Lincolnshire's Local Transformation Plan
For Children and Young People's Mental Health and Emotional Wellbeing
Refresh 2018
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Introduction

This plan is the 2018 Refresh of the Lincolnshire Local Transformation Plan (LTP) for Children and Young People's Mental Health and Emotional Wellbeing. This Refresh should be considered as a supplement to the Lincolnshire Local Transformation Plan 2015-2020 and subsequent refreshed plans of the same.

Following the publication of Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing and subsequent publication of the Five Year Forward View for Mental Health, Lincolnshire embraced the opportunity to review its existing services and develop its support for young people in line with best practice and national guidance, such as the Local Transformation Planning guidance. This plan sets out multiple priorities for service provision and reports progress on the ambitious aspirations for future provision that have required radical service transformation and ongoing joint working across agencies including Schools and Health and also Service Users.

The resulting executive action plan is overseen by the Lincolnshire Future in Mind Steering Group and identifies the work that needs to be undertaken to sustain continuous delivery, respond to changing local needs and empower the voice of Lincolnshire's young people.

This refreshed plan, updated in October 2018, reflects the current position is regards to data and utilises CAMHS contract management performance data for 2017/18 and where applicable for Quarter 1 - 2018/19. However, as identified in the action plan there are some limitations in demonstrating through data, the progress of the transformed service and there is work to be done to establish more robust data collection and analysis, particularly in regards to areas of service delivery that are still in development.

This refreshed Local Transformation Plan, collaboratively developed with CCG’s and members of the multi-agency Lincolnshire Future in Mind Steering Group, will be reviewed at the Health and Well Being Board, shared with NHS Specialist Commissioning and other key agencies for input annually and actions will be monitored as part of the monthly commissioning review meetings. Key measures will be developed to monitor the success of the Local Transformation Plan which will include:

- Engagement of multi agencies and input to annually revised Plan.
- Work achieved in response to priorities identified by gap analysis.
- Increased financial efficiency and spend.
- Improved Outcomes for C&YP demonstrated through increased stakeholder engagement.
In accordance with the arrangements for review the CAMHS service has been monitored through commissioning contract review meetings and through robust mechanisms of collection and analysis of service user outcomes and feedback.

Annual action plan reviews for the CAMHS service are subject to the same governance arrangements.

The service ambitions for the next year 2018/2019 will be outlined, these will include what children and young people would like from children mental health services in the future.

Commissioning of services is aligned with the aims and objectives of the Lincolnshire Children and Young People's Strategy, which aims to provide a strategic framework to support ongoing decision making and guide commissioning activities to ensure sustainability and continuous improvement of services.

The Children and Young People's Strategy provides direction for the future provision of emotional wellbeing and mental health services for children, young people and families. For example:

- Health visitors will be upskilled to better identify a range of maternal/paternal mental health concerns.
- We will work effectively with schools to raise awareness of mental health and emotional wellbeing issues.
- The future delivery of CAMHS will be reviewed to ensure it meets the needs of children and young people.
- The Healthy Minds Lincolnshire Service delivery will be monitored to make sure it is meeting the emotional wellbeing needs of children and young people.

The Children and Young People's Strategy can be downloaded at microsites.lincolnshire.gov.uk//Download/110556.
Alignment with STP

The Lincolnshire STP has a footprint that covers a wide range of plans; the Lincolnshire Future in Mind Steering Group is a sub-group of the STP; actions and recommendations from the FIM feed into the overall 5 year plan. The transformation of mental health services for children and young people included in STP, specifically:

- Ongoing work to support the reduction in out-of-area placements.
- Transformation of community mental health services as part of the wider Integrated Neighbourhood Working programme.
- Continued recurrent investment in the children and young people’s pathway for mental health conditions. This is a continuation of the embedded transformation and funding invested by Lincolnshire County Council in the last year.

Detailed funding information is provided in Appendix 1: Financial Contribution.

Accountability for CAMHS performance

The Community Child and Adolescent Mental Health Service (CAMHS) Annual Contract Performance Report 2017/18 (Appendix 2a) is a review of the year’s performance, highlighting the achievements and challenges faced by the service.

The report also shows the objectives and actions over the year which led to service improvement, and an evaluation of the impact of these actions.

The report also showcases the achievement with service user engagement, focusing on the participation and involvement project. The report includes the results of the annual stake holder engagement survey and an analysis of these results.

Wider services such as Kooth Online Counselling and Healthy Minds Lincolnshire are also required to report against robust key performance indicators, to ensure value for money and continuous improvement and development of service delivery.
Governance Structure

CCG Governance Boards

NHSE Local Area Team

System Executive Team
(commissioner only)

Joint Executive Team

Health and Wellbeing Board
(JSNA)

CYP Scrutiny Committee

Lincolnshire Safeguarding Children’s Board

LCC Executive

Women and Children’s Board

SEND Steering Group

Autism Partnership Board

SEND Health Committee

Future in Mind

Transition Board

Maternity Transformation Board

CYP Transformation Board

CCG Commissioning Leads, Finance

CSU Contracting and Procurement

Children’s Integrated Commissioning Team

LCC Children’s Commissioning Team, Finance and Procurement

Public Health Children’s Team
<table>
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<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
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| 1.1 Will the LTP be both refreshed and republished by the deadline of 31 October 2018 with checked URLs, ensuring it is available on partner websites and in accessible formats for CYP, parents, carers and those with a disability? | • LPT refresh on target for completion including on agenda for approval by relevant Boards.  
• Agreed by all parties that refreshed LTP will be published on Local Authority, Lincolnshire Partnership NHS Foundation Trust and Lincolnshire West CCG websites. | • Accessible format of LTP to be produced and published on websites.  
• Final web content to be approved. | Jan 2019    |
| 1.2 If the plan is not refreshed by the 31st October 2018 deadline, has the CCG confirmed a progress position statement on the refresh on their website? | *Yes                                                                                                                                   |                                                                                         |             |
| 1.3 Is the LTP appropriately referenced in the STP? Does the plan align with the STP and other local CYP LTPs? (CCGs are requested to provide a paragraph on alignment) | *Yes – the Lincolnshire STP has a footprint that covers a wide range of plans; the Lincolnshire Future in Mind Steering Group is a sub-group of the STP; actions and recommendations from the FIM feed into the overall 5 year plan. The transformation of mental health services for children and young people included in STP, specifically:  
1. Ongoing work to support the reduction in out-of-area placements.  
2. Transformation of community mental health services as part of the wider Integrated Neighbourhood Working programme.  
3. Continued recurrent investment in the children and young people’s pathway for mental health conditions. This is a continuation of the embedded | • Work with STP to make specific reference to LTP document. | Sept 2019    |
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<th></th>
<th>Does the LTP include baseline figures (15/16), updated figures (16/17, 17/18) and planned trajectories for:</th>
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<th>transformation and funding invested by Lincolnshire County Council in the last year.</th>
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| 1.4 | • finance (LTP investment and other wider investment that contributes to deliver of transformation)  
• staffing (WTE, skill mix, capabilities)  
• activity (e.g. referrals made/accepted; initial and follow-on contacts attended; waiting times; CYP in treatment) with a clear year on year plan that demonstrates how performance will improve in line with access targets and increase capacity to deliver evidence based interventions?  
*Yes – included in plan are baseline figures, spends and projected spends. These have been agreed by CCG and Local Authority including: Mental Health contributions, CQUIN contribution, Transformation Plan funding and additional funding for Youth Justice and LD work streams.  
• Yes – included in plan are staffing levels, skill mix requirement and capabilities. Future CYP IAPT recruitment and training has been forecast, including Recruit to Train posts within CAMHS.  
• Yes – planned activity trajectories included. These are information by existing clear service KPIs and targets. These are monitored through contract management.  
• Workforce development plan to be developed to include Emotional Wellbeing and Mental Health Services, but also wider workforce needs in the system, such as Early Help and Social Care Teams.  
• All services to report to MHSDS by December 2018.  
• New outcome measure reporting fully operational by March 2019. |   | Apr 2019 |
| 1.5 | Does the refreshed LTP clearly evidence engagement with CYP and their parents/carers from a range of diverse backgrounds, including groups and communities with a heightened vulnerability to developing a MH problem, including CYP with Learning Disability/Autism spectrum disorder/Attention deficit hyperactivity disorder (ADHD)?  
*Yes – Future Commissioning intentions for services for children and young people with LD/ASD/ADHD has been developed through work with the All Age Autism Partnership; children, young people, parents and carers were integral to this work and the ASD/ADHD service will be re-commissioned in alignment with their views.  
* Peer Supporters and CAMHS Participation and  
* Further work to be completed to engage with CYP/Parents and Carers with Learning Disabilities to inform this area of the transformation work. |   | Dec 2019 |
Does it evidence their participation and co-production in:
- governance
- needs assessment
- service planning
- service delivery and evaluation
- treatment and supervision
- feedback to inform commissioning and services

Engagement Lead delivered engagement event with young people on transformation plans in March 2018. Those that attended were CYP that had previously accessed CAMHS and were from diverse backgrounds including LAC, LD, BMET, LGBT+ and also those from a wide geographical area, including areas of high deprivation and rural isolation.

- Engagement with CYP and their parents/carers in developing services is given high priority. CAMHS provider employs a Participation and Engagement Lead with a team of 4 WTE paid Peer Supporters across the County. These Peer Supporters are able to provide a platform for service user engagement and were instrumental in undertaking work with Service Users to put a visual plan in place to drive Service Development.
- Various other forums are engaged with across the County that include Care Leavers and other vulnerable groups in assessing current Service design and delivery, such as the current CAMHS Service Review.
- It is service requirement that Healthy Minds Lincolnshire and CAMHS gain Stakeholder feedback and are able to demonstrate direct service improvement.
- Other mechanisms such as "You Said, We Did" are used throughout Children's Services to demonstrate Stakeholder feedback in service improvement.
• Engagement with children and young people, parents and carers has been a focus of the CAMHS Service Review currently being undertaken and will inform future commissioning intentions and service design.
• Peer Supporters have been involved in the work done within CAMHS to develop self-referral pathways and processes.

