist, and have proved challenging to overcome. Jacobs (2007) suggests that whilst individual partners such as commissioners, service providers, and educational institutions may have different ultimate goals, the ability to reconcile them is a defining feature of integrated systems based workforce development.

The learning disability sector across the region is in agreement about the need to develop capacity and competence in local services, that workforce development is a priority to support this, and also that expert support is needed to develop excellence at a local level. Workforce development within the Transformation Programme will ensure we have the right people with the right skills and knowledge and behaviours to deliver and commission, high quality personalised care and outcomes.

The two main NHS learning disability providers (Calderstones FT and Lancashire Care FT) have been contacted to understand their current workforce planning assumptions.

Calderstones plans are attached, and provide information on the forecasting of future staffing needs up to 2020. They do not see significant reductions in actual staffing numbers, which may reflect the learning disability skills shortages, in particular qualified nurses, and the challenges of managing recruitment difficulties and current vacancy rates of 20%. This may have a significant impact on the implementation of the integrated new community model, and will see the need to develop new learning disability roles and skills. This will need support at a national and regional level with the transformation of the LD workforce. They also offer their views of the development of specialist community services with particular focus on people with significantly complex needs including forensic support.

Lancashire Care FT, do not have a current LD workforce development strategy.

Both providers are fully engaged and supportive of the requirement to develop the LD Workforce plans for the period 2015 - 2020 in alignment with the proposed new service model for Greater Lancashire.

The transformation journey to the proposed new model will almost certainly involve significant provider restructuring and reconfiguration. The demand for training of staff will be significant and is likely to include national and regional training programmes that need to cover the following areas

- Evidence based health and social care interventions/skills (including PBS)
- Transformational change of focus to be person centred and relinquish control to service users and their families
- Leadership of the LD integrated system including performance management (operational and commissioning)
- Planning, commissioning and monitoring
- Use of new technologies in terms of data bases and use of service datasets to manage and

monitor quality improvement for services and outcomes

The national shortage of skilled LD nurses means that the future workforce will include skills and roles that do not currently exist. There is significant concern the closure of beds in Calderstones will not lead to the transfer of qualified and skilled staff to the community, and this will need to be addressed in the workforce strategy.

Workforce commissioning

Health and social care workforce commissioning will influence and shape the labour market including co-producing commissioning plans that are clear about financial investment and disinvestment, and the skills and competencies of the workforce such as PBS. Developing innovative joint commissioning practice will be required to encourage providers to pool resources, work collaboratively and find creative solutions to learning and competency development. Commissioners are key in articulating the workforce requirements within service specifications, and including metrics and specific funding for workforce development within contracts. These contracts will require robust management to ensure providers deliver a workforce with the right people, with the right skills, knowledge and behaviours to deliver personalised, preventative and safe care. The strategy needs to incorporate both the health and social care workforce implications of the integrated model.

There will need to be the appropriate commissioning capacity and capability in place to deliver the LD transformation plans, opportunities need to be explored to ensure there is sufficient commissioning expert LD capacity and capability to deliver improved outcomes for people with learning disabilities and their families.

Developing the Workforce

The NICE Guidelines Development Group published its recommendations for people with learning disabilities who present challenges in May 2015; Many of the recommendations can be summarised as key elements of the new vision and model of care, these principles will need to be a continuous thread through the workforce strategy

- The continuation of development of evidence and best practice
- Development and maintenance of standards CROMs, PROMs, PREMs (including physical health outcomes)
- Engage in the creation of a comprehensive training curriculum that utilises innovative learning methods including work place coaching and mentoring, effective case management and skills supervision
- A rolling programme of appropriately accredited training and development for stakeholders across the health and social care learning disability field.

The parallel development of leadership programmes will be essential to the success of a skills based training strategy to ensure the system change required to delivery true transformational change.

Learning Disability Staff Development

In order to deliver the new integrated model staff will require additional training in the following areas:

- Upskill to reflect the needs of the new model including clinical, therapeutic and management skills

- New technologies: databases, case management systems
- Developing new understandings of care provided through a person centred culture, handing over choice and control back to the service user and their families
- Positive learning and transparency when things go wrong
- Providing education, advice and awareness raising to a range of community stakeholders including health, social care and communities

Learning Disability Leadership Development

Lancashire will develop leaders who have the skills and capability to lead across the integrated health and social care system with a focus on transforming services to generate better outcomes for people with a learning disability and / or autism.

6. Next Steps

Lancashire recognises there has not been sufficient time to develop a comprehensive Workforce Strategy through the Fast Track Planning process. There is a need to ensure the full involvement and engagement with a range of key stakeholders including people who use services, their carers and families, and providers of care. This will enable us to finalise plans on who should provide care, how care should be provided and what are the skills and competencies of the workforce to deliver a positive experience of care, and improved health wellbeing and quality of life, to people with learning disabilities. Lancashire are committed to delivering an outline workforce strategy by December 2015, and a cross organisational workforce development agreement by April 2016

Timeliness of notification of discharge package requirements does not always enable the required workforce to be put into place for individuals when they need them. The requirements need to be mapped out with the expected discharge dates and an outline of the staffing levels and skill requirements that will meet the needs of the individuals.

All stakeholders need to be fully aware of the issues providers face in order to minimise delays due to staffing.

Training programmes, which should include court of protection, are required to enable the development of staff at the rate the care packages are planned.

11. Implementation

Implementation will require transformation programme management and an implementation group. A project team will need to be established for 12 months in the first instance consisting of:

Role	Band	WTE
Project Manager	8a	1
Project Support	6	1
Administrator	3	1
GP		0.1
Clinical Leadership		0.1 x 2

Finance	7	0.5
Business Intelligence	7	0.2
Communication & Engagement	6	0.1

The work programme will be co-ordinated via the Transforming Care Programme Board who will oversee an implementation group, consisting of stakeholders who will each lead on identified areas of the implementation plan. The SRO will report into the Lancashire Collaborative Commissioning Board.
The programme will include the following deliverables:

Programme Area	Key Deliverables	Oct - Dec 15	Jan - Mar 16	Apr - Jun 16	Jul - Sep 16	Oct - Dec 16
PMO	Mobilise the PMO to oversee the programme including: Project Implementation Risk Management and Mitigation Stakeholder, clinical and patient engagement Development of service specification Recruitment of Discharge Coordinator					
Engagement	Establish a Co design Group to further inform the model					
Engagement	Consultation on the new model of care					
Engagement	Patient Group to lead on Advocacy Development Lancashire wide.					
Service Specific	Market Stimulation and work with providers on innovative potential models of care					
Service Specific	Agree system wide definitions and a service specification for integrated community team including Uniform processes / pathways Service footprints defined Responsibilities H&SC Roles Outcomes Lancs wide standard interventions Hub delivery optimisation Uniform approach to pathways Early identification process Early Intervention service Individual Care Planning Forensic Support Community and Residential					

	Individual Persona Centred Culture Carers Support Footprint						
Service Specific	Implement New Service Specification						
Service Specific	Commission Positive Behavioural Therapy Service as part of Integrated Team (pilot in two CCGs)						
Service Specific	Commission Crisis Bed						
Service Specific	Review residential bed model for the system including respite care						
Discharge Coordinators	Implement discharge coordinators and dedicated social workers to ensure standard approach to CTR						
Workforce	Complete workforce strategy and plan						
Quality Impact Assessment	Complete Quality Impact Assessment on the model						
Outcomes	CQUIN for HEF to be contracted						
Outcomes	Providers to implement HEF						
Outcomes	Work with NHSE on children's HEF						
Training	Training plan- Mainstream training programme around the rights of people with LD including specialist Pharmacy support for: • Primary Care • Acute Targeted training to support mainstream services to make reasonable adjustment.						
Training	Explore targeted training to support people with LD to create their own opportunities to support meaningful and employment.						
Training	Develop mentorship / clinical supervision model for new service						
Finance	Develop Contracting Framework for integrated model, including move to more outcomes based model						
Finance	Agree commitment of available funds						
Finance	Model Financial requirements of new community service offer						

Finance	Explore Pooled Budgets - Implications & Risks					
Finance	Understand the Impact of dowries					
Finance	Baseline Contracts Activity & Values					
Finance	Programme to maximise the use of Personal Budgets in individual planning					
Procurement	Procurement advice on new model and procurement options					
Procurement	Explore cross lancs protocol for placement procurement.					
Procurement	Redeployment opportunities					

12. Health outcomes

Measuring the Impact of our plan

1. The Health Equalities Framework

From 2015/16 the Lancashire Health and Care System will use The Health Equalities Framework (HEF) to assess improvement in care for people with a Learning Disability over a five year period. The HEF is an Outcomes Framework based on the determinants of health inequalities for people with learning disabilities. It is designed to measure the impact of interventions on reducing exposure to the known determinants of health inequalities. It is not an eligibility tool or a needs assessment. It was developed by the consultant nurse group, but can be used by all specialist services for people with learning disabilities.

The HEF uses five-point (Likert) impact scales, alongside Indicators for each determinant in order to profile the impact of each determinant on any given person with learning disabilities. High scores indicate a significant detrimental impact of exposure to the determinants, whilst low scores indicate minimal impact. The central role of learning disability services is seen as tackling the impact of exposure to the determinants of health inequalities, which can be demonstrated through individual and population HEF profiles.

The HEF rates the *consequence* of exposure to determinants of health inequalities for individuals, rather than merely profiling the complexity of a person's needs, specific conditions or presentations. People with learning disabilities are much more likely to have medical conditions, require more hospital care and are more likely to suffer premature death than the general population. Rather than focusing on individual diagnoses, the intention is to ensure that long-term conditions and needs are identified and that individuals are receiving appropriate support. For example, someone with complex epilepsy or severe challenging behaviour receiving a good level of care and support in appropriate accommodation may score lower than someone else with a less complex presentation whose needs are being less well met. It is also feasible for an individual's health to deteriorate but for outcome scores to improve (as a result of being in receipt of good quality palliative care, for example). The approach aims to quantify the success of interventions in reducing the impact of these known determinants and therefore demonstrate reduced probability of exposure to health

inequalities.

An electronic template (eHEF) has been designed to enable a team to record this information easily, and enable data to be aggregated to monitor health equality impact and for commissioning purposes. Lancashire will use the HEF to demonstrate improvement across a 5 year period.

The HEF is currently adults only and the Lancashire Health and Care System will work with NHS England to review suitable tools which will allow us to assess improvement in care for people with a Learning Disability over a five year period

For 2016/17 we intend to offer a CQUIN to all NHS providers to implement and embed the HEF. We will also explore opportunities to apply to non NHS contracts including the Private Sector and Residential Care.

Further information is available at
http://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

2. Activity Outcomes

The Lancashire Health and Care System will also deliver improvement in the number of in-patient bed days – the 5 year trajectory is a 70% reduction.

3. Annual Health Checks

From 2009 PCTs were required to fund GP practices to carry out annual health checks for adults with learning disabilities through a direct enhanced service (DES). The health check includes an assessment of physical and mental health; health promotion; review of chronic illness; a physical examination; review of epilepsy; review of behavior and mental health; a syndrome specific check; review of prescribed medications; a review of co-ordination arrangements with secondary care; and a review of transition arrangements where appropriate. Currently the Lancashire CCGs are not achieving the planned target and therefore this has been identified as a priority area within this plan.

Outcome	Metric	Timescale	Baseline performance	
Achieve 80% of people with a learning disability of GP DES Register having an annual health check	80% of people with a learning disability will have an annual health check	Mar-17	13/14 Lancashire Practice participation 66.80%	13/14 Lancashire Health Check coverage 43.60%

4. Clinical Outcomes

Numbers of LD individuals with access to a full range of community services will be identified from personalised care plans. Year on year improvement in the number of care plans identifying community service access is in place.

13. Finance

Total Current Spend

CCG & 2 Unitary

Services	Notes	Totals	
		2014-15	2015-16
Inpatient Services			
ESS Contract - Calderstones	Indicative only for 15-16 - based on information as at 26-08-15	**3,328,354**	**3,721,579**
DaisyBank - Calderstones	Lancs North CCG contract	**1,527,539**	**1,503,158**
Mental Health Contracts			
LCFT	LD Psychology	**638,010**	**749,696**
LCFT	Learning Disabilities		
Community Contracts			
LCFT Community Contract	LDS Admin		**9,473**
LCFT Community Contract	Children's Learning Disability	**545,424**	**1,465,131**
LCFT Community Contract	Learning Disabilities	**2,523,111**	**8,214,098**
LCC		**202,464**	**213,528**
ELHT Community Contract		**21,367**	**21,367**
Blackpool Borough Council		**1,544,261**	**1,519,553**
IPA Team - Personal Health Budgets etc.			
CPOC <65 LD		**1,606,101**	**1,684,479**
LD <65		**1,008,076**	**1,268,507**
LD >65	This information is taken from the IPA teams month end finance report.	**218,274**	**235,607**
CPOC <65 LD		**126,283**	**126,629**
LD Pool			
CCG Contribution	MOA - Budget Setting	**8,511,177**	**8,582,949**

LCC Contribution	MOA - Budget Setting	**87,336,843**	**87,336,843**
LDDF Contribution	MOA - Budget Setting	**58,497**	**58,497**
Other LD Spend		**124,841,270**	**125,376,908**
Total		**234,037,050**	**242,088,003**

Lancashire County Council	**2014-15**	**2015-16**
-Residential	15,250,000	12,280,000
-Nursing	490,000	500,000
-Shared Lives	218,000	174,000
-Dom Care	21,490,000	22,880,000
-Day care	2,420,000	3,790,000
-DP/SDS	41,800,000	43,202,000
-Service User Income	-5,880,000	-6,300,000
-In House Dom care	14,480,000	14,480,000
-In House Respite	3,009,000	3,009,000
-In house Day	8,340,000	8,340,000
-Psychology/Psychotherapy	630,000	630,000
-Historic Supported Living Housing based support top-up commitments	8,500,000	8,500,000
-Advocacy	163,000	163,000
-Gtr Preston CCG Health Comm Service	481,000	481,000
-W Lancs CCG Health Community	277,000	277,000
-C & SR CCG Health Community	699,000	699,000
-LDDF	101,000	0
-Balshaw Block	226,000	226,000
-Care UK/C Support blocks	463,000	463,000
-Transport	2,390,000	2,390,000

-Assessment & Care Management and other Staff costs	5,770,000	5,770,000
LCFT Community Contract		
-Gtr Preston LCFT Social Care	2,278,605	2,278,605
-W Lancs LCFT Social care	1,144,303	1,144,303
	124,739,908	**125,376,908**

Care Package Costs

The cost of care packages for LD individuals managed in the community setting varies greatly and there is a combination of arrangements for the packages currently delivered.

Average costs are:

100% Social Care funded	Joint Funded	100% Health Funded
£70k	£110k	£155k

An average cost for planning assumption purposes has been set at £125k per patient irrespective of the funding source of the care package. Many of the patients currently in hospital settings are complex, long term patients therefore this average has been weighted slightly to a higher value.

Fast Track Bid and Match Funding

The table below demonstrates the required Fast Track funding and the matched funding arrangements agreed by pan Lancashire organisations.

Plan	Fast Track Funding 15/16 £000's	Match Funding 15/16 £000's	Match Funding 16/17 £000's
New Care Packages	680	0	875
Discharge Co-ordinators	150	0	150
Social Worker Support	60	0	120
Notional Capital Costs	200	0	0
PMO	111	0	111
Training & Engagement	180	0	0

PBS pilot in 2 areas	150	0	300
	1531	0	1556

Estimated Cost of New Community Care Packages

The profile of 15/16 discharges delivers a total of 68 months of new community placement costs whilst maintaining an inpatient block contract up to the end of March 2016. At the £125k per annum cost this equates to £680k of new care package costs. The 16/17 costs for these packages up to September 16, when the inpatient block arrangement ceases will be £875k incurred locally (with a further £875k incurred for the following 6 months but without an inpatient block contract).

Discharge Co-ordinators

In order to ensure the discharge process is as effective as possible maximised discharge co-ordinators to be appointed for 12 months. This will facilitate a uniform discharge planning process that commences on admission.

Role	Band	WTE	Cost £
Discharge Co-ordinators	8a	5	293,670

Average caseload 20 individuals to manage.

Social Worker Support / Capital Costs

Additional Specialist support in respect of discharge from Social Care has been agreed for an 18 month period to ensure that all aspects of discharge are facilitated without delay. With this in mind there is a notional request for a £200k provision for potential capital resource to be made available in the event that one or more community placements require reasonable building adjustments.

Implementation Project Management Office (PMO)

The proposal is for 12 months in the first instance and will be responsible for developing the work programmes required to progress the implementation of the plan. Whilst discharging the individuals who have been in-patients for a considerable length of time is an initial phase of the plan, without a whole system culture change and service offer transformation the effects will not be maintained.

The proposed PMO support is:

Role	Band	WTE	Cost £

Project Manager	8b	1	70,917
Project Support	6	1	43,489
Administrator	3	1	25,122
GP		0.1	15,000
Acute Specialist LD/MH Clinician x2		0.1	30,000
Finance	7	0.5	25,143
Business Intelligence	7	0.2	10,057
Communication & Engagement	6	0.1	4,349
			224,017

Training opportunities

A mainstream training programme to be implemented over the next 6 months around the rights of people with LD and the new model of care to be delivered across:

- Primary Care
- Acute Care
- Social Care
- Pharmacy Provision

There will be targeted training to support mainstream services to embedding 'reasonable adjustment' into working practice.

Communication & Engagement

A programme of communication and engagement is to be devised to ensure appropriate stakeholder involvement and consultation is achieved, alongside a wider approach to supporting a better community and social awareness of LD.

Positive Behaviour Support

The cost of developing a PBS service has been completed for the pilot project and extrapolated for a pan Lancashire service is expected to be in the region of £1.2 million, however for the purposes of Fast-Track a pilot approach across two CCG areas is agreed, with Matched funding supported by the respective CCG Governance arrangements. The 12 month cost for the pilot is constructed as follows

Role	Band	WTE	Cost £
Integration and Partnership Co-ordinators	6	3	130,467

Behaviour Support Nurses	5	3	105,420
Positive Behaviour Support Staff	3	6	150,732
Administrative Support	3	2	50,244
Non-Pay			13,000
			449,863

It is expected that the pilot will commence in December and run for a 12 month period. On-going evaluation will ensure appropriate recruitment can be facilitated for a wider roll-out of the pilots

Cost of New Service Model

Full costs have not yet been calculated as a main contributory factor will be workforce. Since there is a plan to work with providers to establish how current services can be aligned and reshaped to fit the new model, it is not possible to understand the full costs of transition from the current service to the new.

Development of the hubs and Lancashire wide support services will require full work up to determine the optimum number and geographical locations, based on population and access. Full business cases will need to be developed and approved by relevant governing bodies.

Intensive Support Service

The development of Crisis support services will need an options appraisal to determine the optimum method of delivery. This may be a process best procured in collaboration with neighbouring areas. 6 Crisis beds are projected to cost in the region of £200k per CCG at an annual cost of £1.6m. It is not expected that these beds can be facilitated within the timeframe of the existing bid proposal.

Activity Reductions

Specialised Commissioning Cohorts

A planned reduction of 25% in Medium Secure and 50% Low Secure with some added provision of short term assessment beds**.** Current expectation and trajectories indicate that Specialised Commissioned patients should be managed within the bed capacity identified and not project into CCG in-patient episodes in the future.

CCG In-patient figures

The new model of care will change the current long-term placements of in-patient care with community care packages. The expectation is for future in-patient care to be short term assessment, treatment and discharge, which has the ability to react to individual requirements via earlier intervention programmes.

Current in-patient services are in the main commissioned on block contract and not per bed. Activity assumptions however reflect that each individual is currently occupying a bed, so the trajectory to 14 beds (representing 1 bed per 100,000 population) is set out below in terms of bed requirements, allowing for the inclusion of a reducing but significant number of new individual admissions (not readmissions) to the system during the period.

The table below identifies the planned changes to achieve the 70% overall reduction from the current in-patient number.

CCG In-Patients	March 15 Baseline	August In-Patient No.	Planned Discharges	Full Year Admission Projections	Year End Projection	% In year Reduction
2015/16	47	39	17	12	34	28
	Discharges					
	March 16 Baseline	Projected Admission	Planned	Escalated	Year End Projection	% In year Reduction
2016/17	34	10	4	12	28	18
	March 17 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2017/18	28	8		12	24	14
	March 18 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2018/19	24	6		12	18	25
	March 19 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2019/20	18	6		10	14	22

The projected admissions number is the annual bed impact rather than number of individual admissions.

14. Risks

Programme Management

A programme management risk log has been maintained and is attached at Appendix XX. The main risks of the model however are captured below, with the current mitigations and residual risk score attributed to them. These form the basis of major discussions at Steering Group Meetings

Risk	Impact (1-5)	Likelihood (1-5)	Overall Risk	Mitigations	Mitigated Risk Score	Comments
There is a risk that we will be unable to recruit appropriately to offer Positive Behavioural Support Interventions, and this may inhibit step down into or maintenance of community placements	4	4	16	Develop a programme to 'grow our own' staff, working locally with HEE. Pilot PBT across CCGs to evidence workforce and outcome delivery	12	Pilots agreed in 2 CCG areas
The system may not support new entrants to any market development, and staff	4	4	16	Develop a framework with providers to support new entrants	9	

transferability may impact on new placements and discharge				Develop training opportunities for providers and staffing cohorts		
CCGs may not be able to afford new packages of care in the current financial climate, leading to delays in discharge where risk shares are supporting differential funding	4	4	16	Collate evidence base of costings and opportunities for savings, facilitate invest to save programmes pan Lancashire Provide evaluation criteria for prioritisation decisions which reflect Winterbourne and Bubb Report	12	

The above risks represent those whose initial ratings are highest. Mitigations and mitigated risk levels are to be monitored via the Steering Group.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Amanda Doyle, Chief Clinical Officer; David Bonson, Chief Operating Officer
Relevant Cabinet Member	Councillor Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	21 October 2015

LANCASHIRE CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH, EMOTIONAL WELLBEING AND RESILIENCE TRANSFORMATIONAL PLAN 2015 – 2020

1.0 Purpose of the report:

1.1 To provide the Board with an overview and background to the development of the 'Children and Young People's Emotional Health and Wellbeing Transformational Plan 2015 – 20'; including an overview of the requirements of NHS England in terms of system change and specific service development.

2.0 Recommendation(s):

2.1 The Board is asked to approve the plan attached at Appendix 6(a) and agree the governance structure.

3.0 Reasons for recommendation(s):

3.1 In 2014, the Government asked for a Taskforce to understand what needs to be done to improve the emotional health and wellbeing of children and young people. The Taskforce led by MP Norman Lamb reviewed the different aspects of care and services which resulted in a suite of seven documents being published with recommendations for systemic changes.

The leading document is entitled *'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing'.* This has been collectively produced by Department of Health (DoH), Department for Education (DfE) and NHS England.

Future in Mind recommends that Clinical Commissioning Groups (CCG) take ownership and be the lead organisation around children and young people's emotional health and wellbeing across all mental health tiers. There is an expectation that the CCG will produce a Transformational Plan relating to this over the next five

years with key partners; local authority – including Public Health, NHS England, third sector and Blackpool Teaching Hospitals. The transformational plans are expected to be completed by 16 October 2015.

The document *Future in Mind* recommends that the Health and Wellbeing Board is the Strategic Forum where the Transformational Plans are owned, accountable to, reported on and led. Blackpool Children and Young People's Partnership have been briefed around the Transformational Plan. Once the Transformational Plan is complete the Health and Wellbeing Board must agree to and sign it off before submission to NHS England.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

There is no alternative option; there is an expectation on CCGs from NHS England that transformation plans will be produced. The deadline for submission to NHS England is 16 October 2015.