1.7 Have the following relevant partners been consulted about the proposed key priorities of the refreshed LTP for 18/19:
- the chair of the Health and Wellbeing Board and their nominated lead members
- Children’s Partnership arrangements
- specialised commissioning
- local authorities including Directors of Children’s Services and Local Safeguarding Children’s Boards
- local Transforming Care Partnerships
- local participation groups for CYP and parents/carers

* Yes – The emotional and psychological wellbeing of children is one of 7 priorities for the Lincolnshire Health and Wellbeing Strategy and as such is reported regularly to the Board.
• The FIM Steering Group reports into the Women and Children’s Board and FIM is a standing item on the agenda
• The DCS chairs the Women and Children's Board and the LSCB is part of the same overall governance structure
• The Chair of the FIM Steering Group sits on the Transforming Care Partnership Board and leads on this for children and young people
• Peer Supporters have contributed to discussions to determine the key areas of continuing transformation of services that support children and young people’s emotional health and wellbeing

1.8 Are there clear and effective multi-agency governance board arrangements in place with senior level oversight for planning and delivery and with a clear statement of roles,

* Yes – Lincolnshire Future in Mind Steering Group has multiagency membership including: CCGs, Local Authority Social Care, Secondary and Further Education, SEND, Public Health, Paediatrics,
• Future developments to include supporting CYP and their Parents and Carers to build confidence in driving Dec 2019
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<td><strong>1.9</strong> Does the plan evidence a strategy on how to track and improve progress over the plan's period that includes KPIs? i.e. show yr1, 2, 3 etc.</td>
<td>See 1.4</td>
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<td><strong>1.10</strong> Does the plan portray a culture of collaborative working across agencies and evidence of where stakeholders have worked in partnership to reduce fragmentation in commissioning and service delivery, including all key investment and performance information from commissioners and providers within the area?</td>
<td>* Yes – A formal Section 75 agreements are in place which put collaborative working between CCGs and the Local Authority at the heart of CYPMH service design, delivery and performance monitoring. Further S75 partnership agreements are in place with our EWB&amp;MH Service Provider, LPFT, to manage our CAMHS and Emotional Wellbeing services. - The Lincolnshire Children's Transformation Board also worked collaboratively to put in place effective S75 agreements that support the delivery of health services for children, young people and families.</td>
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<td><strong>1.11</strong> Does the plan demonstrate links with other key strategic reforms and plans for children and young people with MH conditions, for example Transforming Care and special educational needs and disability (SEND)?</td>
<td>* Yes – the plan has highlighted the need for more dedicated capacity for children and young people's transforming care and a new post has been appointed to and a work plan agreed by the partnership. There are strong links with SEND as demonstrated in the recent joint SEND inspection (outcome currently unpublished)</td>
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Public Health England (PHE) publishes the Children and Young People’s Mental Health and Wellbeing profiles (YPMHW) with a range of indicators around needs, protective factors, prevention and finance. The full profiles can be accessed on the [website](#) and the key findings from the Lincolnshire profiles are summarised below.

The estimated prevalence rates are provided in the absence of an alternative. To calculate those, the prevalence given in the ONS survey Mental health of children and young people in Great Britain (2014) were applied to the number of children aged 5-16 resident in the area stratified by age, sex and socio-economic classification.

Based on the estimates the following number of children aged 5-16 in Lincolnshire would be expected to experience mental health issues in 2015 (numbers are rounded to the nearest 100):

- Mental health disorders – around 8,800 (9.4%),
- Emotional disorders – around 3,400 (3.6%),
- Conduct disorders – around 5,300 (5.7%),
- Hyperkinetic disorders – around 1,400 (1.5%)

The results should be interpreted with caution and consideration of local data and intelligence.

In the school year 2016/17 there was over two thousands pupils in Lincolnshire schools with a statement of special educational needs (SEN) where primary need is social, emotional and mental health. The rates of social, emotional and mental health needs in Lincolnshire schools are below the national levels (2.13% of school age children compared to 2.33% in England).

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is used to measure wellbeing in 15 year olds. The survey consists of 14 positively worded items, which measure aspects of feeling well and functioning well such as feeling relaxed and optimistic as well as ability to handle problems and autonomy. Participants were asked to rate how often they felt like each of the 14 statements (on a scale from 1 to 5). Overall score for an individual is a sum of the points from all the statements and average (mean) WEMWBS scores are reported local authorities. The mean score for Lincolnshire (47.6 in 2014/15) was slightly lower than the England results. (Source: PHE CYPMHW)

What About YOUth? (WAY) survey was established to collect robust local authority (LA) level data on a range of health behaviours amongst 15 year olds. During the school year 2014/15 the responses from Lincolnshire young people were in line with the national level for many aspects affecting health and wellbeing (like bullying or involvement in risky behaviours like alcohol or drug taking). In Lincolnshire, the proportion of 15 year olds who reported having been bullied in the past couple of months was slightly greater than nationally (56.2% compared to 55% in England). Whilst the proportion that reported 3 or more risky

Section 2: Understanding Local Need

Public Health England (PHE) publishes the Children and Young People’s Mental Health and Wellbeing profiles (YPMHW) with a range of indicators around needs, protective factors, prevention and finance. The full profiles can be accessed on the [website](#) and the key findings from the Lincolnshire profiles are summarised below.

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behaviours was 16.9% compared to 15.9% in England. At the same time, the greater proportion of pupils reported positive satisfaction with life in Lincolnshire than nationally: 66.7% compared to 63.8% in England. (Source: PHE, Health behaviours in young people)

In the financial year 2016/17 there were 99 hospital admissions of Lincolnshire residents aged under 18 due to mental health conditions; these include acute Paediatric and CAMHS in-patient beds. The measure includes all first finished episodes for all persons aged 0 to 17 years with primary diagnosis of mental and behavioural disorders (ICD10 codes F00 to F99). The number of admissions recorded in 2016/17 equates to the rate of 68.9 per 100,000 population; lower than the national rate of 81.5. For 2016-17, there were 14 admissions for 0-17 year olds across Lincolnshire for eating disorders, this equates to a rate of 9.7 per 100,000 (Source: PHE, Overview of child health)

In the financial year 2016/17 there were 237 hospital admissions due to self-harm in people aged 10 to 19 in Lincolnshire. Analysis of the admission rates shows that the self-harm admissions in children aged 10-14 have decreased in Lincolnshire from 296 per 100,000 population in 2015/16 to 172.4 in 2016/17. Whereas the national rates have not lowered and compared to Lincolnshire are significantly higher: 230 per 100,000 population. In Lincolnshire the self-harm admission rate in people aged 15-19 was 578.2 per 100,000 population in 2015/16 and has reduced to 410.7 for 2016/17. The national picture remains relatively the same for 2016/17 at 658; Lincolnshire being lower again. (Source: PHE CYPMHW)

There is local intelligence providing more insight into the issues of self-harm in Lincolnshire. The report 'Suicide and Self Harm in Lincolnshire, 2017 Annual Review' highlights that self-harm affects mainly younger people. It shows that the hospital admission due to self-harm are highest in people aged 15-19 out of all the age groups. In the financial year 2015/16, 39% of all the admissions due to self-harm affected people aged under 20, and rates for 15 year olds were especially high. In the youngest age groups (10-19) four out of five admissions were for females.

According to the 2014 Adult Psychiatric Morbidity Survey, the profile of people who self-harm is very different in terms of age and sex from that of people who take their own life, and the great majority of people who engage in these behaviours do not go on to die by suicide. In Lincolnshire, there were 6 suicide deaths of person aged between 15 and 19 registered during the calendar years 2014 to 2016. Majority of those were male deaths. ('Suicide and Self Harm in Lincolnshire, 2017 Annual Review').
Transforming Care in Lincolnshire

In October 2015, NHS England published 'Building the right support', a national programme to develop community services for people with a learning disability and/or autism. This programme known as ‘Transforming Care’ is a national programme to change how we deliver and commission services to children, young people and adults with learning disabilities and/or autism, including those with mental health condition or challenging behaviours. ‘Transforming Care’ aims to transform the way services are commissioned and delivered to stop people being referred to hospital inappropriately, provide the right model of care, and drive up the quality of care and support for people with learning disabilities and/or autism.

In response to the national programme, the Lincolnshire Transforming Care Partnership (TCP) was established to drive local transformation. The Partnership was formed in January 2016 bringing together Lincolnshire County Council and the four local CCGs – South West Lincolnshire CCG, South Lincolnshire CCG, Lincolnshire West CCG and Lincolnshire East CCG. Each local TCP were required to develop a Transformation Plan which describes the local vision for improving outcomes with a focus on more joined-up community based support and a reduced reliance on in-patient beds (non-secure, low and medium secure) which may include the closure of some in-patient facilities.

The Transforming Care plan will continue to be developed in partnership with people with a learning disability and / or autism, their families and carers to make sure the plans meet their needs and continue to drive up quality of care.

The most recent school census data available shows there are 10,137 children and young people that have special educational needs relating to either a learning difficulty, learning disability or emotional and/or behavioural problem in Lincolnshire schools; there are 438 children and young people whose learning difficulty or disability is either severe or profound and 1,332 with autistic spectrum disorder.

There are 138 Lincolnshire children and young people with learning disabilities, autistic spectrum disorder or emotional and/or behavioural problem in either independent or non-maintained schools, of which 41 are in the county and 28 are in counties bordering Lincolnshire.

Children’s and Adult Services are currently working together to redesign the support provided to young people in transition. The intention is to identify dedicated resource that will be responsible for:

- Identifying young people from age 14 that are likely to require additional support, particularly where their current placements are for 52 weeks.
• Supporting service users, families and carers to ensure that the most appropriate services are accessibly in order to meet their needs.
• Working with Children’s Services and adult mental health to ensure a smooth transition for young people that are accessing CAMHS.
• Working with Adult Social Care, where young people are in out of county placements, to identify suitable, community supported living for those that are not able to live in the family home.