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 Following the release of Future in Mind the following Transformational and Systemic work is currently underway across Blackpool with the CCG being the lead partner agency around Children and Young People's Emotional Health and Wellbeing in Blackpool.

5.2 There is an expectation that each CCG locality area co-ordinates the effort across all agencies in relation to how Children and Young People (CYP) Emotional Health and Wellbeing Services are delivered. There is an expectation that transformational change is implemented. Delivering this means making some real changes across the whole system. It means that the NHS, all services within the local authority (public health, social care, schools and youth justice sectors) must work together to ensure the following:

1. Promoting resilience, prevention and early intervention – Place the emphasis on building resilience, promoting good mental health, prevention and early intervention;

2. Improving access to effective support – a system without tiers – Simplify structures and improve access: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service;

3. Care for the most vulnerable – Deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable, so people do not fall between gaps;

4. Accountability and transparency - Harness the power of information: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

5. Developing the workforce - Sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience.

6. Make the right investments: To be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment.

5.3 CCGs will be expected to submit Transformational Plans to NHS England clearly articulating the case for change and evidencing how this will be achieved with all partners over the next five years. The case for change originates from the Department of Health and the Department for Education following governmental work in this area.

5.4 Due to considerable investment in Blackpool from BIG Lottery (Better Start, HeadStart and Fulfilling Lives), around emotional well-being and mental health, the Transformational Planning is timely in that it provides the Strategic Framework to ensure that this work is linked together to ensure a coherent system. This is a must to ensure that complex commissioning arrangements and funding of new programmes is seamlessly linked and creates system change that is effective.

5.5 There will be considerable investment made by central government through CCGs over the next five years to support the transformational process. This investment will be in addition to the baseline budget. As well as the overall expected change highlighted in section one there are key areas where investment is ring-fenced and specific service development is expected. They are:

5.6

- Link Specialist Children and Adolescent Mental Health Services (CAMHS) to schools and to services where there are vulnerable children and young people;
- Implement CYP Increasing Access to Psychological Therapies (IAPT);
- Develop services for young people who have been sexually assaulted and/or are victims of Child Sexual Exploitation;
- Improve services for children and young people with autism and learning disabilities;
- Develop robust peri-natal mental health provision;
- Develop an Eating Disorder service that is in line with the National Institute for Health and Care Excellence (NICE) guidance;
- Develop self-harm services and pathways;
- Establish a one stop shop that is easily accessible by children and young people.

Does the information submitted include any exempt information? No

List of Appendices:

Appendix 6(a) – Lancashire Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan

Appendix 6(b) – Plan on a page

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 To ensure that this is realised a visioning event was held on Monday 7 September that included all key stakeholders and partners. The purpose of the event was to inform key stakeholders of the transformational planning process; consult with and engage key stakeholders in the transformational planning process; begin the process to create a five year vision that will feature in the transformational plan and inform systemic change.

13.0 Background papers:

13.1 Future in Mind: Promoting, protecting and improving our children's mental health and wellbeing
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

This page is intentionally left blank

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

Transformation Plan 2015 – 2020

Our Vision

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

Executive Summary

The Children and young people Mental Health, Emotional Wellbeing and Resilience plan for Lancashire has been developed by the Children and Young People Emotional Wellbeing and Mental Health system board consisting of key partners and has been informed by consultation with children, young people and families. It is based on comprehensive identification of needs and identifying evidence based practice to promote good emotional wellbeing and prevention of mental ill-health, early intervention, care and recovery.

This transformation plan takes a high level strategic approach whilst cognisant of local needs and seeks to improve relationships, knowledge and understanding of each other's issues. It outlines the implications for Lancashire in light of the recent guidance from Department of Health *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*[1].

The plan recognises that the foundations for lifelong wellbeing are being laid down before birth and aims to prevent mental ill health, intervene early when it occurs and improve the quality of mental health care and recovery for children, young people and their families. The focus on a whole child and whole family approach and developing systems which ensure children and families are at the centre of prevention, care and recovery will improve our children and young people population mental health and wellbeing.

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work, and to achieving our potential. Good mental health is the foundation for well-being and the effective functioning of individuals and communities. It impacts on how individuals think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. Through promoting good mental health and early intervention we can help to prevent mental illness from developing and mitigate its effects.

The plan aims to build a healthier, more productive and fairer society for children, young people and their families which builds resilience, promotes mental health and wellbeing and ensures they have access to the care and support to improve their mental health when and where they need it thus reducing health inequalities.

[1] Future in Mind (2015)

Contents

Introduction

"There is now a welcome recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked." [2]

This document sets out the five-year Children and Young People's Emotional Wellbeing, Mental Health and Resilience Transformation Plan for Lancashire which consists of eight clinical commissioning groups, a county council and two unitary authorities and thirteen other partner organisations.

This transformation plan will support local implementation of the national ambition and principles set out in *Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing*[3]. The implementation plan aims to improve the resilience, emotional wellbeing and mental health of young people, make it easier for them and their families to access help and support when they need it and improve the standard of mental health services across Lancashire.

In consultation with key stakeholders, a number of specific challenges have been identified. In particular, these are the increasing demand on services and the ability and capacity of services to meet this demand effectively and consistently across the county. There is an urgent need for a comprehensive workforce strategy to ensure that there is sufficient appropriately skilled staff to meet the future emotional wellbeing and mental health needs of children and young people across Lancashire. This is in addition to concerns with regards to investment levels and the reduction of services.

What is apparent from stakeholder events is the high level of commitment and passion that exists in Lancashire to provide the best possible services for children, young people and their families. This enthusiasm will be harnessed in the development and delivery of high quality and effective services.

This strategy has been written by incorporating the themes, principles and recommendations from Lancashire's Review of Children and Young People's Emotional Wellbeing and Mental Health (2015), the Lancashire Joint Commissioning Strategy (2014), Lancashire Mind (2014) and Future in Mind (2015).

2 Simon Stevens, *Future in Mind,* March 2015

3 Future in Mind (2015)

National policy over recent years has focused on improving outcomes for children and young people by encouraging services to work together to protect them from harm, ensure that they are healthy and help them to achieve what they want in life.

No Health without Mental Health[4], the cross-Government mental health strategy for people of all ages, takes a life-course approach to improving mental health outcomes for people of all ages with a strong focus on early and effective intervention in emerging emotional and mental health problems for children and young people.

The national mental health strategy sets out a clear and compelling vision for the improvement of mental health and wellbeing in England through the achievement of six objectives which emphasise the importance of wider influences on mental health, which include issues relating to housing, education, the criminal justice system, physical health and unemployment. These six objectives are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The Children and Families Act (2014)[5] focused on the improvement of services which are available to vulnerable children and their families. The Act covered provision across a number of different areas of children's services, which together contribute to the achievement of improved mental health outcomes. Key elements include transformation of systems for children and young people with special educational needs and disabilities, and greater input for children, young people and their families in the decisions made regarding their care to ensure their needs are fully met.

In 2015, NHS England and the Department of Health published a joint report Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing. It provides a broad set of recommendations that, when implemented, would facilitate greater access and improved standards for mental health services, promote positive mental health and wellbeing for children and young people, greater system co-ordination and a significant improvement in meeting the mental health needs of children and young people from vulnerable backgrounds.

[4] Department of Health No Health without Mental Health (2011)

[5] HM Government: Children and Families Act 2014

As part of the national strategy the Government has committed to take forward detailed plans to extend the Improving Access to Psychological Therapies (IAPT) programme to children and young people. This service transformation for children and young people's mental health care will embed best evidence based practice, training staff in validated techniques, enhanced supervision and service leadership and monitoring of individual patient outcomes.

Future in Mind identifies key themes fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Also of relevance to this transformation plan is implementation of the Lancashire Mental Health *Crisis Care Concordat*[6]. The Mental Health Crisis Care Concordat was launched by HM Government which is a commitment from key national organisations to work together to support the development of local systems to achieve systematic and continuous improvements for crisis care for people with mental health issues across England. The concordat highlights what needs to happen when people are in mental health crisis and how to make sure effective emergency response systems operate in localities.

Future in Mind is clear in its vision that 'more of the same is simply not an option'. An increased focus on prevention, building resilience, promoting good mental health and early intervention across the whole system will make real change to children and young people's mental health and wellbeing. There is a need to reduce risk factors associated with poor mental health at individual and community level; improve the mental health and wellbeing of children and young people, and reach out to the groups at greatest risk of experiencing mental health problems.

Our vision is for children and young people in Lancashire who have emotional wellbeing and mental health issues to have access to timely, integrated, multi-disciplinary mental health services which will ensure effective assessment, treatment and support for them and their families.

The principles of the THRIVE model will be adopted in order to wrap services around children and young people, allowing access to whichever service is appropriate at

[6] HM Government Mental Health Crisis Care Concordat (2014)

any given time without service users having to begin a new pathway each time they need help or support.

Universal services will deliver promotion, prevention, and early help and intervention. Specialist services will deliver support that is easy to access, readily available and based on the best evidence. Underpinning all this, staff across all services will have a clear understanding of their roles and responsibilities and those of others, and will have an appropriate range of skills and competencies. Children and young people will be involved in the development and delivery of services.

This plan adopts core beliefs to ensure effective delivery including; joined-up working between community and voluntary, statutory and business sectors; commitment to engagement and consultation with local community, children, young people and families; commitment to achieving and sharing evidence-based practice; population and targeted approach to delivering strategy.

It has been informed by a series of consultation events undertaken by partners with key stakeholders who identified a number of specific challenges. In particular, these are the increasing demand on services and the ability and capacity of services to meet this demand effectively and consistently across the county. This is in addition to concerns with regards to investment levels and the reduction of services.

The intention is, over the next five years, to deliver a model identifying how all agencies are required to work together to ensure the holistic mental health and wellbeing needs of children and young people are met. The model will develop a Single Point of Access across targeted and specialist mental health services through a multi-agency triage approach.

Our plan will deliver against the following five key areas and build on work already under way, we will:

1. Promoting Resilience, Prevention and Early Intervention

a. Promoting Mental Health and Building Resilience

Objective 1: To build resilient communities in all settings including home, school and wider community which promote, improve and maintain the emotional health, mental health and wellbeing of children, young people and their families, to encourage them to help themselves.

Objective 2: Improve access to evidenced-based interventions which support attachment between parent and child, to build resilience, improve behaviour and avoid early trauma

Objective 3: Improve public awareness and understanding of children and young people's mental health and wellbeing as well as perinatal mental health and work to reduce stigma and discrimination.

Objective 4: Improve the availability of information regarding self-help and support that is available and how to access it.

b Early Identification

Objective 5: Improve early identification and timely intervention for children and young people at risk off and or experiencing poor mental health

Objective 6: Ensure ease of access to support based on the needs of children, young people and their families, through coordinated care in the most appropriate place

Objective 7: Improve early identification and timely intervention for pregnant women and new parents at risk of and or experiencing poor mental health

Objective 8: Locally adopt and adapt the Thrive model as a conceptual framework for our collective response to improving the emotional health and wellbeing of children and young people.

2. Improving Access to Effective Support

Objective 9: Use the technology available we will develop and promote widely a pan-Lancashire online one stop portal which will include self- help materials in addition to clear information on the support available across Lancashire.

Objective 10: Create a single point of access into all services providing interventions to improve emotional health and wellbeing. This will include consultation as well as direct delivery.

Objective 11: Ensure transitions from children's services will be based on the needs of the young person rather than their age.

Objective 12: Ensure children, young people and families will have timely access to an evidence based community eating disorder service.

Objective 13: Improve access to evidenced-based care and support designed in partnership with children and, young people and their families, treating them as individuals, taking into account both their physical and mental health needs.

Objective 14: Ensure that children and young people have early access to evidence bases early intervention in psychosis services in line with the new access and waiting times standards for people experiencing a first episode of psychosis

3. Care for the Most Vulnerable

Objective 15: Ensure crisis support to be made available whenever it is needed and delivered in an appropriate place of safety as close to the child or young person's home as possible.

Objective 16: Prevent the development of mental illness through targeted interventions for groups identified as being high risk

Objective 17: Ensure equitable access to evidence-based interventions for those most vulnerable children and young people following a holistic and comprehensive assessment of their needs.

4. Accountability and Transparency

Objective 18: Reduce the complexity of current commissioning arrangements through joint commissioning and service redesign, developing a system that is built around the needs of children, young people and their families.

Objective 19: Have clear governance arrangements which hold each partner to account for their role in the system

Objective 20: Increase transparency through the development of robust metrics on service outcomes'

Objective 21: Work together to ensure that our increased levels of investment will be used transparently, equitably and demonstrate value for money.

Objective 22: Ensure our service offer will be designed with children, young people and families and be responsive to needs as opposed to service structures.

5. Developing the Workforce

Objective 23: Work with partners across all sectors to ensure that there is an appropriately resourced, skilled and trained workforce who feel confident in their ability to support the emotional health and wellbeing needs of our children and young people and their families.

Successful implementation of this plan will result in:

- An improvement in the emotional well-being and mental health of all children and young people in Lancashire.
- Multi-agency approaches to working in partnership, promoting the mental health of all children and young people, providing early intervention and also meeting the needs of children and young people with established or complex problems.
- Access for all children, young people and their families to mental health care and support based upon the best available evidence and delivered by staff with the required range of skills, knowledge and competencies.

Case for Change

National Profile

Mental illness has a range of significant impacts with 20% of the total burden of disease in the UK attributable to mental illness (including suicide), compared with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that mental illness is not uncommon:

- At least one in four people will experience a mental health problem at some point in their life.
- One in ten children aged between 5-16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- One in ten new mothers experiences postnatal depression. Over a third (34%) of people with mental health problems rate their quality of life as poor, compared with 3% of those without mental illness.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm
- More than half of all adults with mental health problems were diagnosed in childhood - less than half were treated appropriately at the time
- Number of young people aged 15-16 with depression nearly doubled between 1980s and 2000s
- Proportion of young people aged 15-16 with a conduct disorder more than doubled between 1974 and 1999
- 72% of children in care have behavioural or emotional problems
- Almost 60% of looked after children in England have emotional and mental health issues and a high proportion experience poor physical health, educational and social outcomes after leaving care.
- 95% of imprisoned young offenders have a mental health disorder

Levels of mental illness are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million. However, this does not take account of the current economic climate which may increase prevalence.

Learning Disabilities, Behavioural Conditions and Mental Health

An estimated 25-40% of people with learning disabilities also have mental health problems[7]. Mental health problems such as depression tend to be under-diagnosed in people with learning disabilities. Many symptoms of mental illness are wrongly regarded as challenging behaviour and so do not receive appropriate treatment[8]

[7] Department of Health (1993). Services for people with learning disabilities, challenging behaviour or mental health needs. Project group report. London: Department of Health.

[8] Equality and Human Rights Commission.

Prevalence of anxiety and depression in people with learning disabilities is the same as for the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable mental illness is 36%, compared with 8% of those who do not have a learning disability[9]

Children and young people and Mental Health

Children and young people with emotional disorders are almost five times more likely to report self-harm or suicide attempts; four and half times more likely to rate themselves or be rated by their parents as having 'fair/bad health', and over four times more likely to have long periods of time off school.

Comorbidity of disorders is common – children and young people frequently have both emotional and behavioural conditions and mental illness and physical health problems[10].

Stigma and discrimination in mental health

Nearly nine out of ten people with mental health problems have been affected by stigma and discrimination and more than two thirds reported that they have stopped doing things they wanted to do because of stigma.

Public attitudes to mental ill health are gradually improving, with less fear and more acceptance of people with mental ill-health.

However, according to the annual national surveys of attitudes to mental illness in England:

- 36% of people think someone with a mental health problem is prone to violence (up from 29% in 2003)
- 48% believe that someone with a mental health problem cannot be held responsible for their own actions (up from 45% in 2009)
- 59% agree that people with mental illness are far less of a danger than most people suppose

Direct social contact with people with mental health problems is the most effective way to challenge stigma and change public attitudes[11]

Lancashire Profile

Current information in relation to mental wellbeing is poor. Assessing need in relation to mental health and wellbeing is complex and there are a number of ways in which this challenging problem may be tackled. It is essential to consider sources of information which tell us who and where in our communities are receiving support for mental health issues alongside the range of wider determinants which impact on

9 Foundation for People with Learning Disabilities (2003). Health needs of people with learning disabilities. London: Foundation for People
with Learning Disabilities.

10 Green H, McGinnity A, Meltzer H et al (2005). Mental health of children and young people in Great Britain, 2004. London: Office for national Statistics.

11 TNS UK for CSIP 2010, Attitudes to mental illness 2010: research report. London: Department of Health.

mental health wellbeing and cause individuals to be more vulnerable to poor mental health.

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be greatest. The economic landscape of Lancashire is mixed: Blackburn with Darwen, Blackpool, Burnley, Hyndburn, Pendle and Preston all feature within the top fifty most deprived areas in the UK[12]. In contrast there are areas of Fylde, South Ribble and West Lancashire which are highly placed on the national index of affluence and the Ribble Valley itself is considered one of the most affluent parts of the United Kingdom.

In Lancashire it is recognised that

- there are increasing numbers of young people between the age of 10 and 24 years being admitted to hospital for self-harming[13]
- it is anticipated that there will be more than 45,000 (19% to 23%) children and young people in Lancashire who may have an increasingly complex emotional health need requiring intervention by 2015
- Prevalence estimates for Lancashire vary by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%)
- there are increasing numbers of children and young people approaching a number of different contact points with emotional, behavioural and mental health related problems
- variances in commissioning arrangements and clinical models have led to an inequity in capacity, funding, variation in service models and access to services across the Lancashire footprint[14]
- there is currently no provision or agency who has lead responsibility for children and young people requiring a place of safety for behavioural or perceived behavioural issues

Data aggregated from the Child and Maternal Health (ChiMat) Child and Adolescent Mental Health Service (CAMHS) Snapshot and CAMHS needs assessment reports produced by Public Health England[15]has been used to provide a snapshot of the estimate of certain conditions across Lancashire and is detailed in Appendix 1.

Key data and information which has helped understand the demand, risk factors, provision and outcomes for services is detailed in the mental health needs of

12 http://www.lancashire.gov.uk/
13 JSNA 2014
14 CSU 2014
15 http://www/chimat.org.uk/camhs

children and young people in Lancashire CCGs report published in August 2015[16], Appendix 2.

Those children and young people at higher risk of poor mental health have been identified through needs assessment and are included as vulnerable and at risk within the transformation implementation plan.

Priority vulnerable and at risk groups include children and young people within Lancashire include those:

- who are part of the Looked after system
- from low income households and where parents have low educational attainment
- with disabilities including learning disabilities
- from Black and Minority Ethnic groups including Gypsy Roma Traveller community
- who identify as Lesbian, Gay, Bisexual or Transgender
- who experience homelessness
- who are engaged within the Criminal Justice System
- whose parent (s) may have a mental health problem who are young carers
- who misuse substances
- who are refugees and asylum seekers
- who have been abused, physical and/or emotionally transition from services.

When commissioning and implementing programmes to improve and support emotional and mental health outcomes and build resilience for all children and young people targeted provision will focus on those young people most at risk group.

The level of investment by all local partners commissioning children and young people's mental health services for the period April 2014 to March 2015 will aid local decision making is given in Appendix 3.

Information on investment is inconsistent with each CCG providing their unique way of allocating funds. Block contracts with providers mean that we are unable to identify what the money has been spent on therefore the real costs are unknown. In the case of transition between adult and children's services the discrepancies between the ages at which children's services come to an end varies depending on where they live.

The activity delivered from the children and young people's mental health service providers in Lancashire in 2014/15 and those specialist services purchased on behalf of the Lancashire CCGs by NHS England Specialised Commissioners is detailed in Appendix 4 of this plan.

The review of data and stakeholder events has told us that Lancashire has a highly skilled and diverse workforce that can offer a range of evidence based interventions,

[16] Mental health needs of children and young people in Lancashire CCGs (CHIMAT CAMHS profiles) Business Intelligence www.lancashire.gove.uk

right across the pathway as detailed in Appendix 4. However, there are tangible concerns about the ability to sustain current workforce levels as there are high vacancy rates and numbers of impending retirements and indeed about how to grow the workforce in order to support effective transformation of services.

The National Service framework for Children and Young People and maternity Services[17] recommends a minimum ratio of fifteen whole time equivalent (WTE) for every 100,000 population for non-teaching services or a ratio of twenty WTE for every 100,000 population for teaching services.

The report 'Building and sustaining specialist child and adolescent mental health services'[18] recommends that specialist CAMHS require twenty FTE per 100,000 population to meet the needs of children and young people aged 15 years or less. In addition, the report recommends that five WTE Primary Mental Health Workers (PMHW) per 100,000 population.

The impact of these recommendations for Lancashire, based on Local Authority populations, is also detailed given in Appendix 4.

All but one service in Lancashire is part of the CYP IAPT programme. The involvement supports the development of a skilled workforce. There are difficulties in the ability to provide backfill in order to release staff for training. This issue will need a regional response, as it presents a real opportunity to skill up the CAMHS workforce.

Challenges identified at stakeholder events and audit includes:

- specific concerns about the workforce, with areas reporting that they are carrying vacancy rates and that many staff are nearing retirement, there is a real need for a comprehensive workforce strategy and plan in order to ensure that there are enough skilled staff to meet the mental health needs of children and young people.
- concern that there continues to be insufficient capacity to support Universal services and not enough buy-in to early intervention and training the workforce
- retirement high vacancy rates and the need for specialist training
- Further pressures are being anticipated by services in relation to their workforce. Along with the GP workforce aging and a struggling to recruit appropriate staff, therefore posing problems for early identification of mental health needs. A high number of mental health professionals in CAMHS services are due to retire in the next 5/10 years, which will lead to further difficulties in recruitment if the issue is not addressed immediately. Specialist CAMH training for nurses who make up 34% of the specialist CAMHS

[17] Department of Health 2004
[18] Royal College of Psychiatrists 2006

workforce is no longer available, therefore specialist knowledge is only being developed through practice

- Having enough workforce capacity and a workforce that can deliver evidence-based interventions at times and places suitable for young people was seen as key. There were also priorities around ensuring there is future planning for the workforce needs of mental health services. The current lack of capacity was felt to be preventing services being able to move forward and transform.

The transformation agenda is based on growth and change. The success of implementation and associated investment will be hindered across Lancashire by the difficulties in recruitment and retaining appropriately trained staff. These concerns will cut across all sectors of the children's workforce and have been highlighted within the CYP IAPT programme and local CAMHS strategies. Services for children and young people with mental health needs will need to be properly resourced. There is currently a shortage of appropriately trained practitioners and it is envisaged that difficulties in future recruitment will a significant issue in the future. An adequate and competent workforce is fundamental to the successful delivery of this Transformation Plan. For certain staff groups the predicted demand will outstrip the projected supply. Whilst it is recognise that numbers of staff are important and necessary it will not be sufficient.

Information gathered through stakeholder events and North West workforce audit identified a number of challenges as follows:

- Improve workforce design and planning so as to root it in service planning and delivery
- Identify and use creative means to recruit and people in the workforce
- Facilitate new ways of working across professional boundaries
- Enhance exiting roles and create new roles tapping into new recruitment pool and so complementing existing staff groups
- Develop, workforce through evidence based education and training at both pre and post qualification levels
- Development leadership and change management skills
- Ensure appropriate skill mix within services

Plan for Action

1. Promoting Resilience, Prevention and Early Intervention

There is evidence that supporting families and carers, building resilience through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities[19].

A resilient community is one that expands upon developmental, attachment and ecological approaches and enables a holistic focus. It is built upon the complex interaction and operation of risk and protective factors at individual, family, school and community levels including primary care.

To address this it is our ambition to enable these risk and protective factors to be the four cornerstones that provide the fundamental basis of the resilience model that sits within the THRIVE framework across Lancashire. Appendix 5.