Trends
The PHE Overview of Child Health shows the level of hospital admissions for mental health conditions since 2010/11. Nationally, the rate has been decreasing gradually from 109.4 per 100,000 population in 2010/11 to 81.5 in 2016/17. Whereas in Lincolnshire the rate for 2010/11 being significantly lower than the national figure at 68.2 per 100,000 population, rose steadily to a peak of 94.8 for 2015/16, but has decreased to 68.9 for 2016/17. The decrease in hospital admissions is a positive trend, but it does not provide full picture of mental health prevalence or its impact on other services like A&E, primary care or specialist mental health provision. (Source: PHE CYPMHW)

The admissions for self-harm in children and young people increased between 2011/12 and 2015/16 in Lincolnshire and nationally, with both local and national rates having similar values. However, whereas nationally the rate continued to rise from 87.3 per 100,000 in 2015/16 to 888 per 100,000 in 2016/17. The rates decreased in Lincolnshire over the same period from 874.2 per 100,000 in 2015/16 to 583.1 per 100,000 in 2016/17. Further analysis shows that Lincolnshire rates for 10 to 14 year olds and 15 to 19 year olds are significantly lower than national average. (Source: PHE CYPMHW)

Key Inequalities
Social disadvantage and adversity increase the risk of developing mental health problems. According to the Annual Report of the Chief Medical Officer 2013, children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.

The percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) were lower in Lincolnshire than nationally: 15.2% in Lincolnshire compared to 16.6% in England in 2015. There are however pockets within Lincolnshire where percentage of children in low income families exceeds 40%. Those areas are concentrated along the
Research by the Mental Health Foundation has identified certain risk factors that make some children and young people more likely to experience problems than other children.

These include:

- having a long-term physical illness
- having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law
- experiencing the death of someone close to them
- having parents who separate or divorce
- having been severely bullied
- having been physically or sexually abused
- living in poverty or being homeless
- experiencing discrimination, perhaps because of their race, sexuality or religion
- acting as a carer for a relative, taking on adult responsibilities
- having long-standing educational difficulties.

Local evidence exists to estimate the level of some of those risk factors. For example, 16.9% of 15 year olds in Lincolnshire are reported as having a long-term illness, disability or medical condition diagnosed by a doctor, compared to 14.1% in England. The What About YOUth (WAY) survey, 2014/15 showed that 56.2% of young people in Lincolnshire reported that they had experienced bullying, similar to the level for England, whilst this figure is high at first glance, further analysis is needed to offset this data against the relevant "Protective Factors" such as resilience, support network, education and existing mental health, to ascertain if mental health conditions can be attributed.

In Lincolnshire in 2016, there were 2720 children and young people identifies as 'in need' due to abuse or neglect. This equate to the rate of 191.3 per 10,000 people aged <18, that is higher than England's rate of 171 per 10,000.

The NSPCC paper Achieving Emotional Wellbeing for Looked After Children reports that almost three quarters (72%) of children in residential care experience some form of emotional and mental health problem.

In Lincolnshire, 625 were recorded as looked after in March 2016. This equates to the rate of 43.9 per 10,000 people aged under 18. That is lower than England's rate of 60.31 per 10,000. Emotional wellbeing of looked after children is measured through a strengths and difficulties questionnaire (SDQ). A higher score indicates greater difficulties (a score of under 14 is considered normal; 14-16 is borderline cause for concern and 17 or over is a cause for
An average difficulties score of looked after children aged 5-16 in Lincolnshire was 15.1 in 2015/16 which was slightly higher than England score of 14. (Source: PHE CYPMHW)

Inequalities in accessing services for those children and young people who are Looked After and those receiving support from Youth Offending Services have been considered as a priority in the transformation of the CAMHS service and these children and young people are able to access services in an equitable and non-stigmatising way; they have also been provided with a number of additional supportive measures such as specific reduced waiting times.

Further local data including topics such as Homelessness, educational attainment, alcohol, drugs and adult mental health issues can be accessed on the Lincolnshire Research Observatory: JNSA topics.
## 2. Understanding Local Need

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
</tr>
</thead>
</table>
| **2.1** Is there clear evidence that the plan was designed and built around the needs of all children and young people and their families locally who have or may develop a MH problem, including particular attention to groups and communities with a known heightened prevalence of MH problems, including CYP with LD/ASD/ADHD? | *Yes – Lincolnshire has developed a specific Joint Strategic Needs Assessment (JSNA) topic for Children and Young People’s Emotional Health and Wellbeing that has informed service development and in particular identified those children and young people who have a heightened risk if developing MH problems and identified vulnerable groups such as LAC:  
  - The JSNA is refreshed every year to inform the LTP and other related strategies.  
  - The FIM Steering Group is responsible for the refresh.  
  - The recognised and acknowledged gap in provision of services for CYP with LD/ASD/ADHD is being addressed. | • Adhere to plans to address gaps that are cited in the Children and Young People’s Strategy.                                                                                                                                                                                                 | Mar 2020    |
<p>| <strong>2.2</strong> Does the LTP demonstrate how the needs of disabled children and young people, including those with a learning disability, autism or both will be met? | *Yes – Services specifically commissioned for disabled children and young people, including those with a learning disability, autism or both are detailed in the plan, including for those CYP where there is a co-morbid mental health condition where integration of Specialist services has increased the offer of support to include Crisis and Home Treatment | • Future commissioning of Services to support those Children and Young People with Learning Disabilities is in progress. A new model to be developed and existing services aligned.                                                                 | Sept 2019   |</p>
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>Does the plan evidence a strong understanding of local needs and meet those needs identified in the published Joint Strategic Needs Assessment (JSNA), whilst also identifying where gaps exist, with evidenced based plans in place to address these?</td>
<td>See 2.1</td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Does the plan make explicit how health inequalities are being addressed?</td>
<td>*Yes – JSNAs include gap analysis and inform the Children and Young People's Strategy and Commissioning Plan.</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Does the plan contain up-to-date information about the local level of need and the implications for local services, including where gaps exist and plans to address this?</td>
<td>● Health Equality Audit to be refreshed.</td>
<td>Sept 2019</td>
</tr>
</tbody>
</table>
Appendix 3 provides details of the review of the progress on the ambitions that were set out for 2015/17 to support the implementation of the Lincolnshire Transformation Plan and the initial transformation of the CAMHS service specifically. The majority of these actions have now been successfully completed and are now monitored through robust quarterly contract management.

During the twelve month period from October 2016 to October 2017, the need to address Child and Adolescent Mental Health and Emotional Wellbeing through a whole system change was acknowledged and the approach was taken that will bring about sustainable improvement in both service provision and outcomes for young people. Going forward any remaining actions will transfer to this plan and any future refreshes.

Following the successful completion of much of the CAMHS transformation work, we have looked at the wider provision of emotional wellbeing and mental health support available in Lincolnshire for children, young people and their families.

Emotional Wellbeing and Mental Health Online Pathway – www.lincolnshire.gov.uk/ewb

This online pathway launched in October 2017 and was developed, following engagement with young people, parents/carers and professionals, to enable young people to access information and advice in one place and make them aware of available local services that can help support them when experiencing emotional wellbeing, mental health or behavioural concerns. The information is also designed to help families of children and young people experiencing emotional wellbeing, mental health or behavioural concerns and the professionals working with them.

The pathway aims to provide children and young people, and their families, with better access to the right support at the right time.
Online Counselling Service: Kooth

Previously, an Online Counselling Service was commissioned from March 2013 – March 2018. This was a self-referral, confidence and anonymous service that provided advice, support and guidance in a non-judgemental, safe space. In Lincolnshire there has been increasing demand for online counselling and the previously commissioned Online Counselling Service saw its commissioned hours increase by 242% since it was first commissioned (120 hours per month, increased to 411.5 hours per month).

An Online Counselling Service (https://kooth.com/) has been re-commissioned from April 2018 to March 2021, with the opportunity to extend for up to a further 2 years subject to review.

Online Counselling Support Service is for children and young people living in or attending education in Lincolnshire who are aged 11-18 (increasing to age 25 for Care Leavers and those with SEND) that have emotional wellbeing or mental health concerns.

This is a self-referral, anonymous and confidential Service and is commissioned in recognition that young people may need help, support and guidance in relation to short-lived, low to moderate level mental health concerns. Such concerns may affect the psychological and emotional well-being of young people causing concern to themselves, their families and friends. When supporting young people Kooth provide them with information that they are encouraged to share with their family, where appropriate, and the young person is also encouraged to discuss their concerns with their parent/carer.

The top ten reasons for Lincolnshire young people accessing the Online Counselling Service are (in order of priority) anxiety/ stress; family/relationship issues; depression; lack of confidence; self-harm; lack of self-worth; friendship issues; loneliness; anger and suicidal thoughts.
Healthy Minds Lincolnshire Service

Since October 2015, local authorities became responsible for commissioning public health services for children aged 0-19; this presented new opportunities for bringing together a robust approach for improving outcomes for children and young people up to the age of 19 (25 SEND) across both health and local authority led services.

Between October and December 2015, public and professionals were engaged to understand their views of the children's public health services being reviewed. In relation to emotional wellbeing, feedback from families and professionals highlighted potential gaps in support for school aged children:

- Almost 60% of respondents thought that an emotional wellbeing service would have a positive impact on children and families.
- Parent/carer and professional respondents combined said that the children need the most health related advice and support at age 13-16 in Years 9-11 (32%) and age 4-6 in Reception and Year 1 (23%).
- Emotional wellbeing support was the most important health concern overall.

The Healthy Minds Lincolnshire Service launched in October 2017 and is delivered by Lincolnshire Partnership NHS Foundation Trust through a partnership agreement on behalf of Lincolnshire County Council, supported by the Lincolnshire Learning Partnership. The Service provides countywide emotional wellbeing support to Lincolnshire children and young people up to the aged of 19 (25 SEND and/or care leaver), focusing on the needs of the child, including direct evidence-based interventions to children, young people and their families who are experiencing emotional wellbeing concerns and who do not meet the eligibility for other available services, thus impacting on their ability to thrive.

The service focuses on early intervention, promoting resilience and the prevention of emotional wellbeing concerns escalating to mental health issues.

Qualified practitioners deliver direct evidence-based interventions for Lincolnshire children and young people who are experiencing emotional wellbeing concerns and who do not meet the eligibility for other available services, thus impacting on their ability to thrive. This includes group interventions and 1:1 support (where this is determined as a need by the Service). Parents/carers are involved with the interventions with Healthy Minds Lincolnshire providing advice/guidance to parents/carers and families on the intervention taking place so that a consistent approach can also be modelled in the home environment. The group support model includes a session for parents/carers in order to upskill them on being able to better support the emotional wellbeing concerns of their child. Advice, guidance and signposting is also available to parents/carers and professionals supporting children with emotional wellbeing concerns, as well as training for the Lincolnshire preschool and school workforce, and relevant Children’s Services professionals.
Healthy Minds Lincolnshire also works closely with other children's services teams as well as other services – particularly CAMHS, the new Children's Health Service 0-19, the online counselling service (KOOTH) and relevant adult services – ensuring there are seamless pathways for Lincolnshire children and young people and they receive timely support from the best placed professional.
<table>
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<th>Target date</th>
</tr>
</thead>
</table>
| Does the LTP identify a system-wide breadth of transformation of all relevant partners, including NHS England Specialised Commissioning, the local authority, third sector, youth justice and schools & colleges, primary care and relevant community groups? | * Yes – Throughout the plan collaborative decision making and design of transformed services is referenced in regards to specific pieces of work e.g. Local Authority, Youth Justice and Primary care programmes that support CYPMH.  
- The wide range of partners who are members of the FIM Steering Group demonstrate collaborative transformation across services and partner agencies  
- Local trailblazer work is being undertaken with schools to increase capability and capacity within the school workforce in the early identification and intervention of CYP with emotional wellbeing and mental health concerns | • To build on the transformational work undertaken with CAMHS to address system-wide change that is needed.  
• Identifying gaps and working with partners to commission services to meet the specific needs of CYP such as those in contact with the Youth Justice System.  
• Continuing to develop effective systems with schools and colleges that support both early identification and intervention, whilst providing prompt access to specialist services when needed. | March 2020 |
| Does the LTP align with the deliverables set out in the Five Year Forward View for Mental Health with a clear vision as to how delivery will be different in 2020 and how this will be evidenced? | *Yes – The LTP vision and direction of transformation aligns with the FYFVMH and trajectories for key measures will be evidenced against National targets including expectations for CYP IAPT and Eating Disorders. |
### 3.3 Does the plan evidence the whole system of care including:

- prevention and early intervention, including universal settings, schools, colleges and primary care
- early help provision with local authorities, Public Health and Directors of Children’s Services
- evidenced – based routine care
- crisis care and intensive interventions

- identifying needs, care and support for groups who may require alternative intervention types or settings or further outreach services, such as those who have experienced trauma or abuse, 3 or more adverse childhood experiences (ACEs), looked after children, children with learning disabilities, isolated communities, groups with historically poor access to mental health services, those at risk of entering the justice system. This is not an exhaustive list and will vary depending on area
  - inpatient care
  - specialist care e.g. CYP with learning disabilities or forensic CAMHS

*Yes - The LTP evidences how whole system change is being addressed with examples of how pathways of referral and intervention are improving access and outcomes, with examples of impact throughout.*

- Complete a review of current referral routes and pathways to identify further opportunities for alignment to improve access to appropriate support.
- Future commissioning of services to include evidence of impact, not only for individuals but also as a measure of overall performance.

### 3.4 Where New Models of Care are being tested is there a commitment to continue to invest LTP monies beyond the pilot?

Lincolnshire is not a pilot area for the New Models of Care, however, new and innovative system structures are being considered in regards to reducing the number of CYP accessing inpatient provision and a move to a wider system of community based support and intervention.

- Analyse of outcome of New Models of Care pilots and design new service model based on findings.

Mar 2020
| 3.5 | Does the LTP evidence: a) commissioning practice and b) local operating procedures which promote and encourage prompt referrals and access to services? e.g. does the plan describe proactive work to support those working with CYP to promptly and appropriately refer to CYPMHS? | * Yes - The plan describes the current system in place whereby CYP, their families and professionals supporting them can access different levels of advice and support to meet their needs and provides seamless transition to further specialist interventions when needed. - The model for Self-referral that is already in place for the early intervention service; Healthy Minds Lincolnshire, has been piloted in CAMHS. - Evidence demonstrates that prompt access and wait times to services for those CYP identified as being in a high risk vulnerable group are good and being maintained. | • Development of a referral pathway that aligns services and facilitates access to the right support at the right time. • Continue to develop Self-referral in CAMHS. • CAMHS Service Review is considering the inclusion of additional vulnerable groups, alongside other Children's Services reviews. | Mar 2020 |
| 3.6 | Does the LTP clearly set out, based on the best available evidence, the expected and/or intended impact of local prevention services on the wider pathway and on the outcomes for CYP using the services? | * Yes - The LTP provides details of Early Intervention Services that have been commissioned to meet identified needs and specified deliverables are designed to reduce referrals to wider services including specialist services. - Early Help workers are supporting parental mental health and reducing trauma in the home. | • To identify mechanisms whereby the impact of Early Intervention services can be clearly seen throughout the system, e.g. 0-19 Health Service. • Increased emphasis for early identification and interventions for services such as Eating Disorders. • Gap in provision for perinatal mental health has been identified and work on effective pathways of identification and intervention are being developed. | Mar 2019 |
| 3.7 | Does the plan map out services provided directly by schools to support emotional wellbeing and MH? | * Yes - The plan provides descriptions of services that are delivered directly in schools e.g. Behavioural Outreach Service (BOSS), Healthy Minds Lincolnshire etc. | • To complete mapping of training delivered and accessed e.g. Mental Health First Aid, and support | Sept 2019 |
| 3.8 | Does the LTP include work underway with adult MHS to link to liaison psychiatry in line with the requirements in the Five Year Forward View for Mental Health for CCGs to commission improved access to liaison mental health services? | * Yes - A bid has been sponsored by the STP group and the outcome is awaited. If successful this will improve access to liaison services. |  |
| 3.9 | Does the LTP include joint agencies sustainability plans going forward beyond 2020/21? | * Yes - The current section 75 agreement is in place to April 2020 and a draft Emotional Wellbeing Strategy is being developed with a wide range of partners who currently commission a range of services that it is planned will be collaboratively commissioned beyond 2020. | * To finalise the Emotional Wellbeing Strategy for 2020 onwards. | Sept 2019 |
Section 4: Developing the Workforce

Lincolnshire continues to support the CYP IAPT training programme as outlined in Section 7, including continuing commitment to further develop both the CAMHS workforce and the wider workforce, e.g. Healthy Minds Lincolnshire and Local Authority Early Help and Youth Offending practitioners.

Representatives of the Local Authority and CAMHS attended two Workforce Planning events delivered by the CYP IAPT Midlands Collaborative in September and October 2018. As a result the Local Authority will be bringing together a strategic workforce planning group, which will be a sub-group of the Future in Mind Steering Group, supported by the Collaborative workforce development experts. This group will work to review partner workforce strategies in relation to the system-wide workforce development, with the aspiration to have an over-arching strategy that will enable the delivery services that will address a wide range of emotional wellbeing and mental health needs. Integral to this work will be the use of the Workforce Planning toolkit (Appendix 8a).

Extensive work has already undertaken been through skills and competency audits in CAMHS, Healthy Minds, the Local Authority and wider partner organisations, this needs to be brought together to inform the Workforce and Training Plans, to determine what further development will be necessary, as well as the financial commitment needed to meet our workforce aspirations for 2020.

CAMHS Workforce

Recruitment and retention of staff has been a challenge, particularly in the south of the county. Some long service staff have retired this year. The recruitment pool for CAMHS clinicians is small which is an ongoing challenge for the service. Cover when needed has come from Locum Consultant Psychiatrists. In addition Psychology vacancies have been a challenge to recruit to and when newly qualified Psychologists are recruited there is often a delay in their start while they complete their course. However, during the course of this year 3 newly qualified Clinical Psychologists were successfully recruited, 2 of them coming from the Lincoln based clinical psychology training course. A Highly Specialist Systemic Psychotherapist has been recruited to replace the Systemic Psychotherapist who was leaving and this was done in a timely fashion with no gap in this provision.

The CAMHS workforce has been developed by being offered a variety of training and development over the year:

- 21 CAMHS clinicians have attended Eye Movement Desensitization Reprocessing (EMDR) Levels 1 and 2 training which was arranged and provided locally.
• All clinicians that deliver CBT groups attended local training for the new CBT group content.
• A 3 day in service training “Introduction to CBT with Children and Young People” was provided to a total of 41 CAMHS and Healthy Minds staff.
• 4 clinicians attended DDP level 2 training.
• The 3 newly qualified Clinical Psychologists who joined the service during this year have been supported in attending a STAR supervisor training.

The service will review its Training Need Analysis for 2018/2019 and identify training for that year.

The current funded establishment of CAMHS staff is shown in the table below, including administrative staff, (figures represent Whole Time Equivalent):

<table>
<thead>
<tr>
<th>CAMHS Team</th>
<th>Band 2</th>
<th>Band 3</th>
<th>Band 4</th>
<th>Band 5</th>
<th>Band 6</th>
<th>Band 7</th>
<th>Band 8</th>
<th>Admin B3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS Eating Disorder Service</td>
<td>-</td>
<td>0.8</td>
<td>2.0</td>
<td>-</td>
<td>4.0</td>
<td>1.0</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Boston CAMHS</td>
<td>2.10</td>
<td>1.4</td>
<td>2.4</td>
<td>3.0</td>
<td>5.0</td>
<td>2.0</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Lincoln CAMHS</td>
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<td>2.2</td>
<td>2.8</td>
<td>3.0</td>
<td>5.0</td>
<td>3.5</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Grantham CAMHS</td>
<td>1.5</td>
<td>3.0</td>
<td>2.0</td>
<td>3.0</td>
<td>5.0</td>
<td>2.0</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Louth CAMHS</td>
<td>0.51</td>
<td>1.0</td>
<td>2.88</td>
<td>1.0</td>
<td>2.0</td>
<td>1.9</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>CAMHS Peer Support Workers</td>
<td>-</td>
<td>4.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>CAMHS Youth Offending Service</td>
<td>-</td>
<td>-</td>
<td>3.0</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>CAMHS Learning Disabilities Team</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.0</td>
<td>-</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>CAMHS Therapeutic Psychology</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.8</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>C&amp;HTS South</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>1</td>
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</table>
Online Counselling – Kooth

Kooth Counsellors are qualified counsellors with a minimum of 3 years' post-qualification experience of face to face counselling and are accredited by, or working towards an accreditation with the British Association for Counselling and Psychotherapy (BACP)

Kooth Counsellors receive training on how to apply their skills online when they come to Kooth.