We recognise that resilience building, prevention and early intervention is inconsistent in Lancashire with some schools and other children and young people's settings investing and providing excellent services whilst others have very little support for children and young people's emotional wellbeing and mental health. Public interventions also produce a broad range of benefits associated with improved wellbeing.

Public health, voluntary sector and school leaders therefore have a major role to play in ensuring that there is a fit for purpose equitable provision in all of the above settings and we will work with these partners to deliver our ambitions

"…Pupils' wellbeing and mental health matters and that by intervening early and providing accessible support for our pupils we are giving them the best chance to overcome problems and issues which are currently affecting their young lives." [20]

In order to promote build resilience in Lancashire our ambitions and subsequent actions are:

Objective 1: To build resilient communities in all settings including home, school and wider community which promote, improve and maintain the emotional health, mental health and wellbeing of children, young people and their families, to encourage them to help themselves.

By March 2016 we will:

- Develop resilience training programmes in order to roll out to all people working and/or engaging with children and young people across the following

[19] Fiona Mitchell-Resilience: concept, factors and models for practice – Scottish Child Care and Protection Network

[20] Head teacher Place2Be

- Birth (including pregnancy) to 25 years old
- Schools, colleges and universities
- Universal & Community settings including maternity, early years, primary care, youth work
- Including all staff from football coaches to health visitors to teachers to school nurses
- Mechanism for delivering the training to be developed
- Identification of all people working with children and young people who will receive resilience training.
- We will engage children and young people in the development of a resilience campaign targeted at children and young people themselves.
- Learning from the universal resilience based programme being piloted in Blackpool
- Explore and identify opportunities for engaging family members in the resilience movement promoting family assets
- Identify existing points where data is already collected about children's emotional health and wellbeing.
- Collect samples of this data and use to develop a consistent approach going forward.
- Explore the possibilities of establishing a provider forum including third sector, health and social care of those working around children and young people's emotional health and wellbeing.

By March 2017 we will:

- Use the evidence base from Headstart in Blackpool in order to target schools in Lancashire to deliver universal resilience programmes.
- Develop the training for the family
- Roll out of training to the highest priority groups
- Launch the resilience campaign for children and young people pan-Lancashire
- Use identified data to inform a baseline of all children and young people's emotional health and wellbeing in Lancashire

By March 2020 we will:

- Ensure that children, young people and their families are able to deal with their problems
- Ensure that schools and the wider community are able to support each other and children and young people to become resilient.

Objective 2: Improve access to evidenced-based interventions which support attachment between parent and child, to build resilience, improve behaviour and avoid early trauma

By March 2016 we will

- Identify which evidence-based interventions which support attachment between parent and child are appropriate and meet the need relevant to each CCG area
- Learn from existing programmes of work improving life chances of children aged 0-3 years old across Lancashire including BetterStart Blackpool and Family Nurse Partnership

By March 2017 we will:

- Ensure commissioned services utilise evidence-based interventions identified which support parenting.
- Align the Lancashire and Blackburn parenting strategies and BetterStart Blackpool to develop and embed a comprehensive parenting approach Lancashire

By March 2020 we will:

- Implement the pan-Lancashire parenting strategy
- Ensure service delivery is aligned to pan-Lancashire parenting strategy

Objective 3: Improve public awareness and understanding of children and young people's mental health and wellbeing as well as perinatal mental health and work to reduce stigma and discrimination.

By March 2016 we will:

- Engage children and young people to develop pan-Lancashire awareness raising campaign, with an emphasis on addressing stigma, aimed at the entire population of Lancashire
- Develop and implement a communication strategy including the development of a single brand for emotional health and wellbeing services across Lancashire in partnership with children and young people

By March 2017 we will:

- Implement the pan-Lancashire awareness raising campaign, with an emphasis on addressing stigma, aimed at the entire population of Lancashire

Objective 4: Improve the availability of information regarding self-help and support that is available and how to access it.

By March 2016 we will:

- Scope mechanisms of self-help including peer support that is available for children and young people in relation to emotional health and wellbeing
- Scope mechanisms of self-help including peer support that is available for parents/carers in relation to their resilience and emotional health and wellbeing

- Promote the existing telephone helpline's throughout Lancashire

By March 2017 we will:

- Utilise the learning of the Wellbeing Challenge (peer support programme) and develop a model to roll out across Lancashire
- Develop pathways which ensure that parents/carers are equipped, feel confident in their ability and are supported to nurture the good emotional health and wellbeing of their children
- Ensure all commissioners and providers of universal services, including primary care, deliver mental health promotion and prevention activities on a whole system basis.

In order to promote early identification in Lancashire our ambitions and subsequent actions are:

Objective 5: Improve early identification and timely intervention for children and young people at risk off and or experiencing poor mental health

By March 2016 we will:

- Ensure that clear policies procedures and guidance are in place for the CYP workforce which improve early identification
- Develop guidance for schools to ensure that the provision of school counselling is consistent across Lancashire.
- Develop a pan-Lancashire system process for providing named CAMHs contacts for schools.
- Building on the learning from TAHMS develop the role of primary mental health workers across Lancashire
- Explore methodology of routine enquiry into adverse childhood experiences
- Ensure a consistent continuous assessment process across pan-Lancashire including appropriate use of lead professional

By March 2017 we will:

- Begin implementation of the methodology of routine enquiry into adverse childhood experiences
- Promote the pan–Lancashire pathway to all children and young people's settings, primary/secondary care networks and ensure it is embedded in all services in contact with children and young people
- Monitor the effectiveness of the pathway.

Objective 6: Ensure ease of access to support based on the needs of children, young people and their families, through coordinated care in the most appropriate place

By March 2016 we will:

- Develop a pan-Lancashire system process for providing named CAMHs contacts for all CYP settings working with young people at risk of experiencing poor mental health
- Develop training across workforce to ensure early identification and low level brief interventions for all people working and/or engaging with children and young people across the following
    - Birth (including pregnancy) to 25 years old
    - Schools, colleges and universities
    - Universal & Community settings including maternity, early years settings including children's centres, primary care, youth work
    - Including all staff from football coaches to health visitors to teachers to school nurses

By March 2017 we will:

- Roll out of training to the highest priority groups
- Monitor the effectiveness of the pathway.

Objective 7: Improve early identification and timely intervention for pregnant women and new parents at risk of and or experiencing poor mental health

By March 2016 we will:

- In partnership with the Strategic Clinical Network, benchmark the current peri-natal mental health services provision across Lancashire.
- Develop commissioning intentions for peri-natal mental health services in line with the forthcoming commissioning guidance for peri-natal mental health.
- Ensure that clear policies procedures and guidance are in place for the workforce appropriate for pregnant women and new parents which improve early identification.
- Develop training across workforce to ensure early identification and low level brief interventions for all people working and/or engaging with pregnant women and new parents.
- Developing a pan-Lancashire pathway describing each service and routes of access as part of the single point of access.

By March 2017 we will:

- Roll out of training to the highest priority groups

- Promote the pan-Lancashire pathway settings engaging with pregnant women and new parents
- Monitor the effectiveness of the pathway.

2. Improving Access to Effective Support

As identified in 'Future in Mind' the traditional organisation of services against the four tiered model has resulted in children and young people having to fit the services, rather than the services fitting the changing needs of the child or young person. This inability to access services in a timely manner often results in the escalation of children's needs requiring a response at a higher and more expensive level.

Equally the fragmentation of commissioning and service provision for health and social care has resulted in service users and their carers struggling to access services and navigate their way through the system. In the Children and Young People's Emotional Wellbeing and Mental Health pan-Lancashire Review (March 15) it identified a myriad of potential contacts and relationships with services, a child or young person would have to manage Appendix 2 This is disempowering to children and young people and their carers.

Locally children, young people, teachers, clinicians and other professionals have reported their difficulties in gaining access to the right services or to be signposted to the support they need. There are a number of reasons which have been cited for this, primarily lack of training, understanding or knowledge of the various functions of services and a lack of support for children and young people who do not meet the criteria for specialist CAMHS.

Although access to services is cited as a key issue we know that across Lancashire we have a variety of good services commissioned and provided by our partners.

In response to what children and young people are telling us nationally and locally our service offer will be clear and easy to access. It will build on the strengths of children, young people and families, enabling them to improve their own emotional health and wellbeing with additional support when required.

Instead of the multiple referral processes that are evident now, young people will be directed to the right intervention from one point and where a higher or lower level of support is subsequently required services will support young people to step up or down.

Children, Young people and families will have one assessment, which is shared and built on where additional support is required. Boundaries between different organisations may exist but they will not be evident at the point of delivery.

In order to improve access to services our ambitions and subsequent actions are:

Objectives 8: We will locally adopt and adapt the THRIVE model as a conceptual framework for our collective response to improving the emotional health and wellbeing of children and young people

By March 2016 we will:

- Benchmark current provision against the model, including understanding the drivers for the numbers of DNA's and inappropriate referrals and use this to inform our needs-based model for structuring services
- Develop a performance management and quality improvement dashboard against the model.

By March 2017 we will:

- Promote our model widely
- Strengthen our model through further understanding of children and young people's needs and the building evidence base through IAPT

By March 2020 we will:

- Have an equitable evidence based response across the model and pan-Lancashire
- Be able to clearly demonstrate how children and young people's outcomes have improved.

Objective 9: Using the technology available we will develop and promote widely a pan-Lancashire online one stop portal which will include self- help materials in addition to clear information on the support available across Lancashire.

By March 2016 we will:

- Commission a digital solution provider to develop an appropriate digital platform in which children and young people and parents can access information regarding self-help and support
- Map current online resources locally and nationally to ensure existing best practice is utilised e.g. MindEd e-portal

By March 2017 we will:

- Provide an online single point of access for children and young people, parents and carers and professionals, designed by young people and incorporating online referral.
- Ensure a robust communication strategy and a 'brand' for all services

By March 2020 we will:

- Develop a range of digital therapies accessed through the portal.
- Children, young people, parents, carers and professionals across Lancashire will know the support available and how to access it.

Objective 10: **Locally create a single point of access into all services providing interventions to improve emotional health and wellbeing. This will include consultation as well as direct delivery.**

By March 2016 we will:

- Develop local networks of emotional wellbeing and mental health champions and practitioners across all services to develop practice and increase professional trust.
- Improve relationships between schools and emotional wellbeing and mental health services by naming leads in those organisations.

By March 2017 we will:

- Expand our local single points of access for specialist services to include voluntary sector provision and counselling.
- Develop a single assessment process
- Develop a robust consultation model for professionals to seek advice and support in order to be able to support children and young people.

By March 2020 we will:

- Have explored 'one stop shop' models for children and young people, learning form national and local good practice, where there is access to help and support from a multi-disciplinary team in a setting which is welcoming to children and young people.

Age appropriate Services

The age range for children's services varies across Lancashire with some ending at their 16th birthday and others 18th birthday. The thresholds for adult services mean that some young people are not eligible for ongoing support and the waiting lists for adult services can lead to pauses and gaps in support. Increasing the age range from 0 to 25 years will avoid these gaps and address the peak onset of mental ill-health when there is a need for initial care[21]. The Children and Families Act, through the Code of Practice states that joint commissioning arrangements must cover services 0 – 25.

Stakeholders, in development of the plan, have identified that defining ages as part of the access criteria to services creates additional barriers for young people to access support and is another example where current provision can be service led rather than needs led. A flexible approach which is reflective of individual need and maturity rather than chronological age should therefore be adopted.

In order to improve access to services for young people our ambitions and subsequent actions are:

***Objective 11*: Transitions from children's services will be based on the needs of the young person rather than their age.**

By March 16 we will:

[21] Right Here (2014). *How to provide youth-friendly mental health and wellbeing services*. London, Mental Health Foundation and Paul Hamlyn Foundation

- Include adult services in our performance monitoring framework so that activity and outcomes for young people is understood.

By March 17 we will:

- Have reviewed all (all age) emotional wellbeing and mental health commissioned services and included specific outcomes measures for children and young people.
- Have built on the learning from our previous CQUIN to ensure the mental health workforce delivering all age or adult services has the skills and expertise to work with young people.
- Have a 0-19 CAMHS service model in place.

By March 2020 we will:

- Have developed a clearly defined offer of local provision for 0-25s available on the pan-Lancashire single point of access portal.

Increased access to needs led evidence based interventions

The ambition over the next five years is to build effective, evidence-based, outcome focussed Child and Adolescent Mental Health Services for the future, in collaboration with children, young people and families. This includes delivering improved access and waiting times, development of a fully trained and competent workforce, and self-referral across the system.

Services will work towards the use of technology to achieve accountability to all stakeholders, including children, young people and families, commissioners, and the services themselves.

Our key mechanism for delivery will be through continued roll out of the Children and Young People IAPT programme across Lancashire. As a partner of the North West CYP IAPT learning collaborative, which brings together Children and Young People's Mental Health (CYPMH) provider partnerships across: Local Authority, Voluntary Sector and NHS Child and Adolescent Mental Health Services (CAMHS), we will be assisted in our service transformation and delivery of evidence based practice through mutual learning, support both from across the North West and Nationally.

Our local CAMHS providers, although not all part of the CYP IAPT programme currently, have a well trained workforce in evidenced based therapies and are utilising person reported outcome measures within their delivery. We also have an established CYP IAPT Partnership covering a large part of Lancashire which we can build on and review learning from when supporting and transforming services via new partnerships forming in the Pennine Lancashire and Blackpool areas.

Through further development and implementation of a pan-Lancashire CYP IAPT programme our services will be enabled to transform by:

- Working in partnership with children and young people and families to shape their local services,
- Improving the workforce through training existing CAMHS staff (statutory, voluntary or independent sector) in targeted and specialist (Tier 2, 3 and 4) services in an agreed, standardised curriculum of NICE approved and best evidence based therapies. The training will include modules covering supervision and transformational service leadership
- Supporting and facilitating services across the NHS, Local Authority, Voluntary and Independent Sectors to work together to develop efficient and effective integrated care pathways
- Delivering frequent/session by session outcome monitoring to help the therapist and service user work together in their session, help the supervisor support the therapist to improve the outcomes and to inform future service planning
- Mandating the collection of a nationally agreed outcomes framework on a high frequency or session by session basis across the services participating in the collaborative - have full data from at least two time points, one of which can be assessment.
- Outcome data will be used in direct supervision of the therapist, to determine the progress of therapy, overall effectiveness of the service and to benchmark services and embedding outcome monitoring across the whole of CAMHS will transform how they operate, and how they are commissioned.
- Sharing resources and good practice both with other partnerships within collaboratives but at a national level to support service transformation across the country. By sharing best practice and experiences of what works and what doesn't, implementation and effectiveness of improvements is accelerated and enhanced.
- Enhancing the capability of services to deliver liaison, consultation, outreach, training and support to staff in the universal and early targeted part of the care pathways;
- To encourage those working in universal, targeted as well as specialist settings including CAMHS to utilise the MindEd e-portal[22] and subsequently our pan-Lancashire online portal which offers e-learning sessions to help adults identify and understand children and young people's mental health issues.

In order to ensure that our children and young people have access to a full range of evidenced based interventions our ambition and subsequent actions are:

[22] https://www.minded.org.uk/

Objective 12: Through implementation of the CYP IAPT Programme improve access to evidenced- based care and support designed in partnership with children and, young people and their families, treating them as individuals, taking into account both their physical and mental health needs.

By March 2016 we will:

- Increase geographical coverage of CYP IAPT to 75 %
- Extend the current breadth and depth within current partnerships across pathway to include 3rd sector and Schools.
- Establish the baseline for availability and choice of evidence based interventions across Lancashire and develop a future training plan.
- Secured appropriate training places, support and funding for backfill of posts
- Ensure the implementation of routine outcome monitoring and feedback to guide treatment and future service design
- Work collaboratively with children and young people, their parents and/or carers.
- Ensure appropriate investment in mobile technologies and ensure appropriate information governance arrangements are included in the amendment of trust protocols to allow clinical information to be stored, encrypted and transported.

By March 2017 we will:

- Have increased geographical coverage of CYP IAPT to 100%
- Further increased the provision of availability of evidenced based interventions.
- Developed a pan-Lancashire training plan to detail the local requirements for training to work towards sufficient coverage of all evidenced based interventions across Lancashire

By March 2020 we will:

- Have routine outcomes measures embedded across the whole partnership
- Have secured the full range of evidenced based provision equitably across Lancashire.

Eating Disorders

At present Lancashire does not have a dedicated community eating- disorder service for children and young people, so treatment for eating disorders is currently provided by CAMHS services for <16s and by specialist adult Community Eating Disorder Services for over 16s.

The total weighted population across Lancashire is 1.65million (Transformation Plan allocation formula) and is fairly equally split across the three geographical areas of North (including Blackpool), Central and Pennine Lancashire. These population levels would, in accordance with the ED Commissioning Guidance, exceed the population requirements for a viable dedicated service if commissioned across Lancashire or broken down to the geographical areas mentioned above. It would not be achievable, however, at an individual CCG level.

The total value of the service over a five year period, whether commissioned across Lancashire or on an area basis, will exceed the EU threshold for procurement law and therefore will require a procurement exercise. It is recognised that a robust procurement from service design to service commencement will take a full year, and so running in parallel we will continue to develop our CAMHS and Adult services and pathways to ensure children and young people with an eating disorder experience an improved service.

To inform this plan and to subsequently prepare for implementation of the national access and waiting time standard for children and young people with an eating disorder, an initial stakeholder workshop took place in September 2015. This brought together key stakeholders including all providers across Lancashire, commissioners, young people and parents and provided an opportunity to review existing Eating Disorder provision, identifying gaps, opportunities and good practice to inform future service development. (See workshop summary report)

In order to ensure children and young people have access to a full range of evidenced based interventions our ambition and subsequent actions are:

Objective 13: Children, young people and families will have timely access to an evidence based dedicated community eating disorder service.

By March 2016 we will:

- Jointly fund a robust eating disorder needs assessment incorporating the views of children young people and families to further build on findings from the initial workshop.
- Complete mapping of current practice and service provision against the recommendations identified in the stakeholder workshop and commissioning guidance.
- Improve early detection of eating disorders by increasing awareness in the general population and universal frontline professionals through a targeted promotions campaign.
- Develop and agree joint service development plans for 16/17 with our current services, to address recommendations.
- Secure commissioning and procurement support to lead the service design and procurement

By March 2017 we will:

- We will have procured a co designed evidenced based dedicated community eating disorder service for our children and young people.
- Develop a training programme to ensure that relevant staff are appropriately trained in the specialist assessment of eating disorders in children and YP.

By March 2020 we will:

- The dedicated community eating disorders service will be embedded and evidencing that it meets the Access and Waiting time standard which will

This will lead to:

- Improved waiting times and access,
- Improved outcomes for children and young people
- Reduced admissions to Tier 4 beds
- Fewer referrals to A&E and admission to paediatric wards or Tier 4 admissions.

Objective 14: **Ensure that children and young people have early access to evidence bases early intervention in psychosis services in line with the new access and waiting times standards for people experiencing a first episode of psychosis,**

By March 2016 we will:

- Ensure that he Trust meets the new access and waiting times standards for people experiencing a first episode of psychosis,
- Those children and young people accessing the service are treated with a NICE approved care package within two weeks of referral and for a specials ARMS assessment to have commenced for referrals for those with ‘at risk ‘mental statement.

3. Care for the Most Vulnerable

As referenced in *Future in Mind*, the success measure of any local mental health system is how it responds in a crisis. To address within Lancashire, in line with the national requirements, we have developed an all age crisis concordat plan. The needs of children and young people are specifically referenced within the plan and these have been developed through a series of engagement events with stakeholders and young people Appendix 6. The recommendations formulated by the young people are included in the concordat plan and are as follows.

Blackburn with Darwen CCG as the lead commissioner for adult mental health contract is leading on this work in partnership with key stakeholders and signatories to the concordat. Blackburn with Darwen CCG is also working in close partnership with Lancashire Care NHS Foundation Trust to improve mental health crisis care by reviewing and redesigning the existing mental health crisis services across Lancashire. Alongside eight CCGs and three local authorities, 13 other key organisations have signed the local declaration including Lancashire Police, North West ambulance service, mental health trusts, acute trusts, health watch and voluntary sector organisations.

A Multiagency Crisis Concordat Partnership Group consisting of representatives from all key partner agencies and signatories and led by Blackburn with Darwen Clinical Commissioning Group will act as the programme board for the crisis concordat work in Lancashire and will monitor the implementation of this action plan till April 2017.

Workshops continue to be held with children and young people and their representatives to ensure the relevant actions within the Mental Health Crisis Care Concordat action plan reflect the specific needs of this patient group when suffering from a mental health crisis.

As part of the Mental Health Crisis Care Concordat consideration of the needs of service users with learning disabilities who are suffering with a mental health crisis has been included in the action plan to ensure the specific needs and support are available from the services/ organisations who have signed the local declaration, to develop and deliver crisis intervention services it was thought that there needs to be an investment in the workforce, as well as general financial investment.

In order to ensure appropriate support and intervention for children and young people in crisis in Lancashire our ambitions and subsequent action are:

***Objective 15*: Ensure crisis support to be made available whenever it is needed and delivered in an appropriate place of safety as close to the child or young person's home as possible.**

By March 2016 we will:

- Have a support helpline that have out of hours advice and support for everybody who may be involved with the child/young person, the young person themselves, parents/carers, schools, other key professionals.
- Pilot in Pennine Lancashire an appropriate alternate safe place, staffed by a multi-agency team, for children in Lancashire to be assessed on an emergency basis or where the crisis can be de-escalated.
- Extend the crisis resilience pilots for out of hours response to children and young people in crisis from CAMHS while the crisis response service is redesigned to be all age.

By March 2017 we will:

- Provide mental health training to A&E doctors and consultants.
- Work with the ambulance service to develop better understanding of the presenting complaints of children and young people in mental health crisis and how this group present differently than adults in crisis.
- Increase awareness and knowledge of the range of services and support/treatment that is available for children and young people and their families/carers when they are in crisis for example, access to advocacy services through promotion on the single point of access website.
- Evaluate alternative safe-place pilot and consider roll-out across Lancashire
- Ensure that, at the point of crisis, the workforce who interfaces with these young people will have the skills and training to enable them to empathise and support the young person in crisis with sensitivity to their age and mental health.

By March 2020 we will:

- Skill up parents and significant others to cope with their own issues and support their child/young person. Teach them to identify signs of crisis. Build the resilience of the child/young person and their family/carers/significant others and teach them to identify signs of crisis. Support the family/significant others when child/young person does not want to engage.

Many young people presenting in crisis form some of our most vulnerable and at risk groups. Some of the most challenging and complex cases have been where the young people are Children Looked After (CLA) and those with Disabilities. The cases tend not to be mental health in isolation but surrounded by a complexity of social needs, usually presenting with acute behavioural needs and/or self-harm. Children are usually placed on Paediatric Wards, at weekend or out of hours this can be without immediate mental health assessment, input or care planning. This poses a risk for the young person and others on the Paediatric Ward.

The complexity of their presenting factors can cause confusion over thresholds for Tier 4 entry, particularly where young people are exhibiting escalating behaviour due to circumstance or Learning Disability rather than a diagnosable mental health condition. This seems to be a large gap in provision for children and young people. The gap is not simply about the way services are commissioned but the training and skills of health and social care professionals to care for young people with escalating behavioural needs.

This is another example of children and young people having to fit the services, rather than the services fitting the changing needs of the child or young person as describe earlier in this plan.