Kooth also have Emotional Wellbeing Practitioners who have previous experience and qualifications in working with children and young people in previous roles, e.g. Social Workers, teachers, youth workers, etc.

All Kooth employees access COGS Goals and Outcomes training, Mental Health/IThrive Model training.

Employees are also given access to training on suicide and risk, eating disorders and trauma.

Kooth Inclusion and Participation workers promote Kooth and deliver assemblies/presentations to schools and other professionals. Also support the Kooth Ambassador programme (YP who have previously accessed online counselling support and act as Ambassadors for Kooth).

Kooth would encourage young people to speak to their parents/carers and would also signpost young people to other services for further support but they don't work directly with a whole family. They would provide advice and guidance to the young people and encourage them to share that with their family.

Health Minds Lincolnshire

Healthy Minds Lincolnshire skilled workers deliver interventions, workshops and training. All staff delivering interventions complete the Cognitive Behaviour Therapy (CBT) essentials and Solution Focused Therapy (SFT) essentials training and also undertake positive behavioural (PBS) training.

All HML Band 5 and above are registered practitioners who are from a range of backgrounds including Mental Health Nurses (RMN), Social Workers, School Nurses (RGN or RCN) and registered counsellors (BACP).

The Service has also successfully supported 6 CYP IAPT Wellbeing Practitioners who were undertaking their training during 2016/17 and after successful completion of their training they gained their Certificate in Psychological Wellbeing Practice of Children and Young People through Northampton University and were offered roles within the Service. Four
accepted roles within the Service at Band 4 level, however, 3 out of the 4 have now successfully secured Band 5 roles within the Service.

A further 6 CYP IAPT WPs are undertaking training during the 2018/19 financial year through Northampton University and are being supported by the Service and will also be offered roles within the Service upon successful completion of their training.

Training and support is available from Healthy Minds Lincolnshire to Lincolnshire pre-school and school workforce (including state funded academies), as well as relevant children’s services professionals, to build confidence and provide the tools to support children's emotional wellbeing concerns.

Healthy Minds Lincolnshire will continue to offer both centrally held training programmes and in-house training to professionals in Lincolnshire schools and academies and will contribute to the ITT training programmes in Lincolnshire for the 2018/19 and 2019/20 academic years. The Service will also continue to offer to contribute to relevant providers' Child Care qualification programmes, providing the opportunity to upskill students undertaking those programmes.

For Healthy Minds Lincolnshire in addition to the interventions provided (group support and 1:1) in the group support model there is a session for parents/carers to upskill them on being able to better support the emotional wellbeing concerns of their child.
## 4. Developing the Workforce

<table>
<thead>
<tr>
<th>Requirement</th>
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<th>Future Actions Required</th>
<th>Target date</th>
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</thead>
</table>
| **4.1** Does the LTP include a multi-agency workforce plan or align with wider STP level workforce planning? | * Yes - The plan references work already taken in upskilling and retraining the Specialist workforce e.g. CYP IAPT.                                                                                                 | - To develop a wider workforce plan and align, where possible, to the STP.  
- To increase the focus of the workforce plan by including this work on relevant agendas, e.g. Transformation Board.                                                                                                      | Apr 2019    |
| **4.2** Does this include schools and colleges?                              | * Yes - The plan includes the training offer to schools.  
- The extension of the Caring to Learn project to support the wider school population.                                                                                                                      | - To complete a review of training available to the wider workforce, including colleges and identify where there are gaps.  
- To embed Caring to Learn and agree plans for sustainability  
- Joint planning with schools and colleges to meet the recommendations of the White Paper and actively develop effective pathways of intervention.                                                   | Apr 2019    |
| **4.3** Does the workforce plan identify the additional staff required by 2020 and include plans to recruit new staff and train existing staff to deliver the LTP's ambition? | * Yes - The plan includes information regarding CYP IAPT recruitment and training, including Wellbeing Practitioners and Recruit to Train posts to meet targets for 2020.                         |                                                                                                                                                                                                                                                                                       |             |
| **4.4** Does the workforce plan include CPD and continued training to deliver evidence based interventions (e.g. CYP IAPT training programmes), including resources to support this? | * Yes - The plan details continuing CPD, training needs and resources needed.                                                                                                                                  |                                                                                                                                                                                                                                                                                       |             |
| 4.5 | Does the plan include additional workforce requirements? E.g. to train and retain Wellbeing Practitioners for CYP and additional staff for CYP 24/7 crisis care and dedicated eating disorders services where this is not already in place? | * Yes - The plan includes achievements in regards to workforce development, CPD and recruitment new CYP IAPT posts, e.g. Wellbeing Practitioners. | • Workforce Development Plan to include planning post April 2020. | Apr 2019 |
| 4.6 | Does the workforce plan detail how it will train staff in skills to work with children with specific needs e.g. children and young people with learning disabilities, autism or both, ADHD, and communication impairments? | * Yes - a review of current services to meet the needs of CYP with Learning Disabilities has identified where there are gaps. | • Future service design to include appropriate training requirements for staff supporting those CYP with LD. | Sept 2019 |
| 4.7 | Does the workforce plan detail the required work and engagement with key organisations, including schools and colleges, and detail how the plans will increase capacity and capability of the wider system? | * Yes - The plan gives an overview of the achievements so far in regards to increasing capability and capacity for school staff e.g. access to consultation with CAMHS Clinicians and joint delivery of group interventions in schools. | • To further engage with schools and colleges to evaluate work done so far and inform future support and training. | Sept 2019 |
The Lincolnshire STP seeks to create a sustainable, long term prevention, self-care and early intervention system. We want to support families to look after themselves, working closely within our local communities and neighbourhoods. To do this the STP is overseeing the development of clear, joined up care and health packages where services are provided close to home and with physical health, mental health and social care all working as together as one.

Lincolnshire Children's Services has a vision for integration that "Everyone Working Together for all Children, Young People & Families to be Happy, Healthy, Safe and the BEST they can be".

In order to translate these shared ambitions into effective services for children and young people who are experiencing emotional and psychological distress we are developing a model that has building resilience at its heart and reduces the dependence on specialist services by the promotion of self-care; increasing the effectiveness of universal services; joining up targeted services to work collaboratively with those with increased vulnerabilities.

This model (when agreed) will be used to develop a commissioning strategy, as part of the STP, that will ensure services are in place to support this model. This will include commissioning new services to address current gaps – e.g. for those with ASD/ADHD; ensuring the sustainability of highly effective approaches e.g. behaviour outreach to schools and Healthy Minds Lincolnshire and agreeing New Models of Care for those young people with the highest needs.
Collaborative and place based commissioning

Proposed service model
For Discussion

We have sought to build up a service model/care model that represents the views of the stakeholders we have worked with across the life of this project. It has been designed to respond the emerging vision and to reflect recent good practice. The goal is to promote a whole system approach to united services, but also:

1. Shared ownership of emotional wellbeing
2. Self-care
3. Ease of access
4. Early intervention
5. Emotional Wellbeing Service pathway that engages all the parties and tiers
6. Care close to the child or young person that is personalised
7. Clear connectivity across the spectrum of assessment and delivery
## 5. Collaborative and Place Based Commissioning

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
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<tbody>
<tr>
<td><strong>5.1</strong> Does the LTP include concrete plans to develop and implement joint place based commissioning (between CCGs and specialised commissioning) for integrated urgent and emergency care, including admission avoidance?</td>
<td>* Yes - Planning is currently underway with NHSE and Specialised commissioning to develop a system wide integrated model.</td>
<td>Develop a proposal for New Models of Care which will include:</td>
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<td>• Development of community based models of care supported by social care and education which support young people to remain in their local communities</td>
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<td>• Expanded crisis service to support admission avoidance and reducing length of stay by facilitating early discharge</td>
<td>Service to be operational from Mar 2020</td>
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<td>• Reduce the demand for inpatient beds by intervening early and providing intensive wrap around support</td>
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<td><strong>5.2</strong> Does the LTP include the CYPMH pathway across an appropriate footprint, demonstrating the interdependency of the growth of community services aligned with recommissioning inpatient beds, including plans to support crisis, admission prevention and support appropriate and safe discharge?</td>
<td>* Yes - The CYPMH pathway is Lincolnshire wide - i.e. covering the whole STP footprint. Work is currently underway to consider the potential use of New Models of Care to ensure more young people are supported in their communities and where possible avoid hospital admission. Crisis service have been enhanced to support early discharge in the current model.</td>
<td>Commissioning of services to deliver the agreed model as part of an overarching commissioning strategy that aligns services currently commissioned and provided by a range of organisations.</td>
<td>Commissioning Strategy agreed January 2019</td>
</tr>
<tr>
<td><strong>5.3</strong> Is the role of the STP reflected in joint place-based commissioning plans?</td>
<td>* Yes - Particularly with reference to whole system working to cover transitions and vulnerable groups.</td>
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<td><strong>5.4</strong> Is there evidence of clear leadership and implementation groups in place to oversee progress of place based plans?</td>
<td>*Yes -There is a subgroup of the STP covering mental health and learning disability which is overseeing place based planning.</td>
<td></td>
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</table>
Specialist or Forensic CAMHS (specifically high risk young people with complex needs)

Overarching support is provided by the extensive core CAMHS Service providing support for mild to moderate emotional well-being and mental health problems. This support also includes moderate, acute and severe, complex and/or enduring mental health problems or disorders. Lincolnshire Children Services commissions a dedicated Clinical Psychologist who is employed by LPFT and is also supported through the CAMHS contract by 2 Associate Practitioners to support engagement with a complex YOS and adolescent risk cohort. Consultation & advice is provided by a Specialist Clinical Psychologist within a consultation clinic model as well as links to Forensic Supervision with a Consultant Forensic Psychologist & Specialist HSB Worker from CAMHS if needed.