Our THRIVE model defines this group as 'getting risk support' and identifies their needs as children and young people who routinely go into crisis but are not able to make use of help offered; or who self-harm or have emerging personality disorders. To address this, the model identifies the need for close inter-agency collaboration and clarity about who is leading which may most often be Social Care. It also identifies a lack of specific evidence based interventions for this group

In order to address these issue out aims and objectives are:

Objective 16: **Prevent the development of mental illness through targeted interventions for groups identified as being high risk**

Objective 17**: Ensure equitable access to evidence-based interventions for those most vulnerable children and young people following a holistic and comprehensive assessment of their needs.**

By March 2016 we will:

- Work in close partnership with our local Tier 4 service and paediatric teams to ensure clear pathways and smooth transitions for children and young people requiring an inpatient admission and the identification of alternate solutions for those children and young people who do not need inpatient admission.
- Improve the experience of vulnerable young people with mental health difficulties on paediatric wards by supporting paediatric staff through training initiatives regarding the management of self-harm and eating disorders
- Learn from and replicate/extend current best practice for children in care/CLA across Lancashire.
- Pilot the REACh project which empowers our professional workforce to proactively identify vulnerable children and young people, providing an opportunity for safeguarding and early intervention by training and supporting them to asking young people routinely as part of their assessments about adverse childhood experiences (ACEs).
- Develop and implement a range of multi-disciplinary and multi-agency care pathways for vulnerable groups, eg ADHD and ASD

- Routinely monitor the uptake and use of services by vulnerable groups eg CLA, LD to ensure no young person or family in need fall through the net because of difficulty in engaging, inflexible referral criteria or lack of bespoke pathways
- Identify the additional capacity created from the additional funding provided for eating disorders to support the development of a self-harm pathway in each health economy.

By March 2017 we will

- Conduct empirical evaluation of the medium to long term impact of this (REACh) routine enquiry about adversity in childhood approach and adjust commissioning intentions accordingly.
- In alignment with the LD fast track plan, we will work with providers to ensure children and young people with moderate to severe LD with complex and challenging behaviour have access to skilled support staff and, where necessary, the support of specialist professionals to assist assessment and plan effective support.
- Provide support to the staff so that they are better able to support these young people, including implications of safeguarding protocols and informed decision to disclose.

By March 2020 we will:

- Implement trauma focussed care on a Lancashire wide footprint so that staff are able to meet the needs of traumatised children and young people and their families.
- Develop Paediatric liaison in an acute trusts, for a child/young person with mental health issues.

4. Accountability and Transparency

Across Lancashire, we recognise that current commissioning arrangements are complex. Each CCG commissions services independently from each other with up to eight requests for similar services from each provider. Local authorities contribute to the tier 2/3 CAMHS services however there are currently no formal joint commissioning arrangements in place and therefore a more formalised joint commissioning arrangement through, for example, a Section 75 agreement should be established.

Information on spend is inconsistent with each CCG providing their unique way of allocating funds. Block contracts with providers mean that we are unable to identify what the money has been spent on therefore the real costs are unknown. In the case of transition between adult and children's services the discrepancies between the ages at which children's services come to an end varies depending on where they live.

In real terms (adult mental health spend has increased) the overall spend on children and young people's mental health disorders has fallen over the last six years, the expenditure for England is 6% of the total spend on mental health (DH 2015). In Lancashire this percentage spend varies depending on CCG from 2% to 11%.

There is currently very limited contract monitoring of the main provider for Lancashire CAMHS. It is included within the contract arrangements for all age mental health; however there has been no specific focus on this part of the service and the performance data provided has not been fit for purpose nor is there a mechanism to report the data through the appropriate governance systems.

We need strong leadership across our organisations that support the parity of esteem agenda and recognise that good mental health holds the key to quality of life and should therefore be considered in all service planning, resourcing and training of the front-line workforce. We need services to work together, putting the service user and carer at the centre, to improve the experience and outcome for service users and carers when they may have multiple needs such as mental health and physical health or mental health and substance misuse, or when moving from children's services to adult services.

In order to promote accountability and transparency in Lancashire our ambitions and subsequent actions are:

***Objective 18*: Reduce the complexity of current commissioning arrangements through joint commissioning and service redesign, developing a system that is built around the needs of children, young people and their families**

By March 2016 we will:

- Build on the success of existing joint commissioning arrangements, including Better Care Fund and Transforming Care across Lancashire to

reduce complexity and build a system that is responsive to the needs of children, young people and their families.

- The Lancashire Collaborative Commissioning Board (CCB), with representation from eight CCG's, three Local Authorities and Specialist Commissioning will lead the system change through development and approval of the Transformation Plan. The CCB will ensure where possible and practicable, services are jointly and equitably commissioned on a pan-Lancashire footprint. The CCB's vision of a fully integrated system in place and services that are co-commission in a co-ordinated way to ensure they are provided in an integrated way, around the needs of service users and the families or carers and not the system, to improve quality and reduce inequalities. Providers will expected to work in collaboration with other professionals to ensure care is co-ordinated across organisations, health, local authority and voluntary sector, so that it is seamless and supports delivery of the plan.
- Integrate commissioning approach under the Better Care Fund (virtual-pooled budget) umbrella whilst a more robust system is put into place.
- Support joint commissioning roles within locality footprints to deliver the plan.

By March 2017 we will:

- Formalise the integrated commissioning approach through a detailed Section 75 agreement

Objective 19: We will have clear governance arrangements which hold each partner to account for their role in the system

By March 2016 we will:

- Establish governance arrangements to allow delegated authority to the Children and Young People Emotional Wellbeing and Mental Health Transformation Board for delivery, service transformation and redesign. Members of the transformation board will ensure that consistent engagement with children, young people and their families to inform the plan. Board members will also ensure local area involvement from schools, education establishments and the voluntary sector, see Appendix 7.

- Ensure the Transformation Board, including all providers, will hold each partner to account for delivery of the plan as outlined in the governance section above. Appoint a system leader to lead the delivery of integrated children and young people's emotional wellbeing and mental health services programme as agreed with partners, including the implementation, management and monitoring of agreed programmes to develop systems for partnership and planning and investing in new care models which break down the barriers between organisations and advocating system leadership at a local level.

- Ensure the current level of investment, based on the 2014/15 level of investment by partners is maintained and underpins the ambitions of this transformation plan to develop new capacity in the medium/long term.

March 2017 we will:

- Ensure that investment and/or disinvestment decisions will be based on joint agreement between commissioners on the impact on both the CAMHS service and wider system, and there will be transparency about such decisions.
- Implement a benefits realisation plan for the programme to identify and monitor the impact of prevention and early intervention on both specialist children and young people's services, adult mental health services and social care

Objective 20: Increase transparency through the development of robust metrics on service outcomes

By March 2016 we will:

- Ensure that IT capability is developed in order collect and collate national mental health shared data set in Lancashire.
- Work collaboratively across commissioners and providers to develop a shared performance and outcomes framework for children and young people's emotional and mental wellbeing.
- Ensure the framework will reflect the national mental health shared data set and encompass local outcome measures developed in consultation with key stakeholders, CYP and their families.
- The framework will be informed and build on the learning from our Joint Strategic Needs assessments across BwD, Blackpool and Lancashire.
- Ensure the metrics outlined within the framework will be incorporated into service specifications and information requirements for each provider and monitored through contract management arrangements.

By March 2017 we will:

- Work with the Digital Lancashire strategy programme to ensure IT capability is developed in order to allow records to be shared between providers in Lancashire.
- Ensure an exception report will be provided to the Transformation Board, where performance is off track, with mitigating actions and risks to delivery are escalated where required.
- Support the development and implementation of systems to ensure information about the pathways into and through care and quality data on

service performance and commissioner spend is highly visible, readily accessible and shared across agencies.

- Publish an annual report card on children and young people's emotional wellbeing and mental health, setting out key achievements, areas for improvement and required action
- Require commissioned emotional wellbeing and mental health services to develop and publish quality improvement plans on an annual basis

By March 2020 we will:

- Explore models and feasibility of a single case management system across all providers delivering emotional wellbeing and mental health interventions in Lancashire.
- Develop a single data collection portal to ensure that standardised information is available to inform planning and commissioning of services. This will be made available on the one stop portal for service users and carers to support informed decision on their care and the choices they have.

Objective 21: By working together we will ensure that our increased levels of investment will be used transparently, equitably and demonstrate value for money

By March 2016 we will:

- Undertake a review of how commissioning activity across the CCGs and the Local Authorities can be brought together within a strong strategic framework for a more effective health and social care economy of service providers and commissioners working together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.
- Ensure that investment and/or disinvestment decisions will be based on joint agreement between commissioners on the impact on both the CAMHS service and wider system.
- Undertake a bench marking exercise pan-Lancashire to support the demonstration of good value for money, efficiency and effectiveness compared to similar services.

By March 2017 we will:

- Commission emotional wellbeing and mental health services for the children and young people of Lancashire in accordance with the needs of the population as articulated in our Joint Strategic Needs Assessments.
- Ensure continuous improvement in the quality of services to be achieved whilst achieving financial balance within a challenging economic climate.

- Utilise evidence based approaches and working collaboratively with service users, carers, providers and commissioners on joint commissioning to maximise quality and efficiency and minimise risks to service users and carers.
- Publish an annual local plan for children and young people's emotional wellbeing and mental health, linked to a wider whole population mental health strategy which recognises the clear links between the mental health of family members and the impact in particular on children and young people where their carers have poor mental health.

Objective 22: Our service offer will be designed with children, young people and families and will be responsive to needs as opposed to service structures

By March 2016 we will:

- Further developed in consultation with parents and young people which will be an integral part of the development and implementation of the strategy going forward.
- Building on our learning and engagement with children and young people we will strengthen the support and role that is available to service users and carers who become involved in planning and monitoring of mental health services including a process of induction and training as well as ongoing support.
- Improve capacity of service users, carers and families to take part in local and regional involvement, service improvement work, self-help support and service provision by effectively supporting involvement within our commissioning practice.

By March 2017 we will:

- Work in partnership with service users and carers on their ideas for different approaches to widen involvement
- Ensure that representation for carers in commissioning is supported to represent mental health issues adequately
- Ensure that service user and carer feedback and involvement in delivering and developing services will be mandatory
- Develop a culture of sharing learning of good practice across Lancashire through developing pilots and testing new service provision models ensuring that children and young people and their cares are involved in the measurement of outcomes and the evaluation of these programmes.

By March 2020 we will:

- Ensure that people will be communicated with using formats and means appropriate to their individual requirements e.g. service user led website and carers on-line forums
- Ensure that carers can gain access to their own needs assessment within a primary care, generic or mental health setting and are supported so that their role is valued in the creation of care plans

5. Developing the Workforce

The national vision is for everyone who works with children, young people and their families to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them;
- excellent in their practice and able to deliver the best evidenced care;
- committed to partnership and integrated working with children, young people, families and their fellow professionals;
- respected and valued as professionals

Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions.

Anybody who works with children and young people in universal settings such as early years provision, schools, colleges, voluntary bodies and youth services, should have training in children and young people's development and behaviours, as appropriate to their professional role.

MindEd[23] is a useful resource for promoting this level of awareness in all staff who work with children and young people.

The current workforce employed by local provider partners delivering children and young people's mental health services for the period April 2014 to March 2015, Appendix 4, will be used to undertake a gap analysis around the capacity and skills required which will aid local decision making

As identified previously, Lancashire has a highly skilled and diverse workforce that can offer a range of evidence based interventions, right across the pathway. All but one service in Lancashire is part of the CYP IAPT programme. The involvement supports the development of a skilled workforce. There are difficulties in the ability to provide backfill in order to release staff for training. This issue will need a Lancashire-wide response, as it presents a real opportunity to up-skill the CAMHS workforce.

This transformation plan is based on growth and change. The success of implementation and associated investment will, potentially, be hindered across Lancashire by difficulties in recruitment and retaining appropriately trained staff. These concerns will cut across all sectors of the children's workforce and therefore we will need to:

- Identify and use creative means to recruit and people in the workforce
- Facilitate new ways of working across professional boundaries

[23] https://www.minded.org.uk/

- Enhance existing roles and create new roles tapping into new recruitment pool and so complementing existing staff groups

There is, therefore, a real need for a comprehensive workforce strategy in order to ensure that there are enough skilled staff to meet the mental health needs of children and young people.

In order to promote workforce development in Lancashire our ambitions and subsequent actions are:

***Objective 23*: Work with partners across all sectors to ensure that there is an appropriately resourced, skilled and trained workforce who feel confident in their ability to support the emotional health and wellbeing needs of our children and young people and their families**

By March 2016 we will:

- Work with service providers who deliver specific emotional wellbeing and mental health interventions to undertake an audit of staff numbers, skills, competencies and training building on the returns as part of this planning process.
- Utilise local workforce modelling undertake a gap analysis to identify workforce numbers requirements, succession planning, skills and training needs.
- Ensure clear organisational commitment, resources and time for continuing professional development and training.

By March 2017 we will:

- Establish and agree the key principles for those planning/commissioning services in addition to providers and partner agencies about the workforce and resources required to meet the needs of a population of children and young people to support the development a workforce strategy and plan for Lancashire.
- Enhance existing roles and create new roles to tap into a new recruitment pool and complement existing staff groups.
- Build on training programmes that are currently available in Lancashire to enable continuous professional development of all staff.
- Develop Education and Training plan based on needs analysis which will be updated annually.
- Develop programmes of work with our health education partners, including Health Education NW Higher Education Institutions, CYP IAPT, Local Health Education and Training Boards, NHS England and colleagues across the region, to consider what is required for workforce to address the identified gaps.

- Ensure the roles and responsibilities of each member of the multi-disciplinary team are made explicit.
- Develop a dashboard to allow ongoing review of staffing numbers and competencies and highlights any staff development training/skills deficits.

By March 2020 we will:

- Identify and use creative means to recruit and retain people in the workforce in order to increase the overall numbers in successive years.
- Young people and/or their parents/carers are involved in and their views taken into account in the recruitment and appointment
- Facilitate ways of working within services and across professional boundaries making best use of specialist staff group to meet the needs of children, young people and families.

Appendix 1 Children and Young People Population Profile

	Blackburn with Darwen	Blackpool	Lancashire	Grand Total
Children aged 2 to 5 with a mental health disorder	1,740	1,305	11,025	14,070
Children/young people aged 5 to 16 with a conduct disorder	1,590	1,190	9,120	11,900
Children/young people aged 5 to 16 with a mental health disorder	2,560	1,920	15,030	19,510
Children/young people aged 5 to 16 with and emotional disorder	985	745	5,795	7,525
Number of children/young people who may experience mental health problems appropriate to a response from CAMHS Tier 1	5,740	4,325	36,715	46,780
Number of children/young people who may experience mental health problems appropriate to a response from CAMHS Tier 2	2,680	2,020	17,135	21,835
Number of children/young people who may experience mental health problems appropriate to a response from CAMHS Tier 3	710	535	4,530	5,775
Number of children/young people who may experience mental health problems appropriate to a response from CAMHS Tier 4	30	25	185	240
Grand Total	**16,035**	**12,065**	**99,535**	**127,635**

Appendix 2: Mental health needs of children and young people in Lancashire CCGs

Childrens Mental and Emotional Health nee

CAMHS_Review Report_April 2015 v3

Appendix 3: Level of Investment from Partners

Partner Organisation	Description	2014/15 Spend(£)	Additional Information
Blackpool CCG	CAMHS Specialist Services	£1,639,466	
	Chid Psychology	£338,478	
	Early intervention service	£714,770	Not split between Children and Adults
	Healthy Child Programme	£158,664	
	Paediatric therapy service	£47,471	
	Youth Offending Team	£4,176	
Blackpool Unitary Authority	WISH Team	£198,900	
	The Hub	£247,700	
	Targeted youth support	£137,000	
	Headstart delivery	£750,000	Pilot
	Emotional wellbeing in schools	£112,000	
	Behavioural advisory teachers	£157,000	
	Educational psychology team	£353,000	
Specalised Commissioning	Eating Disorders	£35,685	
	PICU	£22,275	
	MSU	£13,871	
	Acute admissions	£413,349	
Lancashire MIND	Headstart	£35,000	Contribution to Pilot
Blackpool Total		£5,511,805	
Blacburn with Darwen CCG	LCFT Child Psychology	£246,528	
	ELCAS – ELHT	£1,039,702	
Blackburn with Darwen Unitary Authority			
Specialised Commissioning	Eating Disorders	£70,785	
	Childrens	£105,930	
	PICU	£286,902	
	Acute admissions	£141,792	

Blackburn with Darwen Total		£1,891,639	
East Lancashire CCG	Youth Offending Team	£139,411	
	ELHT - ELCAS	£2,445,960	
	ELHT - ELCAS	£115,579	CAMHS OT
	ADHD Northwest	£30,408	1:1 support for families
	Brook	£20,000	Counselling Service
	Place2be	£20,000	Counselling Services based in Schools
	Barnados	£60,000	Young Carers Support
	LCFT	£821,238	Clinical Psychology Services
Specialised Commissioning	Eating Disorders	£56,745	
	Childrens	£54,035	
	PICU	£153,252	
	Acute admissions	505767	
	Mother and Baby	23188	
East Lancashire Total		£4,445,583	
Greater Preston & Chorley, South Ribble CCGs	Youth Offending Team	£70,269	
	CAMHS Community	£2,151,530	
	Child Psychology	£210,861	
	Autism Diagnostic Services	£46,604	Spot purchase
Specialised Commissioning	Eating Disorders	£506,025	
	PICU	£380,457	
	Acute admissions	£839,991	
	Low secure	£152,520	Greater Preston CCG
	Mother and Baby	£14,229	Greater Preston CCG
Greater Preston & Chorley, South Ribble Total		£4,372,486	
Fylde and Wyre CCG	Youth Offending Team	£30,784	
	CAMHS	£680,888	

	Early Intervention in Psychosis	£447,184	
	Child Psychology	£233,845	
	Butterfly and Phoenix Projects with Ncompass	£29,340	
	ACE young people's participation and peer support	£12,213	
Specialised Commissioning	Childrens	£94,160	
	PICU	£31,185	
	Acute admissions	£155,718	
	Mother and Baby	£3,162	
Fylde and Wyre Total		£1,718,479	
Lancashire North CCG	CAMH's services	£331,198	
	Child Psychology	£266,130	
	PMH	£6,807	
	ACE (CYP engagement and peer support)	£6,000	
	YOT	£52,231	
	IAPT (16 – 18yr olds, 4% of total)	£39,572	
	IPA cases (may incl LD cases)	£68,602	
Specialised Commissioning	Eating Disorders	£53,820	
	PICU	£162,162	
	Acute admissions	£472,218	
	Mother and Baby	£24,769	
Lancashire North Total		£1,483,509	
West Lancashire CCG	Youth Offending Team	£21,036	
	Child Psychology	£139,732	
	CAMHS community	£722,816	
	Early Intervention in Psychosis	£381,633	Age 14 to 35
Specialised Commissioning	Eating Disorders	£62,010	

	Childrens	£68,480	
	PICU	£22,275	
	Low secure	£299,300	
	Acute admissions	£54,438	
West Lancashire Total		£1,771,720	
Lancashire County Council	SCAYT+	£388,200	
	CAMHS (LCFT and ELTH)	£1,114,000	
	Targeted Youth Support	£202,195	
	Early Support	£157,180	Funded by the Schools Forum
	Emotional Wellbeing in Schools	£30,000	
	Healthy Child Programme		
	East Lancashire EHWB Service	£440,000	
	Workforce training - ASSIST - SafeTalk	£30,000	Available to adult and CYP Workforce
	CYP Workforce training -Self Harm	£72,000	
	Education Psychology Team	£1,650,000	
Lancashire County Council Total		£4,083,575	
Grand Total		£25,278,796	

Appendix 4: Service Providers Staffing and Activity Levels

Provider Organisation	Number of Staff (WTE)	Roles and Competencies
Blackpool Teaching Hospitals Foundation Trust	5.94	Medical
	2.80	Family Therapist
	6.80	CBT (CYIAPT)
	3.00	Parenting (CYIAPT)
	8.20	Practitioner nurse
	0.80	Practitioner OT
	6.61	Practitioner SW
	3.90	Practitioner YOT
	2.78	Play/Art Therapist
	4.50	Practitioner ADHD
	4.60	Team Leader
	2.85	Paediatric Liaison
	1.00	Transition worker
	1.00	IPT Therapist
	0.20	Dietician
	2.40	Consultant Psychologist
	4.30	Principle Psychologist
	3.60	Senior Psychologist
	7.90	Clinical Psychologist
East Lancashire Hospitals Trust	10.60	Admin
	4.00	Child Psychiatrist
	2.25	Clinical Psychology
	1.00	Clinical Service Lead
	18.20	Mental Health Nurses (including YOT)
	9.20	Mental Health Practitioners
	2.60	Mental Health Support Practitioners
	2.00	NCG Specialty Doctor
	2.40	Occupational Therapists
	0.80	Senior Nurse
	5.60	Specialist Therapists
	4.00	Team Co-ordinators/Senior Practitioners
Lancashire Care Foundation Trust	3.00	Parenting (CYIAPT)
	8.20	Practitioner nurse
	0.80	Practitioner OT
	6.61	Practitioner SW

	3.90	Practitioner YOT
	2.78	Play/Art Therapist
	4.50	Practitioner ADHD
	4.60	Team Leader
	2.85	Paediatric Liaison
	1.00	Transition worker
	1.00	IPT Therapist
	0.20	Dietician
	4.80	Consultant Psychologist
	8.60	Principle Psychologist
	7.20	Senior Psychologist
	15.80	Clinical Psychologist

Local Authority Partner	Number of Staff (WTE, non-teaching)	Number of Staff (WTE, specialist CAMHS/PMHW)
Blackpool Unitary Authority	21	30/10
Blackburn with Darwen Unitary Authority	25	28/7
Lancashire County Council	180	240/60

a) Activity by Provider Organisation 2014/15

Provider	Number of referrals	Number Accepted	% Accepted	Average Waiting Time
Blackpool Teaching Hospitals Foundation Trust	1257	1059	84%	Three weeks
East Lancashire Hospitals Trust	2264	1500	66%	Three weeks
Lancashire Care Foundation Trust	5668	4324	76%	Fourteen weeks

b) Specialised Commissioning Admissions and Occupied Bed Days 2014/15 (Number of Admissions/Occupied Bed Days)