The Youth Offending Service provide a wider range of specialist input including – 2x Police, 2 x Clinical Psychologists, 1 x Assistant Psychologist, 2 x Associate Practitioners all trained in assessing harmful sexual behaviour (HSB) and Technology Assisted HSB. They work jointly with the YOS and social work staff in conducting a multi-disciplinary assessment of risk around these behaviours.

The East Midlands Forensic CAMHS Service (F-CAMHS) is a specialist multi-disciplinary team which has been created to support children or young adults up to 18 years old who exhibit risky behaviours which could lead to offending. The team also support those who are already in the youth justice system and have, or do, display signs of mental health difficulties.

Health and Justice funding from NHS England amounting to £250K has secured through collaborative commissioning with LPFT resulting in the recruitment of an additional Clinical Psychologist and Assistant Psychologist for two years. The addition of 2 Speech and Language Therapist (SALT) within Lincolnshire aims to further improve access to this service for children and young people within the community justice system. These professionals will work within the newly established Future4Me Team working specifically with adolescents demonstrating risk taking behaviours.

Transition to and from the secure estate

The 'Secure Stairs' model commissioned by NHS England Secure provides an integrated care framework that addresses the needs of children and young people in Secure Children’s Homes, Secure Training Centres and Young Offender Institutions. This includes at HMYOI Wetherby and at the Sleaford Secure Children’s Home where Lincolnshire children may be located either on remand or post sentence.
This framework allows for a joined up approach to assessment, sentence / intervention planning and care, including specialist input from mental health staff regardless of previous diagnosis, as well as from social care professionals, education professionals and the operational staff working on a day-to-day basis at the setting. This model also supports effective resettlement through timely information sharing, preparation for release and a smooth transition between custody/community services.

**Presenting at Sexual Assault Referral Centres**

Within Lincolnshire the Police and Crime Commissioner commissions 2 Child Independent Sexual Violence Advisor (ChiSVAs) and 0.4 cyber-crime specialist worker are provided by Victim Support. The age range is from 0-17 years. Since October 2017 Victim Support have been commissioned by PCC to provide ChiSVAs services who work directly with children and young people who have experienced sexual abuse and support them throughout the court process. The cyber-crime specialist worker focuses on prevention concerning awareness of sex texting and cyber safety awareness.

Castle Project: Victim Support is provided under the name ‘Castle Project’ and has provided a Specialist Young Witness Service for two years which is commissioned by the PCC. Home visits are undertaken to provide information on the court process, familiarise the young person and family with the court environment and support the child, young person and their families throughout the court process.

Trusthouse, an independent third sector organisation, has a base in Grantham and has been operating for three and a half years. Offering an all age service of post abuse counselling for the whole of Lincolnshire they do not currently set a limit on the number of the person-centred counselling sessions provided.

Specialist CAMHS are commissioned to provide therapeutic intervention for young people who have experienced historical sexual abuse and have symptoms indicating Post Traumatic Stress Disorder (PTSD). The service model provides pathways of care for other mental health disorders such as anxiety or depression.

**In Crisis Care related to Police Custody**

LPFT Section 136 Protocol – Section 136 care is available to children and young people under the age of 18 years but should only be considered when other alternatives have been explored and deemed not in the young person’s best interests.
These alternatives include, if the young person is under 16 years, using parental responsibility, or if appropriate, removal to suitable accommodation under the Children Act section 46. CAMHS practitioners will offer a phone consultation whenever practical via the police to divert from a S136 detention.

Lincolnshire Police will liaise with the CAMHS Crisis and Home Treatment Service (Via SPA) or if no mental health problem indicated Children’s service/ Emergency Duty Team. Once a child/young person enters the place of safety suite detained under S136 (PHC or A&E) there is a 24 hour period to assess their mental health needs and either discharge them or admit for further assessment.

**Interacting with Liaison and Diversion Services**

Formal Liaison and Diversion Services are still being scoped in Lincolnshire and a health needs assessment is currently taking place to inform the service specification and future implementation.

Whilst there is no Liaison and Diversion Team currently available, Lincolnshire has implemented a weekly ‘Joint Diversionary Panel’. This panel is restorative and consists of members from the YOS, Police and Social Care. It aims to provide a multi-agency forum to review children and young people who are of concern but have not met the threshold for Crown Prosecution Services. The CAMHS Associate Practitioners are tasked with providing health information to the panel to inform and influence appropriate support.

The panel uses the Team around the Child process and the Signs of Safety model in its approach to addressing the needs of the children and young people who are reviewed. Since implementation in June 2017 the panel has reviewed approximately 400 children and young people. The process could have input from education and mental health. As a consequence of the panel being in operation, the number of children and young people formally entering the criminal justice system (First Time Entrant) has fallen by 49% in the year of operation and Youth Cautions has reduced by 90%.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
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</table>
| Does the LTP detail how it is ensuring that there is full pathway consideration for CYP in contact with Health and Justice directly commissioned services and services being commissioned through the CYPMH Transformation Team, including those: | *Yes - The plan demonstrates how the implementation of the Secure Stairs model commissioned by NHSE provides a framework for a joined-up approach, including specialist input from mental health, social care and education teams. Effective resettlement is supported through timely information sharing and smooth transition between custody/community services.  
- CYP receiving specialist or Forensic CAMHS are provided for within the structure of the core CAMH service, enhanced with a dedicated Clinical Psychologist to support engagement with a complex YOS and adolescent risk cohort.  
- Specialist CAMHS is commissioned to provide therapeutic interventions for CYP who have experienced historical sexual abuse and have symptoms indicating PTSD.  
- Alternative provision to Section 136 care includes parental responsibility, if the child is under 16, or if appropriate, removal to suitable accommodation under the Children Act section 46. CAMHS practitioners offer a phone consultation whenever practical via the police to divert from a S136 detention.  
- Joint review of S136 undertaken by Local Authority Children’s Services, CAMHS and Lincolnshire Police. | *Complete scoping of Formal Liaison and Diversion Services in Lincolnshire and use the results of the health needs assessment currently taking place to inform the service specification and future implementation.  
- Implement recommendations from the Joint S136 review to develop robust pathways to services that support CYP.  
- Further development of the local FCAMHS service and pathways that include collaborative work with regional FCAMHS. | March 2019 |
We are making good progress with embedding CYP IAPT Principles into the provision of mental health services for children and young people living in Lincolnshire.

**CYP IAPT Project Lead**

Our CYP IAPT Project Lead is also the CYP IAPT Clinical Lead for Lincolnshire.

The Project Lead attends a range of CYP IAPT monthly meetings and related Lincolnshire meetings:

- CYP IAPT Collaborative meetings at Derby University
- Future in Mind Steering group; CYP IAPT is a standing agenda item.
- The Project Lead, with identified administrative support, completes relevant submissions as required by the CYP IAPT Collaborative:
  - CYP IAPT Quarterly return
  - CYP IAPT Implementation Plan

**Access to evidence based therapies**

During 2016/17 as part of the CYP IAPT Midlands collaborative:

- 6 CAMHS staff have attended and completed the 1 year CBT training
- 6 CAMHS staff have completed and attended the 1 year Systemic practice training
- 2 CAMHS staff and 2 Local Authority staff have attended and completed the EEBP training
- 3 CAMHS staff have attended and completed the Leadership training
- 4 CAMHS staff have attended and completed the Supervisor training
- Outreach training on ROMS has been provided to CAMHS staff and to Local Authority managers
- Bespoke training to the CAMHS Eating Disorder Service has been accessed by the EDS team

During 2017/18:

- 3 CAMHS staff accessing the CBT training at Derby University
- 2 CAMHS staff accessing the Systemic training at Northampton University
- 6 Healthy Minds staff accessing Well Being Practitioner Training at Northampton University
- 9 Local Authority staff accessing the EEBP training at Northampton University
• A further ROMS training day for CAMHS staff and presentations at CAMHS team meetings
• A multi-agency ROMS training day
• Outreach supervisor training for staff from CAMHS, Healthy Minds and Early Help supervisors / managers
• Bespoke training for inpatient Unit (Ash Villa)

**Supervision for evidence based therapies**

Clinical and case management supervision has been set up with appropriately qualified CAMHS staff for all CYP IAPT trainees as stipulated by the universities.

All CAMHS practitioners access regular clinical and line management supervision.

Since being part of CYP IAPT additional posts have been identified as needed and have been created to ensure Lincolnshire Services are providing evidence based therapies to children and young people and staff are accessing the appropriate clinical supervision:

• Highly Specialist Systemic Psychotherapist (permanent funded post)
• An additional CBT Therapist post (funded by WBP supervision monies)
• An EEBP supervisor post (secondment from CAMHS currently funded by EEBP trainee monies)

The staff trainings accessed and the additional CAMHS posts mean that across CAMHS, children and young people with high level of mental health concern are able to access individual therapy; group therapy; family based interventions. Therapies offered include Cognitive Behaviour Therapy and Systemic Therapy which have been supported by the CYP IAPT trainings.

CAMHS Staff who have completed CBT training and systemic training are able to access group CBT supervision; individual supervision; supervision via family clinics to enable them to practice their learned skills and work towards and maintain accreditations relevant to their additional training.

**CYP IAPT Outreach Training**

In 2018 Northampton University delivered three days supervisor training that was completed by a mix of CAMHS, Healthy Minds and Local Authority staff.
Self-referrals and access to low intensity interventions

At the same time as Lincolnshire joined the Midlands CYP IAPT Collaborative there was significant Service Transformation underway in Lincolnshire and during 2017 an accessible service providing low intensity interventions for low level mental health concerns was established. Some of the new roles within this new service have been Well Being Practitioners:

- 6 Well Being Practitioners have completed their training with Northampton University and now have permanent employment within Healthy Minds – Lincolnshire
- 6 Well Being Practitioners in training have started and will work within Healthy Minds – Lincolnshire.

The Healthy Minds Service - Lincolnshire accepts self-referrals.

Provision of Evidence Based Therapies

All Lincolnshire CAMHS hubs are running regular CBT groups delivered for pathways: low mood; generalised anxiety and separation anxiety. Family clinics run at least every two weeks led by qualified systemic therapists and which all the current and past CYP IAPT Systemic trainees work into.

Practitioners in Healthy Minds who have completed the Well Being Practitioner training are providing CBT informed interventions; two of these practitioners have been promoted and are offering supervision to other Healthy Minds staff.

The nine EEBP trainees working within the Local Authority Children's Services are seeing cases and are offering CBT informed interventions to young people presenting with low level worry; anxiety on a one to one basis. The Local Authority has allocated funding post qualification for these practitioners to continue to receive supervision from a CAMHS clinician.

Routine Outcome Measures

In February 2018 the MyOutcomes licenses (Outcome and Session rating system) were renewed and all CAMHS practitioners should now have access to the MyOutcomes data collection system. CYP IAPT trainees have all accessed extensive training on the use of Routine Outcome Measures. Internal training for CAMHS staff has been delivered to further promote the use of routine outcome measures with service users during appointments.
IPads have been provided in the waiting areas at each CAMHS hub to encourage the completion of ESQs by young people and their carers.

Healthy Minds and Local Authority staff who are undertaking CYP IAPT training are routinely completing outcome measures and this data is being collated for the CYP IAPT Collaborative.

Appendix 8: Project Plan for Implementation of CYP IAPT across Lincolnshire.
### 7. Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT)

<table>
<thead>
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<th>Requirement</th>
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<th>Future Actions Required</th>
<th>Target date</th>
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</table>
| 7.1 Does the LTP evidence where CYP IAPT and its principles have been embedded across local CYP MHS in all sectors? These include:  
  - collaboration and participation  
  - evidence-based practice  
  - routine outcome monitoring with improved supervision | *Yes - Embedding of CYP IAPT principles are evident in both Early Intervention and Specialist CAMHS services; whole service CYP IAPT training has been completed, including new recruits who have undergone EEBP training.  
  - Local Authority Early Intervention and Youth Offending Team practitioners have accessed CYP IAPT training and are being utilised to increase capacity for CYP IAPT interventions.  
  - Details of support, including backfill and salary support are provided. |  
  - Plans for sustainability to be agreed across services and included in the Workforce Development Plan.                                           | Apr 2019 |
| 7.2 Are there local arrangements in place to support the participation of staff from all agencies in CYP IAPT training, including salary support? Does it include staff who are in other sectors than health? |                                                                                                                                                                                                               |                         |             |
| 7.3 Are there sustainability plans for CDP to ensure existing and new staff continue to be trained in evidence based interventions? |                                                                                                                                                                                                               |                         |             |
Section 8 Participation and Engagement

Listening to the thoughts, feedback, feelings, views and opinions of C&YP are paramount to ensure we are able to continuously improve and commission appropriate placements in the future and to shape the sufficiency of the required market place.

Throughout the journey of C&YP with Mental Health and Emotional Well Being needs, a high priority is given to ensuring that their views are captured, listened to and responded to, wherever possible. As the age range for these C&YP is so broad; strategies employed, which views can be captured and the method through which this is done, vary considerably.

Where we are seeking to capture the views of our youngest children, we work hard to do this in a way that takes account of the emotional age and the developmental stage of the young person when listening to their views. The expertise of those who have the relationship with the child or young person are utilised to ensure we capture these views. This may include support from a commissioned service provider, in house teams and those staff working within respite and residential homes.

Where it is possible to capture feedback, the voice of the child is central to our practice. C&YP with Mental Health needs are encouraged in a range of ways to contribute their views and opinions and receive a varied level of consultation and participative engagement, ensuring that their concerns are heard and they are given the opportunity to input into their care and adapt services to best meet their needs.

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

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

The young people are recruited from across Lincolnshire and trained in several different techniques of inspection. They are then supported while they go out and inspect services which C&YP use and feedback on their findings so that necessary action and improvements can be implemented.
Children and young people, and their parents/ carers are included in the review of services that benefit them by way of consultation, along with involvement in the development of service specifications and evaluation of tender bids as part of procurement processes.

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

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

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

- Children have equal opportunity to be involved
- Children are valued
- The involvement of Children is a visible commitment which is properly resourced
- The involvement of children is monitored, evaluated, reported and improved.

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

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

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

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

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

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

**Developing services in line with the views of young people**

The most successful services are those that respond best to the needs of those that use them and Lincolnshire has long been committed to embedding service user/carer participation into development of its services.
During consultation Lincolnshire young people have expressed specific requirements for supporting their mental health in a number of areas that they said were important to them:

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

**Service Developments**

Current service developments have been the creation of a Participation Lead for CAMHS who is working with local user groups to further gain the voice of children and young people and authentically engage them in service design. In addition, currently the CAMHS service are recruiting to four Experts by Experience posts for community provision, the post holders will have lived experience of CAMHS and be able to provide valuable insight to the service as well as encourage honest conversations with present service users.
Since being part of CYP IAPT and as part of Local Transformation work additional posts have been identified as needed and created within CAMHS to ensure meaningful service user involvement:

- A Participation Lead (secondment from CAMHS)
- 6 Peer Support workers (equivalent to 4 WTE Peer Support workers)

Initially in 2016 these posts were voluntary, however, further embedding of the CYP IAPT principles and the local aspiration to have authentic engagement with young people, led to these as becoming funded paid posts in 2017. Further development and acknowledgement of the many positive outcomes of the work the Peer Supporters are able to undertake, has allowed funding for these posts to be secured until 2020.

**Overview of Peer Supporters**

- Someone with lived experience of mental health difficulties
- Someone who is employed specifically as a result of their experience
- Someone who has the ability to share their recovery journey with others
- Someone who can motivate and encourage others

**Peer Supporters Core Principles**

PSW work with these 8 underlying core principles, informing their work and relationships with young people:

- Mutual - PSW have different experiences; it is recognised that they have different things they can relate to. What came across in the interviews is that the mutual experiences are associated with being a “patient” - fearful about getting through the door, not thinking that things would get better.
- Reciprocal - There isn’t as much of a power imbalance with these posts – there is more of a focus on being equal and both learning from each other.
- Non-directive - PSWs are not delivering therapy and though they may share what they found helpful in terms of techniques and approaches, it won’t be a one-size fits all – very patient led.
- Recovery focused - supporting and enabling that person to lead a life worth living, instilling a sense of self-agency and change. Strengths-based, rather than problem based. – working with positive qualities and goals of young people.
Progressive - it’s not a permanent relationship, and there will be purpose and movement – working together towards an aim – PSW as a travelling companion.

Safe - It’s not about sharing stories for stories sake- thinking about their own boundaries, and what they are comfortable with sharing – and also how this effects the young people.

Peer Supporters received “Peer Support Training”, delivered by the Institute of Mental Health, which was accredited by the Open University. This included:

- Role of peer Support Worker
- Sharing Lived Experience and Positive Self-Disclosure Training
- Active communication and listening skills
- Strengths spotting
- Boundaries and problem solving approaches

They also received induction training and bespoke training being arranged around risk, note-taking etc.

PSWs have now been in post since December 2017 and have each started to develop their roles within the service. Some of the things they currently do are:

- Problem-solving with young people
- Produce wellness plans (rather than keep safe, crisis plans) which look at setbacks, future planning and ‘who am I?’
- Help connect young people with social supports/communities outside of the service
- Transition
- Support engagement

**Transitions**

As part of the PSW role, CAMHS clinicians can request the support of a PSW if they identify a young people if finding a transition particularly challenging and could benefit from further support. Interpretation of “transition” is considered broadly; this could include transition out of hospital, transition out of services etc.
Transition support can be for a young person who may be coming up to discharge; encouraging them to access other services such as Recovery College and community groups. Also, using lived experience to show how individuals can have a different relationship with their symptoms, as opposed to being ‘symptom free’ – offering an authentic example of a journey after mental health services.

PSWs also support young people to access CAMHS where they have previously been reluctant, this could be being there at the initial assessment, attending medication reviews, supporting them to access groups and also taking part in CAMHS projects ran by the Involvement Network.

**Young Person Involvement Network**

This is a Network which PSW lead to encourage young people who are under or have been under CAMHS to join. The Network offers them the opportunity to take part in projects and have their voices heard about the services they have received.

**Previous and ongoing projects**

- Self-Referral Project, asking people’s views around the idea of self-referral
- E-Learning Project around experiences from staff when young people have been in distress
- Waiting room projects – asking young people to develop artwork for waiting rooms
- Recovery stories/Items within the waiting rooms
- Videos about CAMHS
- Future in Mind event – inviting young people to share their views on what the future of mental health services could look like, identifying things to develop
**Future In Mind Event**

This event was held in Lincoln in February 2018 led by the Participation Lead and Peer Support Workers. Young people who have accessed support from CAMHS were asked to share their views on what they would want to see for the future of mental health services. A had a graphic designer who ‘drew’ the discussions, to create their vision for the future. Young people asked that this form the basis of our future transformation work and can be seen on the front cover of this plan.

“Thank you for giving us a voice”

“IT was wonderful to see so many young people engaged in discussions about mental health.”

**Young Person Event at Lincoln Drill Hall!**
Extract from a Young Person’s Recovery Story

Once I was gaining weight and eating a balanced diet I found I had more energy, didn’t get dizzy all the time, was a lot happier and could start to enjoy good food. It is still tricky but I have to keep reminding myself of my reasons to recover and I know it is worth it. This is the best I have felt in myself and around good in a 4 years. I no longer feel like the anorexia is in control. I am now able to work at a coffee shop because I have a lot more energy and don’t get anxious like I did before. I also go out for drinks with my friends which again is a massive achievement because I wouldn’t have been too anxious to do that before. I also go out for meals with my mum and sister and get things like pizza and pancakes which I never thought was possible.

The Lincolnshire CAMHS Eating Disorder Team was developed as a result of the £30 million recurrent funding pledged in 2014 and as part of the Local Transformation Plan 2015.