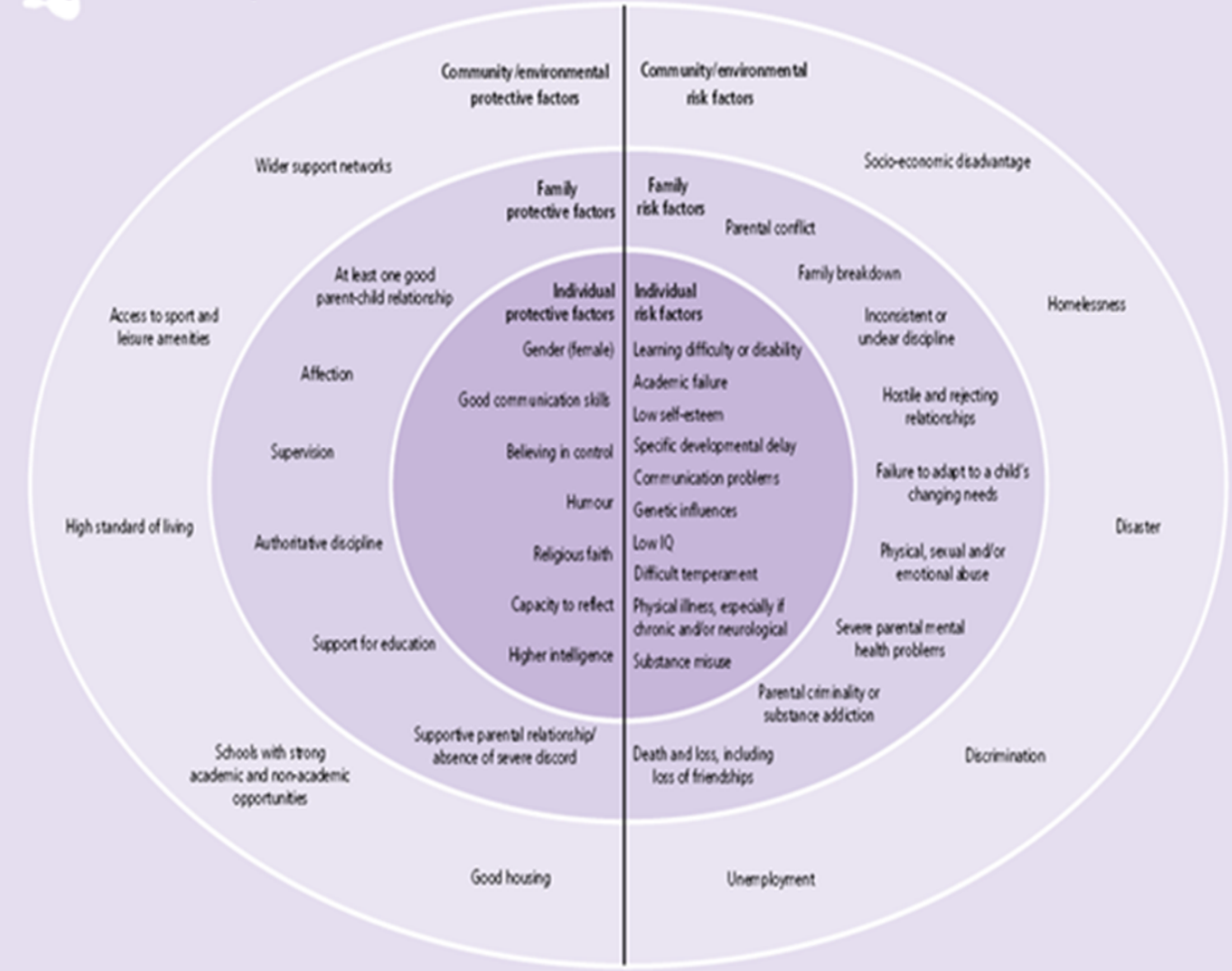
Specialism	NHS Blackburn with Darwen CCG	NHS Blackpool CCG	NHS Chorley & South Ribble CCG	NHS East Lancashire CCG	NHS Greater Preston CCG	NHS Lancashire North CCG	NHS West Lancashire CCG	NHS Fylde & Wyre CCG
Eating Disorders	1/121	1/61	2/408	1/97	2/457	1/92	1/106	
Children's	2/198			2/101		1/128	1/176	
PICU		1/25	1/18	2/172	3/409	3/182	1/25	1/35
MSU		1/13						
Low Secure								
Acute Admissions	6/224	10/653	11/533	17/799	11/794	13/746	2/86	6/246
Mother and Baby				1/44	1/27	1/47		1/6
LD Secure								

Appendix 5: Four Cornerstones Model and Risk Protective Factors

Individual Resilience	Outlook	Good cognitive abilities such as problem solving and executive functions, good emotional and behavioural regulation strategies, positive view of self, positive view on life, sense of meaning/purpose
	Social Capital	Ability to form and maintain positive peer relationships, positive and adaptable
	Wellbeing	Values and maintains mental wellbeing, e.g. five ways to wellbeing
Family resilience	Parenting	Positive and appropriate parenting style and practices. Responsive to changing needs. Good physical and mental health of parents. Parents involved in young person's education Positive expectations for education and attainment. Post-secondary education of parents. Support from none –parental adults
	Relationships	Harmonious inter-parental relationships. Positive sibling relationships. Supportive connections with extended family member's Positive attachments warmth and affectionate. Able to resolve relationship difficulties and conflict appropriately. Faith and religious affiliations
	Environment	Supportive and positive family climate. Stable and safe home environment. Social Economic advantages. Appropriate housing and standard of living meeting the needs of the family
School Resilience	Relationships	Fosters high quality relationships with parents and carers. Promotes a sense of belongingness and participation. Facilitates high-quality staff-pupil interactions to promote resilience and resilient responses. Encourages staff to fine-tune responses to individuals according to their emotional state and current life situation. Encourages positive interactions between YP. Encourages mutual, supportive collaborative relationships between staff. Provides specialised social/pastoral support mechanisms. Adopts a problem-solving orientation across school.
	Achievement	Good academic provision, Social & Emotional Learning (SEL), Robust PSHE offer. Reflects back evidence of multi-dimensional achievement. Provides a range of extra-curricular opportunities. Actively promotes regular attendance.
	Autonomy	Encourages the active involvement of YP in school life. Encourages the active involvement of CYP in their own learning. Encourages a 'growth mindset' via school ethos and classroom orientations. Teaches and encourages independence skills. Person Centered

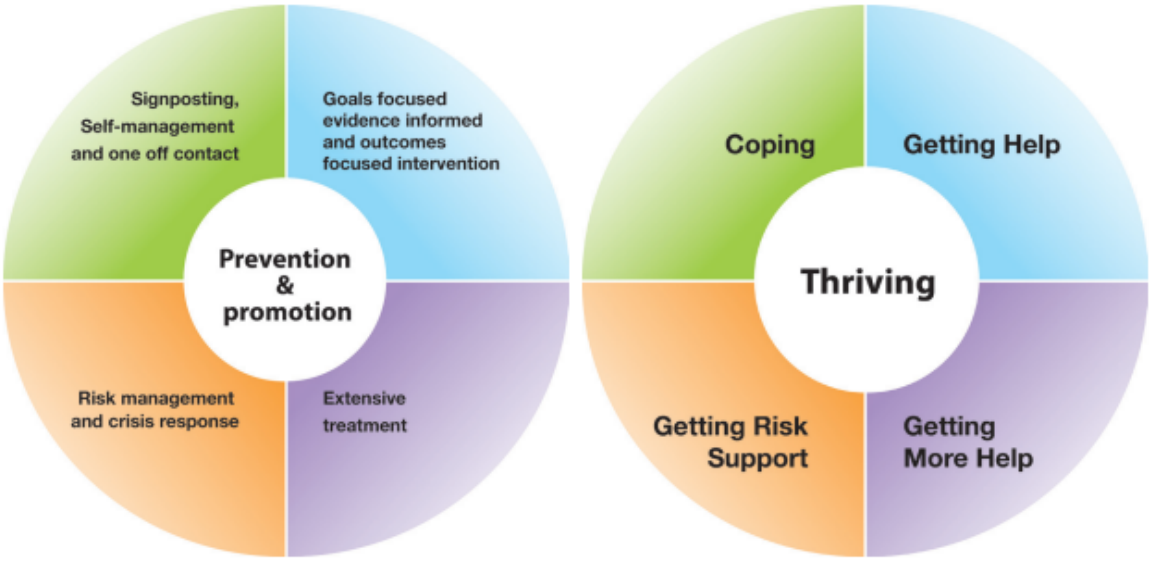
		Planning is regularly employed in school in the SEND department and others
	Encouragement	Develops and promotes policies in the area of Emotional Health and Well-Being: communicates vision/mission/priorities/expectations. Promotes an Inclusive environment. Seeks to create a welcoming environment. Physical buildings are accessible to all. Students take care of the fabric of the school. Operates a structured and positive behaviour management system. Contributes to creating a positive neighbourhood environment. Adopts positive communication practices.
	Safety	Seeks to create a sense of social and physical well-being. Actively resolves issues of bullying according to the anti-bullying policy. Seeks to work towards the creation of physical structures which support positive interaction. High quality conflict resolution.
Community	High Neighbourhood quality	Safe neighbourhood. Low level of community violence. Affordable housing Access to recreational centres. Clean air and water. Employment opportunities for parents and teenagers
	Cultural/societal	Protective child policies (Child labour, child health, and welfare). Value and resources directed at education. Prevention of and protection from oppression or political violence. Low acceptance of physical violence
	Relationships	Connections to caring adult mentors and prosocial peers
	Safety	Good public health care Access to emergency services police fire medical

Figure 1: Risk and protective factors



Sources: Audit Commission, 1999 and Mental Health Foundation, 1999[19]

THRIVE model



Appendix 6 Consultation Events

Activity	Focus of activity	Protected Group	Geographical area	Date	Additional information
Presentation at Lancashire Mental Health Insight Network	Crisis Care Concordat		Lancashire	10/07/2015	Lancashire Mental Health Insight Network - a consortium of over 50 charity and not for profit agencies from across the county who are involved in providing mental health support.
Presentation at Lancashire Mental Health Insight Network	Patient choice		Lancashire	10/07/2015	As above
Workshop to obtain the perspective of people working with children and young people	Crisis Care Concordat		Lancashire	22/07/2015	Workshop took place at the CSU and attendees were representatives from a variety of services and organisations who could come into contact with at some stage of a mental health crisis
Workshop to obtain the views of the Preston Learning Disability Forum	Crisis Care Concordat	Disability	Central	03/09/2015	Contact: Rosemary Trustam - Volunteer co-ordinator rosemarytrustam@btinternet.com 01257 270430
Focus group to obtain the views of The Crew (a service development group made up of young people who have used the Tier 4 services and the parents of young people who have used the services).)	Crisis Care Concordat	Age	Lancashire	07/09/2015	The Crew, The Platform, Royal Preston Hospital Contact: Ian Voyle Ian.Voyle@lancashirecare.nhs.uk 01524 550360

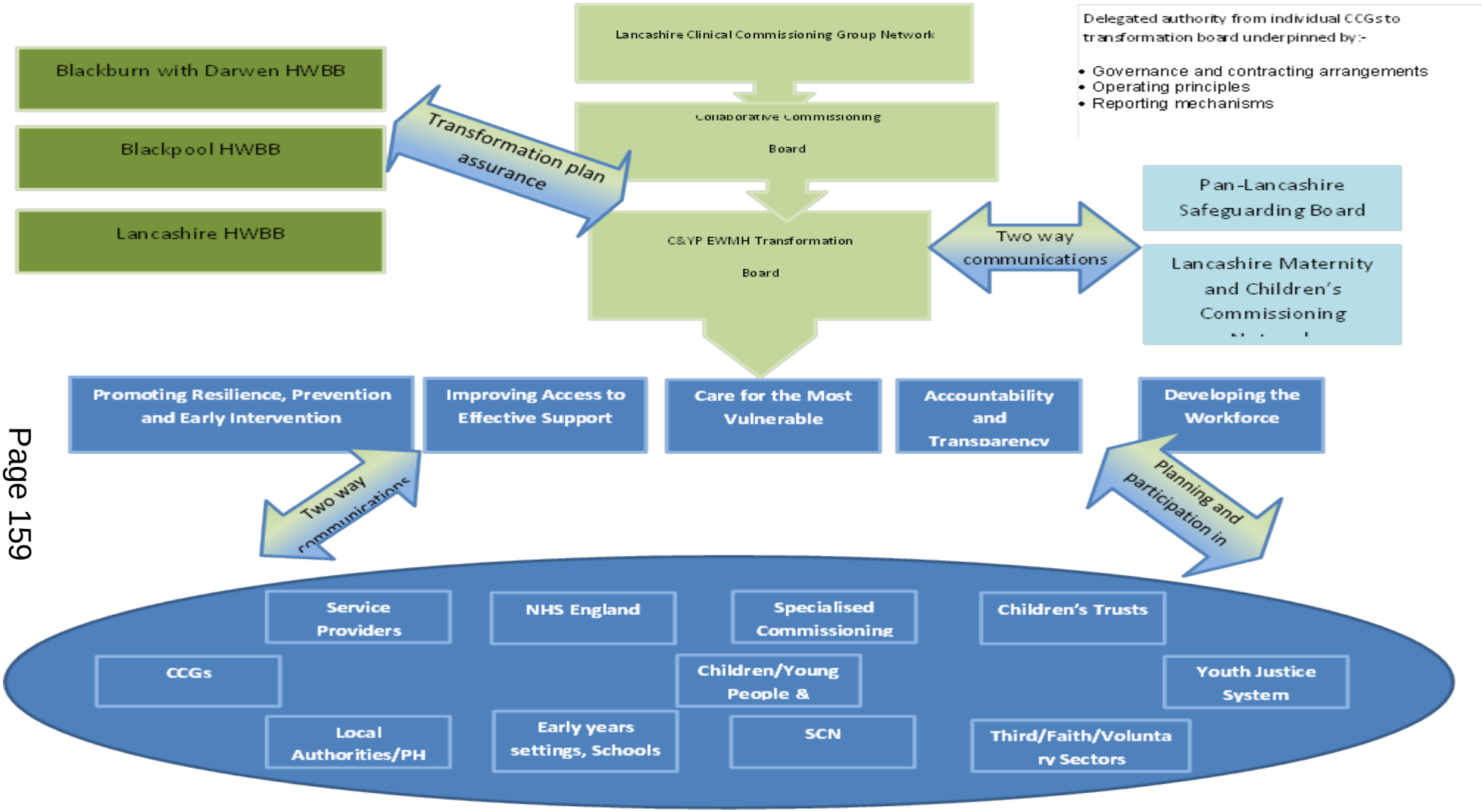
Focus group to obtain the views of The Crew (a service development group made up of young people who have used the Tier 4 services and the parents of young people who have used the services).	Local Transformation Plan	Age	Lancashire	07/09/2015	As above
Engagement activity to obtain the views of transgender people	Crisis Care Concordat	Transgender	Blackpool	22/09/2015	Renaissance group Contact: Lynda Collins renaissance2@blueyonder.co.uk 01253 314747
Obtaining patient story around experiences of supporting someone with learning disabilities and mental health condition	Crisis Care Concordat	Disability	Central	25/09/2015	Via Jo Adshead at Linkability j.adshead@linkability.org.uk 01257 241899
Workshop to obtain the views of the Lancashire Parent and Carer Forum	Crisis Care Concordat		Lancashire	29/09/2015	Forum focuses on the particular concerns and issues affecting parent carers, who provide unpaid care for children up to 25 years with a disability or additional need. Contact: Sue Titterington - Chair suseet@aol.com 07712 621237
Workshop to obtain the views of the Lancashire Parent and Carer Forum	Local Transformation Plan		Lancashire	29/09/2015	As above
Meeting to plan streams and themes of discussion for engagement with	Crisis Care Concordat	Ethnicity	Blackburn	01/10/2015	Three focus groups are going to take place during October and November - one for Asian women, one for Asian middle aged men and one for Asian youth.

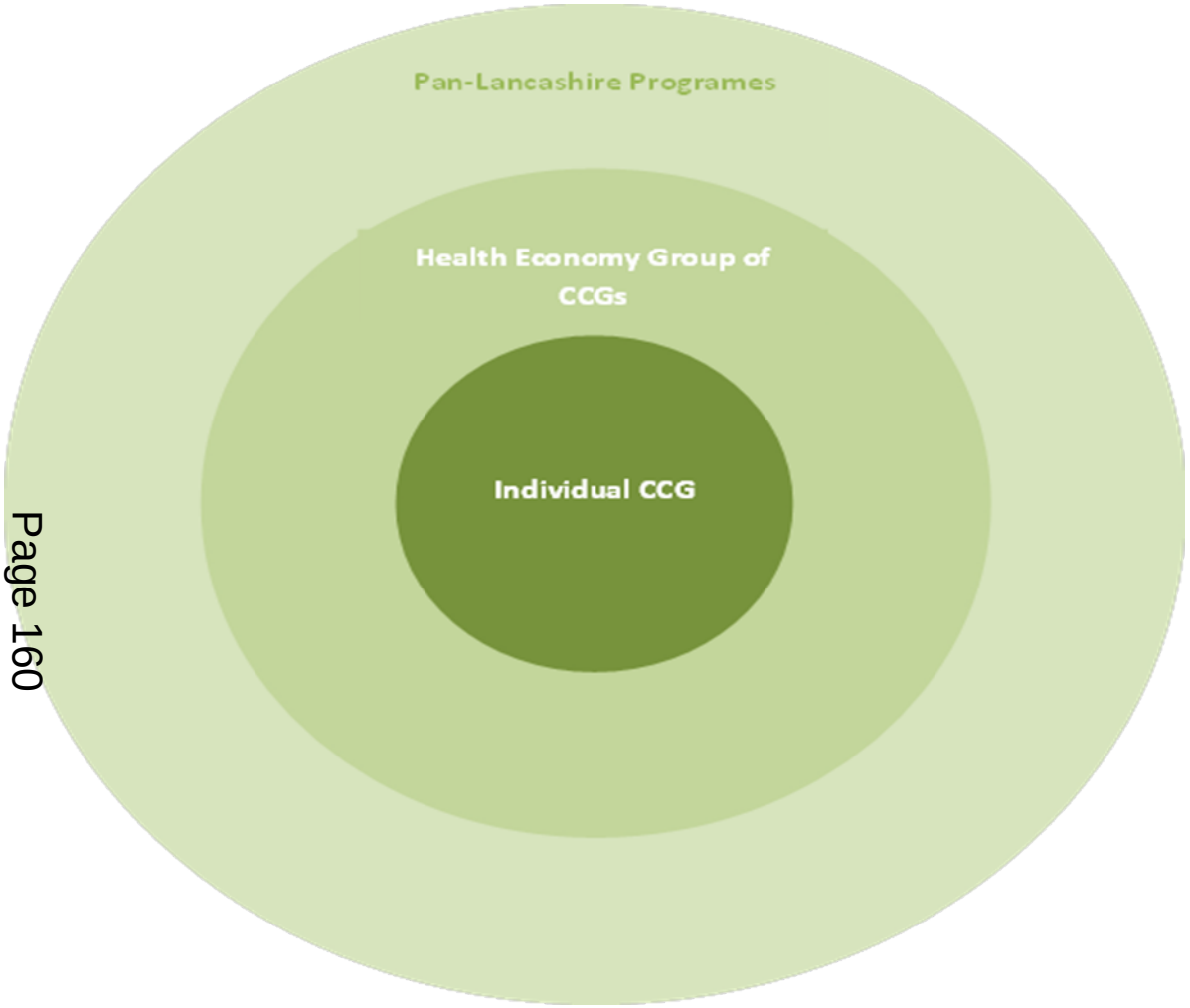
BME community					The focus groups' aims are to find out what participants understand by the term "mental health", where would they look for more information e.g. internet, friends/family, GP etc, and what do they know about the services available. The findings will be available in January 2016. Contact: Jal Iqbal - Community Development Blackburn with Darwen Community Restart Team T: 01254 226367 M: 07791045560 E: jal.iqbal@bwdssd.nhs.uk
Meeting to plan streams and themes of discussion for engagement with BME community	Crisis Care Concordat	Age	Blackburn	01/10/2015	As above
Meeting to plan streams and themes of discussion for engagement with BME community	Crisis Care Concordat	Gender	Blackburn	01/10/2015	As above
Meeting to plan streams and themes of discussion for engagement with BME community	Local Transformation Plan	Ethnicity	Blackburn	01/10/2015	As above
Meeting to plan streams and themes of discussion for engagement with BME community	Local Transformation Plan	Age	Blackburn	01/10/2015	As above

Meeting to plan streams and themes of discussion for engagement with BME community	Local Transformation Plan	Gender	Blackburn	01/10/2015	As above
Workshop with Lancashire LGBT to obtain views of representatives from different LGBT support groups	Crisis Care Concordat	LGBT	Lancashire	16/10/2015	Contact: Dr Lewis Turner - Project Manager Lancashire LGBT Tel: 01772 717461 Mobile: 07788294993 Email: Lewist@lancslgbt.org.uk
Workshop with Lancashire LGBT to obtain views of representatives from different LGBT support groups	Local Transformation Plan	LGBT	Lancashire	16/10/2015	As above
Meeting with PULSE - Healthwatch's young people's group	Crisis Care Concordat	Age	Lancashire	19/11/2015	Contact: Sheralee Birchall-Turner, Volunteers & Project Officer Manager Healthwatch Lancashire Tel: 01524 239108 Mob: 07809 309275 sheralee.turner-birchall@healthwatchlancashire.co.uk
Meeting with PULSE - Healthwatch's young people's group	Local Transformation Plan	Age	Lancashire	19/11/2015	As above
Discussing options for engagement with Lancashire BME Network	Crisis Care Concordat	Ethnicity		TBA	Information regarding current pieces of work and request for involvement has been shared with stakeholders and service users via their newsletter on 18/09/15 Contact: Nathan Isom Lancashire BME Network, Accrington Tel: 01254 392974

					nathan.isom@lancashirebmenetwork.org.uk
Discussing options for engagement with Lancashire BME Network	Local Transformation Plan	Ethnicity		TBA	As above
Discussing options for engagement with Asian ladies' group	Crisis Care Concordat	Ethnicity	East	TBA	Contact: Nazya Khalid - Development Officer, LCC nazya.khalid@lancashire.gov.uk 07876 844338
Workshop to share information and priorities across a wide group of local partners working with CYP	CYP Emotional Health and Wellbeing		West Lancashire	18/03/2015	
Workshop to map local services and identify gaps in provision	CYP Emotional Health and Wellbeing		West Lancashire	29/04/2015	
Workshop to develop local mapping and understand referral routes	CYP Emotional Health and Wellbeing		West Lancashire	20/05/2015	
Workshop to update partners on wider Transformation and Joint Commissioning Strategy agendas	Transformation Plans		West Lancashire	01/07/2015	

Appendix 7: Governance Framework




Pan-Lancashire Programes
Health Economy Group of CCGs
Individual CCG

	March 2016	March 2107	March 2020
Objective 1: To build resilient communities in all settings including home, school and wider community which promote, improve and maintain the emotional health, mental health and wellbeing of children, young people and their families, to encourage them to help themselves.	• Develop resilience training programmes in order to roll out to all people working and/or engaging with children and young people across the following • Birth (including pregnancy) to 25 years old • Schools, colleges and universities • Universal & Community settings including maternity, early years, primary care, youth work • Including all staff from football coaches to health visitors to teachers to school nurses • Mechanism for delivering the training to be developed • Identification of all people working with children and young people who will receive resilience training. • We will engage children and young people in the development of a resilience campaign targeted at children and young people themselves. • Learning from the universal resilience based programme being piloted in Blackpool • Explore and identify opportunities for engaging family members in the resilience movement promoting family assets • Identify existing points where data is already collected about children's emotional health and wellbeing. • Collect samples of this data and use to develop a consistent approach going forward. • Explore the possibilities of establishing a provider forum including third sector, health and social care of those working around children and young people's emotional health and wellbeing.	• Use the evidence base from Headstart in Blackpool in order to target schools in Lancashire to deliver universal resilience programmes. • Develop the training for the family • Roll out of training to the highest priority groups • Launch the resilience campaign for children and young people Pan-Lancashire • Use identified data to inform a baseline of all children and young people's emotional health and wellbeing in Lancashire	• Ensure that children, young people and their families are able to deal with their problems • Ensure that schools and the wider community are able to support each other and children and young people to become resilient.
Objective 2: Improve access to evidenced-based interventions which support attachment between parent and child, to build resilience, improve behaviour and avoid	• Identify which evidence-based interventions which support attachment between parent and child are appropriate and meet the need relevant to each CCG area • Learn from existing programmes of work	• Ensure commissioned services utilise evidence-based interventions identified which support parenting. Align the Lancashire and Blackburn parenting strategies and BetterStart Blackpool to develop	• Implement the pan-Lancashire parenting strategy • Ensure service delivery is aligned to pan-Lancashire parenting strategy

early trauma	improving life chances of children aged 0-3 years old across Lancashire including BetterStart Blackpool and Family Nurse Partnership	and embed a comprehensive parenting approach Lancashire	
Objective 3: Improve public awareness and understanding of children and young people's mental health and wellbeing as well as perinatal mental health and work to reduce stigma and discrimination.	• Engage children and young people to develop pan Lancashire awareness raising campaign, with an emphasis on addressing stigma, aimed at the entire population of Lancashire • Develop and implement a communication strategy including the development of a single brand for emotional health and wellbeing services across Lancashire in partnership with children and young people	• Implement the Lancashire awareness raising campaign, with an emphasis on addressing stigma, aimed at the entire population of Lancashire	
Objective 4: Improve the availability of information regarding self-help and support that is available and how to access it.	• Scope mechanisms of self-help including peer support that is available for children and young people in relation to emotional health and wellbeing • Scope mechanisms of self-help including peer support that is available for parents/carers in relation to their resilience and emotional health and wellbeing • Promote the existing telephone helpline's throughout Lancashire	• Utilise the learning of the Wellbeing Challenge (peer support programme) and develop a model to roll out across Lancashire • Develop pathways which ensure that parents/carers are equipped, feel confident in their ability and are supported to nurture the good emotional health and wellbeing of their children • Ensure all commissioners and providers of universal services, including primary care, deliver mental health promotion and prevention activities on a whole system basis.	
Objective 5: Improve early identification and timely intervention for children and young people at risk off and or experiencing poor mental health	• Ensure that clear policies procedures and guidance are in place for the CYP workforce which improve early identification • Develop guidance for schools to ensure that the provision of school counselling is consistent across Lancashire. • Develop a pan-Lancashire system process for providing named CAMHs contacts for schools. • Building on the learning from TAHMS develop the role of primary mental health workers across Lancashire • Explore methodology of routine enquiry into adverse childhood experiences	• Begin implementation of the methodology of routine enquiry into adverse childhood experiences • Promote the pan–Lancashire pathway to all children and young people's settings, primary/secondary care networks and ensure it is embedded in all services in contact with children and young people • Monitor the effectiveness of the pathway.	

	• Ensure a consistent continuous assessment process across pan-Lancashire including appropriate use of lead professional		
Objective 6: Ensure ease of access to support based on the needs of children, young people and their families, through coordinated care in the most appropriate place	• Develop a Lancashire system process for providing named CAMHs contacts for all CYP settings working with young people at risk of experiencing poor mental health • Develop training across workforce to ensure early identification and low level brief interventions for all people working and/or engaging with children and young people across the following ○ Birth (including pregnancy) to 25 years old ○ Schools, colleges and universities ○ Universal & Community settings including maternity, early years settings including children's centres, primary care, youth work ○ Including all staff from football coaches to health visitors to teachers to school nurses	• Roll out of training to the highest priority groups • Monitor the effectiveness of the pathway.	
Objective 7: Improve early identification and timely intervention for pregnant women and new parents at risk of and or experiencing poor mental health	• In partnership with the Strategic Clinical Network, benchmark the current peri-natal mental health services provision across Lancashire. • Develop commissioning intentions for peri-natal mental health services in line with the forthcoming commissioning guidance for peri-natal mental health. • Ensure that clear policies procedures and guidance are in place for the workforce appropriate for pregnant women and new parents which improve early identification. • Develop training across workforce to ensure early identification and low level brief interventions for all people working and/or engaging with pregnant women and new parents. • Developing a Lancashire pathway describing each service and routes of access as part of the single point of access.	• Roll out of training to the highest priority groups • Promote the Lancashire pathway settings engaging with pregnant women and new parents • Monitor the effectiveness of the pathway.	

Objective 8: Locally adopt and adapt the Thrive model as a conceptual framework for our collective response to improving the emotional health and wellbeing of children and young people.	• Benchmark current provision against the model, including understanding the drivers for the numbers of DNA's and inappropriate referrals and use this to inform our needs-based model for structuring services • Develop a performance management and quality improvement dashboard against the model.	• Promote our model widely • Strengthen our model through further understanding of children and young people's needs and the building evidence base through IAPT	• Have an equitable evidence based response across the model and Lancashire • Be able to clearly demonstrate how children and young people's outcomes have improved.
Objective 9: Use the technology available we will develop and promote widely a pan Lancashire online one stop portal which will include self- help materials in addition to clear information on the support available across Lancashire.	• Commission a digital solution provider to develop an appropriate digital platform in which children and young people and parents can access information regarding self-help and support • Map current online resources locally and nationally to ensure existing best practice is utilised e.g. MindEd e-portal	• Provide an online single point of access for children and young people, parents and carers and professionals, designed by young people and incorporating online referral. • Ensure a robust communication strategy and a 'brand' for all services	• Develop a range of digital therapies accessed through the portal. • Children, young people, parents, carers and professionals across Lancashire will know the support available and how to access it.
Objective 10: Create a single point of access into all services providing interventions to improve emotional health and wellbeing. This will include consultation as well as direct delivery.	• Develop local networks of emotional wellbeing and mental health champions and practitioners across all services to develop practice and increase professional trust. • Improve relationships between schools and emotional wellbeing and mental health services by naming leads in those organisations.	• Expand our local single points of access for specialist services to include voluntary sector provision and counselling. • Develop a single assessment process • Develop a robust consultation model for professionals to seek advice and support in order to be able to support children and young people.	• Have explored 'one stop shop' models for children and young people, learning form national and local good practice, where there is access to help and support from a multi-disciplinary team in a setting which is welcoming to children and young people.
Objective 11: Ensure transitions from children's services will be based on the needs of the young person rather than their age.	• Include adult services in our performance monitoring framework so that activity and outcomes for young people is understood.	• Have reviewed all (all age) emotional wellbeing and mental health commissioned services and included specific outcomes measures for children and young people. • Have built on the learning from our previous CQUIN to ensure the mental health workforce delivering all age or adult services has the skills and expertise to work with young people. • Have a 0-19 CAMHS service model in place.	• Have developed a clearly defined offer of local provision for 0-25s available on the pan-Lancashire single point of access portal.
Objective 12: Ensure children, young people and families will have timely access to an evidence based community eating disorder service.	• Increase geographical coverage of CYP IAPT to 75 % • Extend the current breadth and depth within current partnerships across pathway to include 3rd sector and Schools. • Establish the baseline for availability and choice of evidence based interventions across Lancashire and develop a future training plan. • Secured appropriate training places, support and funding for backfill of posts	• Have increased geographical coverage of CYP IAPT to 100% • Further increased the provision of availability of evidenced based interventions. • Developed a pan-Lancashire training plan to detail the local requirements for training to work towards sufficient coverage of all evidenced based interventions across Lancashire	• Have routine outcomes measures embedded across the whole partnership • Have secured the full range of evidenced based provision equitably across Lancashire.

	• Ensure the implementation of routine outcome monitoring and feedback to guide treatment and future service design • Work collaboratively with children and young people, their parents and/or carers. • Ensure appropriate investment in mobile technologies and ensure appropriate information governance arrangements are included in the amendment of trust protocols to allow clinical information to be stored, encrypted and transported.		
Objective 13: Improve access to evidenced-based care and support designed in partnership with children and, young people and their families, treating them as individuals, taking into account both their physical and mental health needs.	• Jointly fund a robust eating disorder needs assessment incorporating the views of children young people and families to further build on findings from the initial workshop. • Complete mapping of current practice and service provision against the recommendations identified in the stakeholder workshop and commissioning guidance. • Improve early detection of eating disorders by increasing awareness in the general population and universal frontline professionals through a targeted promotions campaign. • Develop and agree joint service development plans for 16/17 with our current services, to address recommendations. • Secure commissioning and procurement support to lead the service design and procurement	• We will have procured a co designed evidenced based dedicated community eating disorder service for our children and young people. • Develop a training programme to ensure that relevant staff are appropriately trained in the specialist assessment of eating disorders in children and YP.	• Improved waiting times and access, • Improved outcomes for children and young people • Reduced admissions to Tier 4 beds • Fewer referrals to A&E and admission to paediatric wards or Tier 4 admissions.
Objective 14: Ensure that children and young people have early access to evidence bases early intervention in psychosis services in line with the new access and waiting times standards for people experiencing a first episode of psychosis	• Ensure that he Trust meets the new access and waiting times standards for people experiencing a first episode of psychosis, • Those children and young people accessing the service are treated with a NICE approved care package within two weeks of referral and for a specials ARMS assessment to have commenced for referrals for those with ‘at risk ‘mental statement.		
Objective 15: Ensure crisis support to be made available whenever it is needed and delivered in an appropriate place of safety as close to the	• Have a support helpline that have out of hours advice and support for everybody who may be involved with the child/young person, the young person themselves, parents/carers, schools, other key	• Provide mental health training to A&E doctors and consultants. • Work with the ambulance service to develop better understanding of the presenting	• Skill up parents and significant others to cope with their own issues and support their child/young person. Teach them to identify signs of crisis. Build the resilience of the child/young

child or young person's home as possible.	professionals. • Pilot in Pennine Lancashire an appropriate alternate safe place, staffed by a multi-agency team, for children in Lancashire to be assessed on an emergency basis or where the crisis can be de-escalated. • Extend the crisis resilience pilots for out of hours response to children and young people in crisis from CAMHS while the crisis response service is redesigned to be all age.	complaints of children and young people in mental health crisis and how this group present differently than adults in crisis. • Increase awareness and knowledge of the range of services and support/treatment that is available for children and young people and their families/carers when they are in crisis for example, access to advocacy services through promotion on the single point of access website. • Evaluate alternative safe-place pilot and consider roll-out across Lancashire • Ensure that, at the point of crisis, the workforce who interfaces with these young people will have the skills and training to enable them to empathise and support the young person in crisis with sensitivity to their age and mental health	person and their family/carers/significant others and teach them to identify signs of crisis. Support the family/significant others when child/young person does not want to engage.
Objective 16: Prevent the development of mental illness through targeted interventions for groups identified as being high risk *Objective 17*: Ensure equitable access to evidence-based interventions for those most vulnerable children and young people following a holistic and comprehensive assessment of their needs.	• Work in close partnership with our local Tier 4 service and paediatric teams to ensure clear pathways and smooth transitions for children and young people requiring an inpatient admission and the identification of alternate solutions for those children and young people who do not need inpatient admission. • Improve the experience of vulnerable young people with mental health difficulties on paediatric wards by supporting paediatric staff through training initiatives regarding the management of self-harm and eating disorders • Learn from and replicate/extend current best practice for children in care/CLA across Lancashire. • Pilot the REACh project which empowers our professional workforce to proactively identify vulnerable children and young people, providing an opportunity for safeguarding and early intervention by training and supporting them to asking young people routinely as part of their assessments about adverse childhood experiences (ACEs). • Develop and implement a range of multi-disciplinary and multi-agency care pathways for vulnerable groups, eg ADHD	• Conduct empirical evaluation of the medium to long term impact of this (REACh) routine enquiry about adversity in childhood approach and adjust commissioning intentions accordingly. • In alignment with the LD fast track plan, we will work with providers to ensure children and young people with moderate to severe LD with complex and challenging behaviour have access to skilled support staff and, where necessary, the support of specialist professionals to assist assessment and plan effective support. • Provide support to the staff so that they are better able to support these young people, including implications of safeguarding protocols and informed decision to disclose.	• Implement trauma focussed care on a Lancashire wide footprint so that staff are able to meet the needs of traumatised children and young people and their families. • Develop Paediatric liaison in an acute trusts, for a child/young person with mental health issues.

	and ASD • Routinely monitor the uptake and use of services by vulnerable groups eg CLA, LD to ensure no young person or family in need fall through the net because of difficulty in engaging, inflexible referral criteria or lack of bespoke pathways • Identify the additional capacity created from the additional funding provided for eating disorders to support the development of a self-harm pathway in each health economy.		
Objective 18: Reduce the complexity of current commissioning arrangements through joint commissioning and service redesign, developing a system that is built around the needs of children, young people and their families.	• Build on the success of existing joint commissioning arrangements, including Better Care Fund and Transforming Care across Lancashire to reduce complexity and build a system that is responsive to the needs of children, young people and their families. • The Lancashire Collaborative Commissioning Board (CCB), with representation from eight CCG's, three Local Authorities and Specialist Commissioning will lead the system change through development and approval of the Transformation Plan. The CCB will ensure where possible and practicable, services are jointly and equitably commissioned on a pan-Lancashire footprint. The CCB's vision of a fully integrated system in place and services that are co-commission in a co-ordinated way to ensure they are provided in an integrated way, around the needs of service users and the families or carers and not the system, to improve quality and reduce inequalities. Providers will expected to work in collaboration with other professionals to ensure care is co-ordinated across organisations, health, local authority and voluntary sector, so that it is seamless and supports delivery of the plan. • Integrate commissioning approach under the Better Care Fund (virtual-pooled budget) umbrella whilst a more robust system is put into place. • Support joint commissioning roles within locality footprints to deliver the plan.	• Formalise the integrated commissioning approach through a detailed Section 75 agreement	
Objective 19: Have clear governance arrangements which hold each partner to	• Establish governance arrangements to allow delegated authority to the Children and Young People Emotional Wellbeing and Mental	• Ensure that investment and/or disinvestment decisions will be based on joint agreement	

account for their role in the system	Health Transformation Board for delivery, service transformation and redesign. Members of the transformation board will ensure that consistent engagement with children, young people and their families to inform the plan. Board members will also ensure local area involvement from schools, education establishments and the voluntary sector, see Appendix 7. • Ensure the Transformation Board, including all providers, will hold each partner to account for delivery of the plan as outlined in the governance section above. Appoint a system leader to lead the delivery of integrated children and young people's emotional wellbeing and mental health services programme as agreed with partners, including the implementation, management and monitoring of agreed programmes to develop systems for partnership and planning and investing in new care models which break down the barriers between organisations and advocating system leadership at a local level. • Ensure the current level of investment, based on the 2014/15 level of investment by partners is maintained and underpins the ambitions of this transformation plan to develop new capacity in the medium/long term.	between commissioners on the impact on both the CAMHS service and wider system, and there will be transparency about such decisions. • Implement a benefits realisation plan for the programme to identify and monitor the impact of prevention and early intervention on both specialist children and young people's services, adult mental health services and social care	
Objective 20: Increase transparency through the development of robust metrics on service outcomes'	• Ensure that IT capability is developed in order collect and collate national mental health shared data set in Lancashire. • Work collaboratively across commissioners and providers to develop a shared performance and outcomes framework for children and young people's emotional and mental wellbeing. • Ensure the framework will reflect the national mental health shared data set and encompass local outcome measures developed in consultation with key stakeholders, CYP and their families. • The framework will be informed and build on the learning from our Joint Strategic Needs assessments across BwD, Blackpool and Lancashire. • Ensure the metrics outlined within the framework will be incorporated into service	• Work with the Digital Lancashire strategy programme to ensure IT capability is developed in order to allow records to be shared between providers in Lancashire. • Ensure an exception report will be provided to the Transformation Board, where performance is off track, with mitigating actions and risks to delivery are escalated where required. • Support the development and implementation of systems to ensure information about the pathways into and through care and quality data on service performance and commissioner spend is highly visible, readily accessible and shared across agencies. • Publish an annual report card on children and young people's emotional wellbeing and mental health, setting out key achievements, areas for improvement and required action • Require commissioned emotional wellbeing and	• Explore models and feasibility of a single case management system across all providers delivering emotional wellbeing and mental health interventions in Lancashire. • Develop a single data collection portal to ensure that standardised information is available to inform planning and commissioning of services. This will be made available on the one stop portal for service users and carers to support informed decision on their care and the choices they have.

	specifications and information requirements for each provider and monitored through contract management arrangements.	mental health services to develop and publish quality improvement plans on an annual basis	
Objective 21: Work together to ensure that our increased levels of investment will be used transparently, equitably and demonstrate value for money.	• Undertake a review of how commissioning activity across the CCGs and the Local Authorities can be brought together within a strong strategic framework for a more effective health and social care economy of service providers and commissioners working together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access. • Ensure that investment and/or disinvestment decisions will be based on joint agreement between commissioners on the impact on both the CAMHS service and wider system. • Undertake a bench marking exercise pan-Lancashire to support the demonstration of good value for money, efficiency and effectiveness compared to similar services.	• Commission emotional wellbeing and mental health services for the children and young people of Lancashire in accordance with the needs of the population as articulated in our Joint Strategic Needs Assessments. • Ensure continuous improvement in the quality of services to be achieved whilst achieving financial balance within a challenging economic climate. • Utilise evidence based approaches and working collaboratively with service users, carers, providers and commissioners on joint commissioning to maximise quality and efficiency and minimise risks to service users and carers. • Publish an annual local plan for children and young people's emotional wellbeing and mental health, linked to a wider whole population mental health strategy which recognises the clear links between the mental health of family members and the impact in particular on children and young people where their carers have poor mental health.	
Objective 22: Ensure our service offer will be designed with children, young people and families and be responsive to needs as opposed to service structures.	• Further developed in consultation with parents and young people which will be an integral part of the development and implementation of the strategy going forward. • Building on our learning and engagement with children and young people we will strengthen the support and role that is available to service users and carers who become involved in planning and monitoring of mental health services including a process of induction and training as well as ongoing support. • Improve capacity of service users, carers and families to take part in local and regional involvement, service improvement work, self-help support and service provision by effectively supporting involvement within our commissioning practice.	• Work in partnership with service users and carers on their ideas for different approaches to widen involvement • Ensure that representation for carers in commissioning is supported to represent mental health issues adequately • Ensure that service user and carer feedback and involvement in delivering and developing services will be mandatory • Develop a culture of sharing learning of good practice across Lancashire through developing pilots and testing new service provision models ensuring that children and young people and their cares are involved in the measurement of outcomes and the evaluation of these programmes.	• Ensure that people will be communicated with using formats and means appropriate to their individual requirements e.g. service user led website and carers on-line forums • Ensure that carers can gain access to their own needs assessment within a primary care, generic or mental health setting and are supported so that their role is valued in the creation of care plans
Objective 23: Work with	• Work with service providers who deliver	• Establish and agree the key principles for those	• Identify and use creative means to recruit and

partners across all sectors to ensure that there is an appropriately resourced, skilled and trained workforce who feel confident in their ability to support the emotional health and wellbeing needs of our children and young people and their families.	specific emotional wellbeing and mental health interventions to undertake an audit of staff numbers, skills, competencies and training building on the returns as part of this planning process. • Utilise local workforce modelling undertake a gap analysis to identify workforce numbers requirements, succession planning, skills and training needs. • Ensure clear organisational commitment, resources and time for continuing professional development and training.	planning/commissioning services in addition to providers and partner agencies about the workforce and resources required to meet the needs of a population of children and young people to support the development a workforce strategy and plan for Lancashire. • Enhance existing roles and create new roles to tap into a new recruitment pool and complement existing staff groups. • Build on training programmes that are currently available in Lancashire to enable continuous professional development of all staff. • Develop Education and Training plan based on needs analysis which will be updated annually. • Develop programmes of work with our health education partners, including Health Education NW Higher Education Institutions, CYP IAPT, Local Health Education and Training Boards, NHS England and colleagues across the region, to consider what is required for workforce to address the identified gaps. • Ensure the roles and responsibilities of each member of the multi-disciplinary team are made explicit. • Develop a dashboard to allow ongoing review of staffing numbers and competencies and highlights any staff development training/skills deficits.	retain people in the workforce in order to increase the overall numbers in successive years. • Young people and/or their parents/carers are involved in and their views taken into account in the recruitment and appointment • Facilitate ways of working within services and across professional boundaries making best use of specialist staff group to meet the needs of children, young people and families.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Paul Greenwood, Chairman Blackpool, Wyre and Fylde Council for Voluntary Services
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	21st October 2015

BLACKPOOL, WYRE AND FYLDE COUNCIL FOR VOLUNTARY SERVICES

1.0 Purpose of the report:

1.1 To inform the Board of the objectives, purpose and value of a Third Sector Infrastructure Organisation (Blackpool, Wyre and Fylde Council for Voluntary Service) and to request that fund holders consider funding to enable the Council for Voluntary Services to continue the work it has been undertaking for the last 81 years.

2.0 Recommendation(s):

2.1 That the constituent organisations represented on the Health and Wellbeing Board consider jointly funding the Blackpool element of Blackpool Wyre and Fylde Council for Voluntary Services in the sum of £150,000 per year to enable it to continue to function. This support is requested for three years (2016-2019).

3.0 Reasons for recommendation(s):

3.1 The Council for Voluntary Services is a vital link between the Public Sector and the Third Sector.

3.2 It is necessary to undertake development work across the Third Sector.

3.3 Council for Voluntary Services enables good communication to take place within the sector and between the sector and other sectors.

3.4 Co-ordination of work within the sector to focus on strategic objectives is key to maximising the value of the Third Sector in difficult financial times.

3.5 The objectives and purposes of the majority of Third Sector organisations match

those of the Council and other Public Sector bodies.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

The Council currently commissions services from Council for Voluntary Services

3.3 Other alternative options to be considered:

Not to offer funding. The Council for Voluntary Services would then cease to operate in Blackpool.

4.0 Council Priority:

4.1 The relevant Council Priorities are

- Tackle child poverty, raise aspirations and improve educational achievement
- Safeguard and protect the most vulnerable
- Expand and promote our tourism, arts, heritage and cultural offer
- Improve health and well-being especially for the most disadvantaged
- Attract sustainable investment and create quality jobs
- Encourage responsible entrepreneurship for the benefit of our communities
- Improve housing standards and the environment we live in by using housing investment to create stable communities
- Create safer communities and reduce crime and anti-social behaviour
- Deliver quality services through a professional, well-rewarded and motivated workforce

4.2 Council for Voluntary Services supports member organisations who contribute to all of these priorities.

5.0 Background Information

5.1 The Blackpool Wyre and Fylde Council for Voluntary Services has been in existence for 81 years. It seeks to co-ordinate and develop the work undertaken by the many organisations which make up the sector in Blackpool.

5.2 Funding a Third Sector infrastructure organisation is notoriously difficult. Over time many plans have been adopted to achieve the objectives of the organisation but

many have proved unsuccessful as they involve either very tightly written contracts which detail particular pieces of work or they stray from the core objectives of the Council for Voluntary Services. To gain maximum value from the organisation there needs to be an element of core funding which enables the organisation to exist and to have staff available to undertake not only the administrative tasks to keep the organisation functioning but also have the time to properly engage in the core activities.

5.3 The Aims of the Council for Voluntary Services are as follows:

1. To be an organization that is a flagship for best practice in the voluntary and community sector.
2. To be a high quality organization that attracts retains and values staff, volunteers and board members.
3. To be open and accountable to our stakeholders, and to communicate effectively with and between them.

5.4 The Core Functions of the Council for Voluntary Services are as follows:

1. Development. To support sustainable development in the voluntary and community sector.
2. Support. To provide the support which will underpin the functioning and develop the capacity of local voluntary and community groups.
3. Liaison. To develop and maintain links across the voluntary, community, statutory and private sectors and promote the ability for all sectors to engage in networking with each other.
4. Representation. To enable the diverse views of the local voluntary and community sector to be represented to local statutory bodies and others and, where appropriate, to be a conduit for this representation.

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 The Council currently commissions Council for Voluntary Services to deliver its services, but this funding is only available on a rolling 12 month basis – in order to recruit and run the organisation effectively, a 3 year commitment, at £150,000 per year – split across Health and Wellbeing Board partners is sought.

10.0 Risk management considerations:

10.1 The risk of a number of third sector organisations failing is difficult to quantify, but would have a significant impact on the Borough and the Council.

11.0 Ethical considerations:

11.1 The Council is committed to supporting the third sector to grow and develop, to take over responsibility for delivering services that the council will no longer be able to deliver.

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Simon Jenner, Principal Educational Psychologist/ SEND Service Manager, Blackpool Council.
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	21st October 2015

SPECIAL EDUCATIONAL NEEDS AND DISABILITIES UPDATE

1.0 Purpose of the report:

1.1 To update the board on the progress of the implementation of the 2014 Children and Families' Act across agencies and outline recent developments in the area. A written and verbal report was made to Health and Wellbeing Board on the 9th July 2014 to update on progress towards the implementation of the Act (September 2014). It was agreed that a report would occur 12 months following this.

1.2 To update the Board on the new OFSTED/ Care Quality Commission inspection framework for Special Education Needs (0-25 year olds and their families) in a local area.

2.0 Recommendation(s):

2.1 To note that current work continues to meet statutory obligations and work to prepare for external inspections should continue.

3.0 Reasons for recommendation(s):

3.1 Blackpool is continuing to meet its statutory obligations and self evaluation has indicated that some areas for future inspection still need work on them.
The Blackpool area needs to be ready for potential inspections.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None, the obligations are laid in statue and the pending OFSTED / Care Quality Commission inspection framework is applicable to all local areas nationally.

4.0 Council Priority:

4.1 The relevant Council Priorities are:

Tackle child poverty, raise aspirations and improve educational achievement and safeguard and protect the most vulnerable.

5.0 Background Information

5.1 The 2014 Children and Families Act was implemented in September 2014 (the youth offending aspects from April 2015). A national Code of Practice was released, outlining statutory and non statutory duties. There were significant changes for Special Education Needs and disability, as outlined below with Blackpool progress noted against the headings. Work streams had met since 2012, including parents, care, health, colleges, schools and others. The work outlined below is a summary of the key aspects of the initiatives taken.

The approach to identifying Special Education Needs was changed from service led to person centred

Significant training across health, education and care has occurred, with trainers trained in the area. This has involved providers and members of staff continue to roll out training. The department for area advisor, local charities and parent groups have noted how person centred the approach is now within Blackpool.

Statements of Special Education Needs have been replaced by Education, Health and Care (EHC) Plans

Blackpool has maintained a 100% record for completing these on time and moderation by the Department for Education has highlighted how they "totally" meet the spirit of the Code. Councils have to convert all existing Statements of Special Educational Need to Education, Health and Care Plans within the next three years. Close work with health has ensured this has occurred. The Council had to publish a plan on this. Department for Education monitoring has highlighted how Blackpool is one of the few authorities, regionally, to be on track to do this within the statutory timescales, whilst still using a person centred approach. The target for August 2015 was to convert 232 Statements of Special Educational Need / their post school equivalent. 231 were converted or close to the final point in the process. Close work has occurred with health and care to ensure that aspects of the Plan cover all relevant areas and assessments are joined up.

Approaches have to be outcome focussed and aspiration driven
This has been a key ethos change away from the needs driven approaches used previously. Parents have commented how the person centred/ outcome focussed approach has made a big difference. The service will need to ensure that the ethos change for service delivery is maintained as other pressures (budgetary/ meeting statutory targets) occur.

Increase to a 0-25 age range
The Act covers to the age of 25, whilst previously it was to the end of schooling. Post school covers when the young person is in education and/or training. Outcomes in terms of being in employment or an alternative are important. Work has occurred with colleges and post 16 providers to ensure that provision meets need and a specific post 16 Special Educational Need Officer appointed.

Personal budgets
If there is an Education, Health and Care Plan the young person post 16, or parent, can have access to a personal budget for aspects of this. Blackpool had a significant take up of personal budgets in regard to care provision for disabled children and young people and this has been built upon.

Coproduction
All strategic and personal plans have to be co-produced with parents and young people. Blackpool has been praised by parents and charities for this. There have been some significant events that have input into the co-production process and stakeholder engagement occurs in all work streams and strategic groups.

Local Offer
There is a duty on the local authority to host an offer of all provision available within the area for children and young people with Special Educational Needs and their families. This is a web site within the Family Information Service. Other communication routes including deaf text and the use of leaflets/ meetings are also utilised. Initially all legal aspects were put onto the offer site and this was monitored by the Department for Education. A part time local officer has been appointed on a temporary basis to ensure the site is now more user friendly. It continues to be updated and modified following feedback. The site is also a two way communication for service users to feed into the commissioning process. A national charity highlighted Blackpool's Local Offer as one of four national examples of good practice.

Joint Commissioning
This has to occur between the Clinical Commissioning Group and local authority. A strategic board has been set up and meets regularly. The Joint Strategic Needs Assessment, other assessments and service user comments feed into this

Mediation

If there is a dispute about aspects of an Education, Health and Care Plan the Local Authority or the Clinical Commissioning Group has to commission independent mediation. This has occurred via an independent firm. Work has also occurred with independent parent supporters, supplied by Barnados for Blackpool.

Early stages of support

Work is ongoing to ensure that needs are identified at as early a stage as possible and statistics indicate that this is the case. However, there are corresponding increases in needs amongst early years (due for instance to more babies surviving traumatic births), a rise in the number of cases of autism identified and that Blackpool is a net importer of need. Work has occurred with early years' providers, schools and colleges to improve their identification processes and provision. A reasonable expectations document, outlining the type of provision to be expected from school provisions, has been developed and shared at the SENCO conference in June.

5.2 Blackpool is one of 13 local authorities nationally to be engaged in a pilot to extend the remit of tribunal (a legal process led by a judge) to rule on care and health aspects of an Education, Health and Care Plan as well as education ones, if there is a disagreement that can not be resolved. It is early days yet in the pilot, which was promised as part of the national changes. Blackpool has a tradition of low numbers of cases needing to go to tribunal.

5.3 OFSTED and the Care Quality Commission (for health) have been charged with inspecting local areas in relation to Special Educational Needs. The promised draft criteria is yet to be published, but will occur in the near future. Once it does a desk top exercise will occur to review Blackpool against the criteria.

5.4 The inspection will cover a local area, including health (adult and children), the Council (adult and children services) and providers (schools, colleges, early years settings, care providers for example). The first inspections nationally will be likely from May 2016. Members of the Board may be interviewed as part of the process. Many aspects of the inspection framework have been released informally and a self evaluation has occurred. There are many areas that Blackpool is seen by the Department for Education as doing well in and we have been asked to present regionally on these. Some areas for improvement or possible concern have been identified and action plans are in place/ being developed to address these. They include the involvement of children and young people, securing a robust data set, reducing numbers that have to use expensive out of borough specialist provision, secondary academic attainment and ensuring the joined up work across agencies strategically also occurs when delivering services.

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

None

6.0 Legal considerations:

6.1 The statutory obligations under the act are monitored and continue to be met. National case study judgments from high courts and first tier tribunals are considered as part of future decision making.

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 Under the Equalities Act the needs of those with disabilities are met. Race/ gender / free school meal data is kept to ensure no discrimination occurs.

9.0 Financial considerations:

9.1 The obligations are met within budget and the two new burdens grants from central government to all local authorities (covering the financial years 2014/2015 and 2015/2016). The Council is yet to hear of a grant for 2016/2017.

10.0 Risk management considerations:

10.1 If we fail to meet statutory obligations in terms of the Act the authority and/or health bodies would be at risk from individuals taking legal action and/or central government / OFSTED/ CQC taking action.

11.0 Ethical considerations:

11.1 The needs of a vulnerable group within the town continue to be met appropriately.

12.0 Internal/ External Consultation undertaken:

12.1 There is a duty under the Act to co-produce all policies with parents and children/ young people (CYP). Positive feedback has occurred from parent and charity groups to the DFE about parental engagement and engagement with children/ young people was seen as not being a major concern on a DFE monitoring visit. However, it has been highlighted by internal self evaluation that engagement with children and young people could be better and work is ongoing to put in further structures to enable this to improve. It was also recognised that “hard to reach” parents’ views

have not been obtained and a parent telephone survey is proposed.

13.0 Background papers:

13.1 None

Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Cain, Cabinet Secretary (Resilient Communities)
Date of Decision/ Meeting	21 October 2015

New Models of Care Value Proposition

1.0 Purpose of the report:

1.1 To inform the Board of the Value Proposition for New Models of Care on the Fylde Coast that was submitted to NHS England for their Investment Board meeting week beginning 28th September. The Fylde Coast partners expect to hear shortly on whether or not the Investment Board supports our proposition and will allocate the money that has been requested to assist in rolling out Extensive Care services across the Fylde coast and begin the implementation of Enhanced Primary and Community Care services.

2.0 Recommendation(s):

2.1 The Health and Wellbeing Board (HWB) is asked to consider the contents of the Value Proposition document and discuss how the joint work required to design and implement Enhanced Primary and Community services could be organised.

3.0 Reasons for recommendation(s):

3.1 Blackpool's HWB is committed to reducing health inequalities and improving health outcomes for the local population. The submission of the Value Proposition is a significant step towards achieving the Board's aims.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

There is no alternative option to be considered

4.0 Council Priority:

4.1 The relevant Council Priority is 'improve health and well-being especially for the most disadvantaged'

5.0 Background Information

5.1 So far most of the efforts of those working on the new models of care have been to design Extensive Care services, get at least two services operational from June 2015 at Moor Park and Lytham Health Centres and get the Value Proposition written for submission to NHS England. Having made a start on implementing the new models of care before we asked for any NHS England Vanguard money was an important aspect of our Vanguard application. The savings in acute services (£3.6m for Blackpool) arising from Extensive Care services will be sufficient to offset the cost of the new services, but no more. NHS England money will enable partners on the Fylde coast to roll out the Extensive Care services model more quickly than we might otherwise have been able to achieve on our own.

5.2 The expectation is that Enhanced Primary Care services represent a more transformational aspect of new care models and will result in net savings of circa £10m for Blackpool. About £6m of this sum is planned to be re-invested into primary, community and social care services as part of the Enhanced Primary and Community services proposals. At present the precise shape of these new services has not been scoped and therefore the local partners need to ensure that the necessary joint design and implementation programme is in place quickly to enable the money from NHS England (assuming it comes) to be spent effectively in ways that meet our overall aims and objectives.

Does the information submitted include any exempt information? No

List of Appendices:

Exempt

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 Financial analysis is included in the Value Proposition document

10.0 Risk management considerations:

10.1 Analysis of risk is included in the Value proposition document

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Hilary Shaw, Head of Business Support and Resources (Children and Adults)
Relevant Cabinet Member	Councillor Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	21st October 2015

SECTION 75 POOLED BUDGET AGREEMENT

1.0 Purpose of the report:

1.1 To inform the Board of the Section 75 Pooled Budget Agreement that has been developed by Blackpool Council and Blackpool Clinical Commissioning Group.

2.0 Recommendation(s):

2.1 To ratify the Section 75 Pooled Budget Agreement as attached to this report, which has been approved by Blackpool Clinical Commissioning Group and by Blackpool Council.

3.0 Reasons for recommendation(s):

3.1 The Better Care Fund requires funding to be paid through the vehicle of a pooled budget and a legal agreement is therefore required between Blackpool Council and Blackpool Clinical Commissioning Group (CCG) under Section 75 of the NHS Act 2006.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is 'improve health and well-being especially for the most

disadvantaged.'

5.0 Background Information

5.1 One of the requirements of the Better Care Fund is that the agreed funding is paid through the vehicle of a pooled budget. This is a type of partnership arrangement whereby NHS organisations and local authorities contribute an agreed level of resource into a single pot (the "pooled budget") that is then used to commission or deliver health and social care services.

5.2 In August 2015, the Strategic Commissioning Group approved the Pooled Budget Agreement covering the Better Care Fund schemes, and incorporating the following aspects:

- Strategic Commissioning Group to be the decision-making body, with ratification as necessary by the Health and Wellbeing Board.
- Risk and rewards to remain with the lead commissioning organisation for each of the schemes within the Better Care Fund.
- CCG to bear the risk of the performance-related element of the funding.
- Blackpool Council to be the host organisation for the pooled budget.

The Agreement is attached at Appendix 10(a) to this report for noting by the Board.

Does the information submitted include any exempt information? No

5.3 **List of Appendices:**

Appendix 10(a) – Section 75 Pooled Budget Agreement between Blackpool Council and Blackpool Clinical Commissioning Group

6.0 Legal considerations:

6.1 The Agreement has been drawn up in accordance with Section 75 of the National Health Service Act 2006 relating to pooled budgets between local authorities and NHS bodies, and has been fully supported by the Council's Legal Services Division.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 As part of their Better Care Fund plans, CCGs and local authorities had to indicate the level of funding that would initially be committed through the plan. NHS England has confirmed that CCG Better Care Fund monies will only be paid through the vehicle of a formal pooled budget. For Blackpool, approximately £13.6 million of the £15.2 million in the 2015/16 Better Care Fund will be received from NHS England.

10.0 Risk management considerations:

10.1 See section 9.1 for description of financial risks.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 The Pooled Budget Agreement has been drawn up in liaison with Blackpool Clinical Commissioning Group, and in consultation with the Strategic Commissioning Group, which includes representatives from both organisations as well as other stakeholders.

13.0 Background papers:

13.1 None.

This page is intentionally left blank

Dated **2015**

BLACKPOOL BOROUGH COUNCIL

and

NHS BLACKPOOL CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES AND OTHER ARRANGEMENTS

THIS AGREEMENT is made on day of 2015

PARTIES

(1) **THE BLACKPOOL BOROUGH COUNCIL** of PO Box 11, Town Hall, Blackpool, FY1 1NB(the **"Council"**)

(2) **NHS BLACKPOOL CLINICAL COMMISSIONING GROUP** of The Stadium, Seasiders Way, Blackpool, FY1 6XJ(the "**CCG"**)

BACKGROUND AND INTRODUCTION

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Blackpool.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Blackpool.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements and Other Arrangements. It is also a means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives of the Better Care Fund;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for expenditure on the Services;

d) work together towards achieving the vision for health and care services in Blackpool; and

e) utilise the benefits of the flexibilities available to the Partners pursuant to Section 75 of the 2006 Act.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(I) The Partners are committed to continuing to work together towards the further pooling of resources to deliver integrated services, and this agreement may be extended by the addition of new Individual Schemes to enable integration to be delivered across a wider range of services.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Aims and Outcomes are the objectives of the Partners, setting out how the Partnership Arrangements are likely to lead to an improvement in the way the Functions are exercised.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Annual Development Plan has the meaning set out in Clause 10.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Payment for Performance means the amount payable by NHS England relating to the achievement of performance targets for non-elective admissions to hospital.

Better Care Fund Plan means the plan submitted by the Health and Wellbeing Board to NHS England in September 2014 setting out the Partners' plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act and such other legislation as may be issued from time to time as relevant to such duties.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.

Commencement Date means 00:01 hrs on 1 April 2015.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Service Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) (in whole or in part) under the relevant Service Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Service Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions.

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Service Contract.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in the Schedule of Schemes and as added from time to time with the agreement of both Partners and the Strategic Commissioning Group.

Initial Term: means the period commencing on the Commencement Date and ending on the first anniversary of the Commencement Date.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated ways of working.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Working Obligations means the respective obligations on the Lead Commissioner and the other Partner under Lead Commissioning Arrangements as set out in Schedule 4.

Law means:

(d) any statute or proclamation or any delegated or subordinate legislation;

(e) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(f) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(g) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Scheme under a Service Contract.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions relating to the Better Care Fund as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Schedule of Schemes.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 11.4

Other Arrangements means other initiatives, schemes, plans and arrangements which improve health and well-being in accordance with this Agreement.

Overspend means any expenditure from an Individual Scheme in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Arrangements means the arrangements made between the Partners under this Agreement.

Performance Payment Arrangement means any arrangement agreed with a Provider and one or more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 11.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

And "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Schedule of Schemes means the list of Individual Schemes covered by this Agreement as detailed in Schedule 1 Part 1.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Service Contract.

Service Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Strategic Commissioning Group means the group established pursuant to paragraph 10.(2) of the Regulations, whose terms of reference are set out in Schedule 2, to provide leadership and accountability for the delivery of integrated commissioning and care across Blackpool and responsibility for review of performance and the overseeing of this Agreement.

Term means the period of the Initial Term as may be varied by:

(a) any extensions to this Agreement that are agreed under clause 2; or

(b) the earlier termination of this Agreement in accordance with its terms.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Strategic Commissioning Group.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking and Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date and shall continue for the Term.

2.2 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Service Contract.

2.3 The Partners may extend this Agreement for a period on varied terms as they agree, beyond the Initial Term, subject to approval of the Partners' boards.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function; or

3.1.3 the rights and powers, duties and obligations of the Partners in the exercise of their functions as public bodies or in any other capacity; or

3.1.4 the Council's power to determine and apply eligibility criteria for the purposes of assessment under the Community Care Act 1990

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Service Contract.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning;

4.1.4 the establishment of one or more Pooled Funds.

in relation to Individual Schemes (the "Flexibilities")

4.2 The Council delegates where required under an Individual Scheme to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates where required under an Individual Scheme to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Individual Scheme and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

4.5 Other Arrangements or additional services may be brought within the scope of this Agreement during the Term by agreement between the Partners.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Service Contract shall be entered into in accordance with this Agreement.

5.4 The Partners shall not enter into a Service Contract in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Strategic Commissioning Group, which must also be agreed by the Partners.

5.6 In addition to introducing a new Individual Scheme the Partners may agree from time to time to introduce Other Arrangements.

5.7 The introduction of any Other Arrangements will be subject to all relevant considerations by the Strategic Commissioning Board and recommendations of the Health and Wellbeing Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in the Schedule of Schemes are commissioned within each Partner’s Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Service Contract.

6.5 Each Partner shall keep the other Partners and Strategic Commissioning Group regularly informed of the effectiveness of the arrangements including the Better Care Fund, Other Arrangements and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Strategic Commissioning Group will report back to the Health and Wellbeing Board as required by its Terms of Reference and also the Partners.

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Service Contract;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year;

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Service Contract;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Service Contract.

6.7.9 keep the other Partner and the Strategic Commissioning Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.7.10 comply with Part 1 of the Joint Working Obligations.

6.8 The Other Partner shall comply with Part 2 of the Joint Working Obligations.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for expenditure as set out in the Schedule of Schemes.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider or enters into a Service Contract, the Permitted Budget; and where the CCG enters into a Service Contract, the agreed budget that Partners have set in relation to a particular Service ;

7.3.3 Performance Payments;

7.3.4 Third Party Costs as agreed in relation to a particular Service;

7.3.5 Approved Expenditure.

("Permitted Expenditure")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Schedule of Schemes. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Service Contract;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Strategic Commissioning Group and Partners as required;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Strategic Commissioning Group Quarterly reports (or more frequent reports if required by the Strategic Commissioning Group) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Strategic Commissioning Group to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete

their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.2.9 prepare an annual voucher to the other Partner, as per the format set out in Schedule 5.

8.3 The internal auditor of the Host Partner will be responsible for the internal audit of the Pooled Fund. It will agree its audit plans in relation to the Pooled Fund with the Audit Committee of the Host Partner.

8.4 The external auditor of the Host Partner will be responsible for the external audit of the Pooled Fund. It will agree its audit plans in relation to the Pooled Fund with the Audit Committee of the Host Partner.

8.5 Copies of all audit reports in relation to the Pooled Fund will be made available to the Strategic Commissioning Group, Partners and Blackpool Health and Wellbeing Board.

8.6 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Strategic Commissioning Group and shall be accountable to the Partners.

8.7 The Strategic Commissioning Group may agree to the viring of funds between Pooled Funds, subject to the relevant Statutory Financial Instruments, Standing Orders and accountable procedures of the Partners.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Service Contract. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund.

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Service Contract.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

9.6 The Host Partner shall prepare an annual voucher to the other Partner, as per the format set out in Schedule 5 and in accordance with paragraph 5 (3) of the National Health Service Commissioning Board (Payments to Local Authorities) Directions 2014.

10 ANNUAL DEVELOPMENT PLAN

10.1 The Partners shall develop an Annual Development Plan, in order to implement their joint strategic plans, for each of the Services at least four weeks before the start of the Financial Year. The Annual Development Plan shall:

(a) set out the agreed Aims and Outcomes for the specific Services;

(b) describe any changes or development required for the specific Services;

(c) provide information on how changes in funding or resources may impact the specific Services; and

(d) include details of the estimated contributions due from each Partner for each Service and its designation to the Pooled and/or Non Pooled Fund.

10.2 The Annual Development Plan shall commence on 1st April at the beginning of the Financial Year and shall continue for 12 months.

10.3 The Annual Development Plan may be varied by written agreement between the Partners. Any variation that increases or reduces the number or level of Services in the scope of the Agreement shall require the Partners to make corresponding adjustments to the NHS body's Financial Contribution and the Council's Financial Contribution.

10.4 If the Partners cannot agree the contents of the Annual Development Plan, the matter shall be dealt with in accordance with Clause 23. Pending the outcome of the dispute resolution process or termination of the Agreement under Clause 23, the Partners shall make available amounts equivalent to the Financial Contributions for the previous Financial Year.

11. FINANCIAL CONTRIBUTIONS

11.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for each Financial Year of operation of each Individual Scheme shall be as set out in Schedule 1 Part 2.

11.2 The Financial Contribution of the CCG and the Council to any Pooled Funds or Non-Pooled Funds for subsequent years will be considered annually by each Partner through their budget setting processes and their respective organisational governance structures. The Strategic Commissioning Group considers and approves expenditure annually in consultation with the Providers (other key stakeholders determined by the Partners from time to time). The Strategic Commissioning Group will make recommendations to both Partners with regards to the future level of their financial contributions.

11.3 Financial Contributions will be paid as set out in the Schedule of Schemes.

11.4 With the exception of Clause 14, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Strategic Commissioning Group minutes and recorded in the budget statement as a separate item.

12. RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 The Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Strategic Commissioning Group in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Strategic Commissioning Group is informed as soon as reasonably possible and the provisions of Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Strategic Commissioning Group .

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Strategic Commissioning Group.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, the surplus monies shall be retained by the Lead Commissioner unless otherwise decided by the Strategic Commissioning Group. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 VAT

13.1 The Partners agree that where the Council acts as host body for the Pooled Budgets, the Council will calculate the amount of VAT incurred in the purchase of goods and services required to deliver the programme that is recoverable under section 33 VAT Act 1994, where the supply has incurred tax and relates to non-business activities for VAT purposes.

13.2 In respect of Non Pooled Funds the VAT regime of the Lead Commissioner will determine the VAT recovery for the relevant Individual Scheme.

13.3 The Partners will review the VAT arrangements at least annually to ensure that this approach remains appropriate, and in accordance with the latest relevant guidance from HM Customs and Excise.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control and shall ensure that full and proper records for accounting purposes are kept in respect of the arrangements

under this Agreement. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require external auditors to make arrangements to certify an annual return of those accounts.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee or member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15. LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Service Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Service Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Strategic Commissioning Group.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause15 the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance in respect of all potential liabilities arising from this Agreement. In the case of the CCG it may (where available) effect through the National Health Service Litigation Authority, alternative arrangements in respect of NHS schemes in lieu of commercial insurance.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

15.6 The Lead Commissioner for each Individual Scheme shall ensure that all Providers maintain policies of insurance in relation to the potential liabilities arising from the Services under a Service Contract and ensure that such Service Contract provides indemnities in respect of any loss sustained by the Partners as a result of any breach or negligence by the Provider.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners shall develop operational guidance and procedures to reflect compliance with Clause 16.

16.2 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partner's respective Standing Orders and Standing Financial Instructions, CCG's Constitution and the Council's Constitution).

16.3 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.4 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties, clinical governance obligations, the NHS Constitution (including the statutory Duty of Cabdour) and the relevant public procurement rules issued from time to time.

16.5 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17 CONFLICTS OF INTEREST

17.1 Each Partner shall comply with its own Policy for identifying and managing conflicts of interest.

17.2 The Partners shall from time to time review and if necessary adopt new policies for identifying and managing conflicts of interests.

17.3 The Partners will ensure that their employees involved in administrative and decision-making responsibilities under the arrangements set out in this Agreement comply with the respective Conflict of Interest Policy and would address any failure through their respective disciplinary processes.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established the Strategic Commissioning Group, which is accountable to the Council Executive, the CCG Governing Body and the Health and Wellbeing Board.

18.3 The Strategic Commissioning Group is based on a joint working group structure and is responsible for agreeing key actions in relation to this Agreement and reporting the performance to the Health and Wellbeing Board. Membership of the Strategic Commissioning Group shall include officers of the Partners who will have individual delegated responsibility from the Partner employing them to make decisions which enable the Strategic Commissioning Group to carry out its objects, roles, duties and functions as set out in this Clause18 and Schedule 2.

18.4 The terms of reference of the Strategic Commissioning Group shall be as set out in Schedule 2.

18.5 Each Partner shall secure internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Strategic Commissioning Group shall be responsible for the overall approval of the Individual Services and Other Arrangements, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

18.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Service is reported to the Strategic Commissioning Group and Health and Wellbeing Board.

18.8 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Strategic Commissioning Group and Health and Wellbeing Board.

19 REVIEW

19.1 Save where the Strategic Commissioning Group agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Subject to any variations to this process required by the Strategic Commissioning Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

19.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. A copy of this report shall be provided to the Strategic Commissioning Group.

19.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

20 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services. Upon termination of this Agreement for any reason whatsoever this Clause 20 shall continue to survive.

21 TERMINATION AND DEFAULT

21.1 This Agreement may be terminated by any Partner giving not less than 6 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

21.2 Termination of approved Individual Schemes will be recommended and approved by the Strategic Commissioning Group, Where an Individual Scheme is provided by third parties, notice periods and termination conditions will be governed by the conditions contained within the contract for services: - for the CCG this is the Standard NHS Contract and for the Council this is the Standard Council Terms and Conditions for Services. Where an Individual Scheme is provided in-house by either party under this Agreement, notice periods and termination conditions will be agreed by the Strategic Commissioning Group. Notice periods and conditions will not exceed those contained in third party contracts: for the CCG this would be the Standard NHS Contract and for the Council this would be the Standard Council Terms and Conditions for Services,

21.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause23.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach, any other rights of termination contained in this Agreement or Individual Schemes or Other Arrangements.

21.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

21.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

21.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.6.5 the Strategic Commissioning Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

21.8 Upon termination of this Agreement for any reason whatsoever the following clauses shall continue to survive:

21.9.1 Clause 20 (Complaints)

21.9.2 Clause 23 (Dispute Resolution)

21.9.3 Clause 25 (Confidentiality) for a period of 6 years from the date of termination

21.9.4 Clause 26 (Freedom of Information and Environmental Protection Regulations) in so far as the request relates to the provision of this Agreement

21.9.5 Clause 27 (Ombudsman)

21.9.6 Clause 28 (Information Sharing) for a period of 6 years from the date of termination

22 PUBLICITY

The Partners shall use reasonable endeavours to consult one another before making any press announcements concerning the Services or the discharge of either Partner's Functions under this Agreement.

23 DISPUTE RESOLUTION

23.1 The Partners shall try to resolve any disputes that arise in relation to this Agreement through the Strategic Commissioning Group before going through the formal dispute resolution procedure stated in this clause 23.

23.2 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.3 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.2, at a meeting convened for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, the Council's Chief Executive and the Accountable Officer of the CCG or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.5 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23.7 Upon termination of this Agreement for any reason whatsoever this Clause 23 shall continue to survive.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 26.2 , the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 26.4 , facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25 , each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25.4 Upon termination of this Agreement for any reason whatsoever this Clause 25 shall continue to survive for a period of 6 years from the date of termination.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

26.3 Upon termination of this Agreement for any reason whatsoever this Clause 28 shall continue to survive.

27 OMBUDSMEN

27.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Ombudsman for England (or both of them) in connection with this Agreement.

27.2 Upon termination of this Agreement for any reason whatsoever this Clause 27 shall continue to survive.

28 INFORMATION SHARING

28.1 The Partners will follow and ensure that the arrangements under this Agreement comply with the Law including any guidance on information sharing produced by the Government.

28.2 Without prejudice to Clause 28.1, when sharing information pursuant to these Arrangements, the Partners will at all times act in accordance with the Information Sharing Protocol to be developed between the Partners within the first year of the operation of this Agreement. The information sharing arrangements will be developed in line with NHS Information Governance guidelines.

28.3 Upon termination of this Agreement for any reason whatsoever this Clause 30 shall continue to survive for a period of six (6) years from the date of termination.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Chief Corporate Solicitor, PO Box 11, Town Hall, Blackpool, FY1 1NB;

Tel: 01253 477148
Fax: 01253477149

and

29.3.2 if to the CCG, addressed to the Accountable Officer, The Stadium, Seasiders Way, Blackpool, FY1 6XJ;

Tel: [01253 951227]
Fax: [01253 951268]

30 VARIATION

No variations to this Agreement will be valid unless they are considered and approved by the Strategic Commissioning Group and thereafter recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

40. FAIR DEALINGS

The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

The Common Seal of the
BLACKPOOL BOROUGH COUNCIL
Was hereunto affixed
in the presence of:-

Chief Corporate
Solicitor or Authorised
Signatory

Signed for on behalf of **CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1 PART 1 - SCHEDULE OF SCHEMES

Health and Wellbeing Board Expenditure Plan

Blackpool

	Expenditure						
Scheme Name	**Area of Spend**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2015/16 (£000)**
Rollout of care homes support scheme (new)	Continuing Care	CCG			NHS Community Provider	CCG Minimum Contribution	223
Out of Hospital IV therapy service (new)	Community Health	CCG			NHS Community Provider	CCG Minimum Contribution	41
Acute Visiting Service (new)	Community Health	CCG			Charity/Voluntary Sector	Additional CCG Contribution	100
999 frequent callers pilot (new)	Community Health	CCG			NHS Community Provider	Additional CCG Contribution	49
Increasing capacity to provide reablement services (CCG £1.6)	Community Health	Local Authority			Local Authority	CCG Minimum Contribution	300
Single Point of access and care co-ordination (new)	Community Health	CCG			Charity/Voluntary Sector	CCG Minimum Contribution	100
Community Equipment &adaptationsexisting plus (S256)	Community Health	Joint	85%	15%	Local Authority	CCG Minimum Contribution	935
Vitaline (S256)	Community Health	Local Authority			Local Authority	CCG Minimum Contribution	680
Integrated Crisis and Rapid Response (S256)	Social Care	Local Authority			Local Authority	CCG Minimum Contribution	561
Maintaining Eligibility Criteria (existing(£125k) plus S256)	Social Care	Local Authority			Local Authority	CCG Minimum Contribution	1,459
Reablement Services (S256)	Social Care	Local Authority			Local Authority	CCG Minimum Contribution	584
Bed Based Intermediate Care Services (from CCG £1.6m plus S256)	Community Health	Local Authority			Local Authority	CCG Minimum Contribution	591
Early Supported hospital Discharge (CCG £1.6m plus S256)	Community Health	Joint		100%	Local Authority	CCG Minimum Contribution	463
Mental Health Services (S256)	Mental Health	Local Authority			Local Authority	CCG Minimum Contribution	498
Dementia Services (CCG £1.6m)	Mental Health	Local Authority			Local Authority	CCG Minimum Contribution	243
Other Preventative Services (S256)	Social Care	Local Authority			Local Authority	CCG Minimum Contribution	65
Carers support workers/grants(from CCG £1.6m)	Community Health	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	125
AHP /Nursing Support to ARC (from CCG £1.6m)	Community Health	Local Authority			NHS Community Provider	CCG Minimum Contribution	166
Rapid Response (existing plus £1.6m)	Community Health	CCG			NHS Community Provider	CCG Minimum Contribution	800
HD Team (from CCG £1.6m)	Community Health	Joint	100%		NHS Community Provider	CCG Minimum Contribution	127
Hospital Aftercare service (existing)	Social Care	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	71
Disabled Facilities and Social Capital Grants	Social Care	Local Authority			Local Authority	Local Authority Social Services	1,649
Extensivist Service (new in 15/16)	Community Health	CCG			NHS Community Provider	CCG Minimum Contribution	2,000
Support for Social Care Act (new in 15/16)	Social Care	Local Authority			Local Authority	CCG Minimum Contribution	600
GP Plus NEL scheme	Primary Care	CCG			Primary Care	CCG Minimum Contribution	1,800
Community Schemes aimed at NEL reduction and OOH	Community Health	CCG			NHS Community Provider	Additional CCG Contribution	1,000
Total							**15,230**

SCHEDULE 1 PART 2 – FINANCIAL REPORTING ARRANGEMENTS

1. FINANCIAL CONTRIBUTIONS AND FINANCIAL MANAGEMENT ARRANGEMENTS

1.1 In exercise of the irrespective powers under Section75 of the 2006 Act, the Partners have agreed to establish and maintain a Pooled Fund. The table below shows the Financial Contributions made by the Partners into the Pooled Fund:

Partner Organisation	Financial Contribution2015/16 (BCF) £000
Blackpool Council	1,649
Blackpool CCG	13,581
Total Contribution	15,230

1.2 The Council shall act as the Host Partner for the Pooled Fund. The Council will account for the Contributions and will invoice each Partner monthly in advance on the first of the month to which the payment relates for one twelfth of their Contribution. Each Partner shall charge back to the Pooled Fund any expenditure incurred directly up to the maximum amount that they have contributed to the Pooled Fund. The Pooled Fund will record the actual expenditure incurred in relation to the Services.

1.3 In the event that additional Financial Contributions are proposed to be made into the Pooled Fund, a business case proposal should be developed, proportionate to the scale of funding requested. The business case will be submitted to the Partners for consideration and decision. Partners will usually agree any additional contributions as part of their annual investment planning rounds.

1.4 The Pooled Fund will be used solely for commissioning Services set out in Schedule 1 Part 2.

1.5 Each Partner will be responsible for adhering to its own standing orders and Financial regulations in respect of the Contributions and expenditure charged back to the Pooled Fund. The Host Partner is under no obligation to ensure the other Partners' compliance in this regard.

1.6 Lead commissioning arrangements outlined in Schedule 1 Part 2 will continue for the duration of this Agreement. The responsibility for financial payments to Providers will remain with the Lead Commissioner.

1.7 The Strategic Commissioning Group shall have overall responsibility for performance managing and monitoring of actual income and expenditure in relation to the Pooled Fund. The Host Partner will provide regular financial reports to the Strategic Commissioning Group and each Partner (at least Quarterly), using information from its accounting system and/or information provided by each Partner or Agent, where appropriate. The Strategic Commissioning Group shall recommend that any cost pressures and mitigating actions are reported through the appropriate governance structures in each Partner organisation. Financial information should be supported by appropriate and proportionate activity reports. From the Second Quarter onwards, financial reporting should include a forecast of the year end position.

1.8 Each Partner shall bear the full costs incurred in respect of Non-Pooled Fund services/activity including, but not limited to, overheads, internal recharges, incidental expenses and damages).For the avoidance of doubt, Non-Pooled Fund services/activities shall not be paid out of the Pooled Fund.

1.9 Providing the information required for the year end accounts to each Partner and its auditors, in line with final reporting deadlines.

1.10 The Partners shall co-operate in the prompt provision of information, and access to premises and staff, to ensure compliance with any statutory inspection requirements, or other monitoring or scrutiny functions. The Partners shall implement recommendations arising from these inspections, where appropriate.

SCHEDULE 2– GOVERNANCE

Blackpool Strategic Commissioning Group – Terms of Reference

The operation of this agreement will be overseen by the Strategic Commissioning Group and all decisions will be subject to ratification by the Health and Wellbeing Board. The Terms of Reference of the Strategic Commissioning Group are detailed below:

	• To provide strategic leadership on commissioning arrangements for children and young people, adults, older people and adults with mental health problems across NHS, Public Health, Social Care and Children's Services. • To work in an advisory role to support Blackpool Health and Wellbeing Board to fulfil its responsibility **to drive integrated commissioning of health and social care services** in particular for the most vulnerable individuals and groups with the worst health outcomes. • To lead, on behalf of Blackpool Health and Wellbeing Board on the development and implementation of plans for an improved and integrated health and social care system for adults, older people and adults with mental health problems. • To be responsible for planning the way in which Blackpool Council and Blackpool CCG and other health commissioners work together to commission health and social care for children and young people, adults and older people and adults with mental health problems. • To have oversight of pooled budgets and resources for identified services as and when required including funding arrangements for the Better Care Fund. • **To have strategic oversight of the commissioning plans for Better Start, HeadStart and Complex Needs.** • To have oversight of funding opportunities across NHS, Public Health, Adult Social Care and Children's Services and manage the inflow/influx of bids to ensure that these are aligned to strategic priorities as far as possible. • To take into account existing governance and partnership structures to ensure a more co-ordinated **and integrated** approach to commissioning and the delivery of the vision of Blackpool Health and Wellbeing Board. • To oversee on behalf of Blackpool Health and Wellbeing Board the development and implementation of action plans against agreed priorities in the current **JHWS and to oversee the development of the new JHWS for 2015-18.** • To comply with statutory guidance, where it exists. To have oversight of and provide co-ordination to the overall agenda for Blackpool Health and Wellbeing Board.
2	**SCOPE**
	• To provide advisory support and oversee the delivery of commissioning approaches across services for children and young people, adults and older people in Blackpool in conjunction with other governance partnerships. • To optimise opportunities to integrate commissioning and service delivery of effective health and social care services • To work closely with: - JSNA Strategic Group - **Blackpool Children and Young People's Partnership**

	- Fylde Coast End of Life Strategic Group - Quality Surveillance Group - Fylde Coast Out of Hospital Strategy Steering Group - **Better Start Executive Board** - **HeadStart Executive Board** - ***Complex Needs Executive Board*** • To enable commissioning of services across health and social care including the use of Section 75 Agreement or Section 256 agreements. To have oversight of performance management arrangements across NHS, Public Health Adult Social Care and Children's Services.
3	**RESPONSIBILITIES**
	• **To develop and implement an annual work programme of joint commissioning priorities and intentions.** • To monitor and report progress on implementation of the work programme in accordance with agreed reporting schedules and processes to the Health and Wellbeing Board. • To review outcomes across the JHWS and other strategies to identify areas for integrated working. • **To have oversight of commissioning strategies and plans for the partner organisations on the group to support integrated working.** • **To have oversight of financial strategies and plans for partner organisations on the group to support financial planning and aligning of budgets to support integrated working.** • **To develop a joint programme of communications and engagement.** • To develop a robust performance framework to monitor progress against agreed priorities within the JHWS and across NHS, Public Health, Social Care and Children's Services. • **To work collaboratively with lead officers to develop robust action plans to deliver the priorities in the JHWS; this will involve developing and implementing action plans and reporting on progress, including barriers of specific actions, and sanctioning remedial action, where required to ensure that action plans remain on track.** • To sponsor task and finish groups and working groups to develop and implement action plans in relation to specific themes as these arise. These will be established at the discretion of the Chairs of the Health and Wellbeing Board and Strategic Commissioning Group with membership drawn from appropriate partners. • **To jointly agree any national reporting responsibilities based on integrated commissioning responsibilities.**
4	**REPORTING ARRANGEMENTS AND GOVERNANCE**
	To report six weekly on the work programme to: • Blackpool Health and Wellbeing Board To report quarterly on performance arrangements to: • Blackpool Health and Wellbeing Board • Blackpool Clinical Commissioning Group Board

5	**MEMBERSHIP**
	Core Members • Director of Children's Services (Chair) – Blackpool Council • Director of Adult Services – Blackpool Council • Director of Public Health – Blackpool Council • Director of Resources – Blackpool Council • Chief Clinical Officer – Blackpool CCG • Chief Operating Officer – Blackpool CCG • Chief Finance Officer – Blackpool CCG • Head of Commissioning – Blackpool CCG • Senior Public Health Specialists x 3 – Blackpool Council • **Head of Commissioning – Blackpool Council** • Director – NHS England (Lancashire) • Director – Blackpool Teaching Hospitals NHS Foundation Trust **Invited members** • Corporate Development Manager – Blackpool Council • Director of Integration and Transformation – Blackpool CCG • Head of Public Health – NHS England Wider partners will be invited to meetings as appropriate. The quorum for the meeting will be half of the membership with representatives from at least two organisations, in attendance.
6	**RELATIONSHIP TO OTHER GROUPS**
	• To act as an advisory group to Blackpool Health and Wellbeing Board. • To work collaboratively with the Children and Young People's Partnership on key health priorities for children and young people. • To work collaboratively with health commissioners and relevant departments and organisations across the NHS, Public Health, Social Care and Children's Services. • To have oversight and contribute to the work of: - JSNA Strategic Group - **Children and Young People's Partnership** - Fylde Coast End of Life Strategic Group - Quality Surveillance Group - Fylde Coast Out of Hospital Strategy Steering Group - **Better Start Executive Board** - **HeadStart Executive Board** - *Complex Needs Executive Board*

7	**FREQUENCY OF MEETINGS**
	Six weekly preceding the meeting of Blackpool Health and Wellbeing Board.

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

1 The Partners agree that Overspends are to be met by the Lead Commissioner for that Scheme as set out in the Schedule of Schemes at Schedule 1 Part 1 of this Agreement.

2. To the extent that the Better Care Fund Payment for Performance is not available to the Pooled Fund the Partners have agreed that an additional contribution will be made by the CCG of an amount required to meet the shortfall to the lower of the expected income or the value of the actual payments from the pooled fund in that year, or payment for one or more of the Individual Schemes for which the CCG is the Lead Commissioner will be reduced by an amount required to meet the shortfall in the expected income.

3. Where new Individual Schemes are added to this Agreement, the Strategic Commissioning Group will determine the arrangements to apply to any overspends against each additional Individual Scheme.

4. The Strategic Commissioning Group shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to any forecast Overspends, including, but not limited to, whether there is any action that can be taken in order to contain expenditure.

5. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

6. Where there is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates save to the extent that such overspend is not the fault of the other Partner.

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

Part 1– LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Partner if it receives or serves:

- a notice notifying an organisational and/or managerial change in control of the Lead Commissioner or the Provider;
- a notice providing notification of a force majeure event;
- Notice of a Event of Force Majeure;
- any other formal notice or contract query;

and provide copies of the same.

2. The Lead Commissioner shall provide the other Partner with copies of any and all:

2.1 CQUIN Performance Reports where appropriate;

- Reports under Commissioning for Quality and Innovation Guidance required under the Service Contract; and
- Other records, reports, plans which the parties under a Service Contract are required to provide.

3. The Lead Commissioner shall consult with the other Partner before attending any meetings with a Provider pursuant to a Service Contract and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4. The Lead Commissioner shall not:

- permanently or temporarily withhold or retain monies pursuant to the Service Contract;
- vary any plans, processes or procedures of the Provider prescribed under the Service Contract;
- agree (or vary) the terms of a joint investigation or a joint action plan;
- give any approvals under the Service Contract;
- agree to or propose any variation to the Service Contract (including any Schedule or Appendices);
- suspend all or part of the Services;
- serve any notice to terminate the Service Contract (in whole or in part);
- serve any notice;
- agree (or vary) the terms of a plan for transition or succession of the Service on expiry or termination of the Service Contract;

without the prior approval of the other Partner (acting through the Authorised Officer) such approval not to be unreasonably withheld or delayed.

5. The Lead Commissioner shall advise the other Partner of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of the other Partner as part of that process.

6. The Lead Commissioner shall notify the other Partner of the outcome of any dispute or conflict that is agreed or determined by Dispute Resolution.

7. The Lead Commissioner shall share with the other Partner copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports).

Part 2– OBLIGATIONS OF THE OTHER PARTNER

1. The other Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

    - resolve disputes pursuant to a Service Contract;

    - comply with its obligations pursuant to a Service Contract and this Agreement;

    - ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2. The other Partner shall not unreasonably withhold or delay consent requested by the Lead Commissioner.

    - The other Partner (other than the Lead Commissioner) shall:

    - comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

    - notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Service Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 –ANNUAL VOUCHER

The following annual voucher must be used as required by direction 5(1)

Section 75 of Section 256 Annual Voucher

Blackpool Borough Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2016

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Reference Number and Title of Expenditure	Revenue Expenditure (£)	Capital Expenditure (£)	Total Expenditure (£)
Better Care Fund			
Total:			

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions of the Section 75 Agreement, including any cost variations, for each scheme approved by the Strategic Commissioning group in accordance with these Directions, and endorsed by the Health and Wellbeing Board.

Signed…….

Position:

Date:

The designated Pooled Fund Manager on behalf of the Host Partner, as recipient of funds (see paragraph 5(3) of the Directions)

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Venessa Beckett, Corporate Development and Policy Officer
Relevant Cabinet Member:	Cllr Graham Cain, Cabinet Secretary and Chair
Date of Decision/ Meeting:	21 October 2015

Health and Wellbeing Board Draft Forward Plan

1.0 Purpose of the report:

1.1 To inform members that a draft Forward Plan has been developed for the Board.

2.0 Recommendation(s):

2.1 It is recommended that members of the Board consider the draft Forward Plan and advise of any agenda items from individual organisations that the Board is required to approve so that they can be timetabled into the plan as appropriate.

3.0 Reasons for recommendation(s):

3.1 The forward plan will enable the Health and Wellbeing Board to plan in greater detail its forthcoming agendas.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is 'improve health and well-being especially for the most disadvantaged'.

5.0 Background Information

5.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, a draft Forward Plan has been developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to, and relevant to, the delivery of the Board's priorities.

Does the information submitted include any exempt information? No

5.2 **List of Appendices:**

Appendix 11 (a) - Draft Forward Plan

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

This page is intentionally left blank

(Draft) Health and Wellbeing Board Forward Plan 2015 – 16

BOARD MEETING	BOARD	BUSINESS ITEMS	THEMED DEBATE	DEADLINE FOR REPORTS
Wednesday 21 October 2015 3.00 – 5.00pm	Formal	**Items requiring a decision** 1. SCG update 2. Health Protection terms of reference 3. Children and Young People's Partnership update 4. Section 75 Pooled Budget Arrangements 5. Children and Young People's Emotional Health and Wellbeing Strategy (Transformation Plan) 6. New Models of Care Vanguard Value Proposition 7. CVS Business Plan – Why Infrastructure (Paul Greenwood – Chair of CVS) 8. Learning Disability Transformation Plan 9. Special Educational Needs and Disabilities update **Items for information** 10. Draft Forward Plan (SI)	**Healthier Lancashire – separate training session to take place.**	All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 7 October 2015**
Wednesday 2 December 2015 3.00 – 5.00pm	Formal	**Items requiring a decision** 1. SCG update 2. Intermediate Care Review update	**Due North Action Plan/HWB Strategy (45 mins)**	All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 18 November 2015**

BOARD MEETING	BOARD	BUSINESS ITEMS	THEMED DEBATE	DEADLINE FOR REPORTS
		3. HWB Annual Report 4. Blackpool Safeguarding Children's Board Annual Report 5. Healthy Weight Strategy 6. Health Protection – cryptosporidium 7. Children's Centres Vision **Items for information** 8. Draft Forward Plan (SI)		
Wednesday 27 January 2015 3.00 – 5.00pm	Informal		Comprehensive Spending Review impact and implications for partners	All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 13 January 2015**
Wednesday 2 March 2015 3.00 – 5.00pm	Formal	**Items requiring a decision** **1.** SCG update 2. Intermediate Care Commissioning Review 3. Health Protection update 4. HealthWatch 5. Drug Prevention Strategy 6. Draft Forward Plan (SI)		All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 17 February 2015**
Wednesday 20 April 2015 3.00 – 5.00pm	Formal	1. SCG update 2. Draft Forward Plan (SI)		All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 6 April 2015**