The Team was commissioned to provide services aligned to the standards set out in the Access and Waiting Time Standards for Children and Young People with an Eating Disorder, with clear targets set for waiting times. This included recommendations for staffing numbers, skills development and the disciplines required in the team to meet the needs of the young people in the commissioned area. Local needs assessment data was used to calculate the workforce required for CEDS-CYP.

Service Development

Since May 2017 the CYP Eating Disorder Team have accessed training to ensure that NICE Concordant Treatments are being offered to young people referred to the Service:

- Family Based Therapy: whole team attended 1 day training.
- Cognitive Behaviour Therapy – Eating Disorders: 3 band 6 nurses accessed training and went on to deliver internal training.
- Adolescent Focused therapy: 1 nurse attended training and then disseminated to the whole team at an extended team meeting.
- National Diploma in Eating Disorders: 1 nurse and 1 psychologist have completed the 8 day course, delivered by Janet Treasure, Director, Eating Disorder Unit and Professor of Psychiatry, Institute of Psychiatry, Kings College, London.
- EMDR: 5 nurses completed in May 2018. 1 psychologist already trained.
- CYP-IAPT: Systemic Training: 1 nurse has been seconded for a year and has now returned to the team.
- CYP-IAPT: PG Cert Service Transformation and Leadership: Team Leader has successfully completed the course.
- East Midlands Leadership Academy Course: 1 nurse has successfully completed this course.

**Key Targets**

1. **Local Target: 100 new referrals/year:**

   ![Graph showing referrals (2016-17 and 2017-18)]

<table>
<thead>
<tr>
<th>Year</th>
<th>Accepted referrals</th>
<th>Referrals declined</th>
<th>Total Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>124</td>
<td>17</td>
<td>141</td>
</tr>
<tr>
<td>2017-18</td>
<td>75</td>
<td>26</td>
<td>101</td>
</tr>
</tbody>
</table>

2. **95% of referrals to be screened within 24 hours:**

   ![Graph showing screening targets (2016-17 and 2017-18)]

<table>
<thead>
<tr>
<th>Year</th>
<th>Screening target met</th>
<th>Screening target unmet</th>
<th>% Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>136</td>
<td>5</td>
<td>96</td>
</tr>
<tr>
<td>2017-18</td>
<td>99</td>
<td>2</td>
<td>98</td>
</tr>
</tbody>
</table>

Referrals should be assessed and NICE concordant treatment commenced:
3. **Target: Urgent – within 1 week and Routine within 4 weeks**

![Graph showing routine referrals and percentage target met]

**East Midlands Clinical Network – Eating Disorders Network**

Lincolnshire CAMHS CYP-EDS is a member of the East Midlands Clinical Network – Eating Disorders Network which meets regularly to share experience, ideas, research and innovation and best practice as new National Standards emerge, and Trusts and CCG commissioners evaluate the extent of service re-design needed in order to meet them.

**Multi-Disciplinary Team Assessments model introduction**

The introduction of the Multi-Disciplinary Team Assessment Clinic was as a result of discussions at both a national and local level. The aim of the clinic is to provide a more robust wide-ranging assessment, formulation and care plan for children and their families. Additional benefits were expected in supporting staff have joint responsibility of complex cases.

The model was piloted for a period of time in one area of the County from May 2017 and the impact and effectiveness was evaluated by comparing scores from MyOutcomes, Outcomes Rating Scales and Session Rating Scales, CHI-ESQ (Child Experience of Service Questionnaire), expressions of satisfaction and complaints to the Service. The analysis of this information was then used to plan the future delivery model.

Despite some initial concerns that families would be reluctant to travel a greater distance for the initial assessment appointment and would be critical of the extended period of time take for the assessment appointments, the feedback from families has been predominantly positive. Parents report feeling supported and contained by the team approach.
Families requiring an urgent appointment for initial assessment and all families unable to travel to the clinic are offered a locality assessment appointment within Service target times.

An additional benefit of this approach is that the knowledge within the team has been increased and consolidated through the joint working opportunities. As well as being able to undertake multi-dimensional assessments, staff report an increase in their confidence and clinical ability to individualise the understanding of the concerns presented by families and the interventions necessary to support their care.

**Parent/Carer Groups**

Parent/Carer groups have been set up the north and south of the county. These monthly, evening meetings are facilitated by a minimum of 2 CYP-EDS staff. The groups are an open forum for all parents/carers of young people who are currently open or historically known to the Service. The delivery model is a combination of formal information giving and informal facilitation of experience sharing between parents.

**Training and Consultation**

The Team have offered training to Paediatric wards, which have been positively received. There are plans to offer further such training in 2018-19.

Clinical Psychologists offer consultation clinics for all staff to discuss cases open to the Service, which may have disordered eating issues, without a primary eating disorder diagnosis.

The Team has developed a Body Image Workshop for young people that commenced delivery in September 2018. The Workshop consists of a five week interactive programme, challenging individual's and society's expectations of body image.

**Service User Participation**

CYP-ED service users have been involved in providing artwork for CAMHS communal areas and CAMHS web page design.

Young people continue to be encouraged to write their own recovery stories and, where agreed, these will be published on the web page for inspiration for other young people. (Appendix 6)
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Does the LTP identify current performance against the Eating Disorder Access and Waiting Time standards and show improvement from the baseline measure?</td>
<td>* Yes - data is provided to evidence achievement of national ED access and wait times.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.2 Where relevant, does the plan clearly state which CCGs are partnering up in the eating disorder cluster?</td>
<td>* Yes - the plan outlines CCG partnership arrangements for commissioning ED services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.3 Where in place, is the community eating disorder service (CEDS) in line with the model recommended in NHS England’s commissioning guidance?</td>
<td>* Yes - there is Community ED service in place, details on the model, performance and outcomes are provided with recovery stories from CYP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.4 Is the CEDS signed up to a national quality improvement programme?</td>
<td>* No</td>
<td>To consider QNCC ED accreditation</td>
<td>Mar 2020</td>
</tr>
</tbody>
</table>
Section 10: Data

CAMHS Data

Referrals Received and Accepted

Figure 1 shows referrals accepted/rejected from Q1 2016-17 to Q4 2017-18.

![Fig. 1: Referrals](chart1.png)

<table>
<thead>
<tr>
<th></th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
<th>Q3 2016-17</th>
<th>Q4 2016-17</th>
<th>Q1 2017-18</th>
<th>Q2 2017-18</th>
<th>Q3 2017-18</th>
<th>Q4 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals accepted</td>
<td>941</td>
<td>743</td>
<td>957</td>
<td>1036</td>
<td>899</td>
<td>701</td>
<td>907</td>
<td>943</td>
</tr>
<tr>
<td>Referrals rejected before assessment</td>
<td>221</td>
<td>191</td>
<td>276</td>
<td>292</td>
<td>324</td>
<td>308</td>
<td>320</td>
<td>255</td>
</tr>
<tr>
<td>Referrals rejected after assessment</td>
<td>8</td>
<td>10</td>
<td>17</td>
<td>14</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Total Referrals</td>
<td>1162</td>
<td>944</td>
<td>1250</td>
<td>1341</td>
<td>1223</td>
<td>1013</td>
<td>1232</td>
<td>1211</td>
</tr>
<tr>
<td>% of referrals rejected</td>
<td>19.7%</td>
<td>21.3%</td>
<td>23.4%</td>
<td>22.8%</td>
<td>26.7%</td>
<td>31.3%</td>
<td>26.4%</td>
<td>22.1%</td>
</tr>
</tbody>
</table>

Attainment of Target Waits within the Service

Figure 2 shows attainment of target wait times by Urgency from Q1 2016-17 to Q4 2017-18.

![Fig.2: Percentage in Response time](chart2.png)

<table>
<thead>
<tr>
<th></th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
<th>Q3 2016-17</th>
<th>Q4 2016-17</th>
<th>Q1 2017-18</th>
<th>Q2 2017-18</th>
<th>Q3 2017-18</th>
<th>Q4 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency - telephone within 4hrs</td>
<td>78.7%</td>
<td>91.3%</td>
<td>90.2%</td>
<td>84.6%</td>
<td>73.2%</td>
<td>98.1%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Emergency - Face to Face within 13 hrs</td>
<td>71.4%</td>
<td>79.6%</td>
<td>75.0%</td>
<td>89.0%</td>
<td>87.4%</td>
<td>85.5%</td>
<td>92.5%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Emergency - Face to Face within 24 hrs (next day)</td>
<td>56.1%</td>
<td>59.1%</td>
<td>74.8%</td>
<td>83.6%</td>
<td>80.5%</td>
<td>87.6%</td>
<td>88.1%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Urgent - Face to Face with 72hrs (3 days)</td>
<td>31.9%</td>
<td>38.4%</td>
<td>67.1%</td>
<td>51.2%</td>
<td>55.8%</td>
<td>56.8%</td>
<td>67.8%</td>
<td>70.9%</td>
</tr>
<tr>
<td>Routine - Face to Face within 6 weeks</td>
<td>56.1%</td>
<td>59.1%</td>
<td>74.8%</td>
<td>83.6%</td>
<td>80.5%</td>
<td>87.6%</td>
<td>88.1%</td>
<td>89.5%</td>
</tr>
</tbody>
</table>
**Crisis Response Rates**

Figure 3 shows the breakdown of CYP who are seen by the Crisis Team in hours.

![Fig. 3: Crisis - Actual Waits in Hours - 2017/18](image)

Analysis of this data for the year shows that on average:

- 35% of CYP were seen in less than 12 hours
- 12% of CYP were seen in 12 – 24 hours
- 7% of CYP were seen in 24 – 36 hours
- 7% of CYP were seen in 36 – 48 hours
- 13% of CYP were seen in 48+ hours

Where wait times are longer this is reportedly often due to the support given during the telephone response, whereby young people and their families are given appropriate support and strategies that reduce the anxiety and can lead to the young person and their family choosing to be seen the next day or later. Incidences where CYP are seen outside the 24 hour target are reported by exception by individuals to the Commissioner as part of contract management.

As a result of Crisis Team support United Lincolnshire Hospitals Trust have reported a directly correlated reduction in paediatric admissions of 45% during 2016-17. As yet 2017-18 figures are not available.

Similarly due to support with Tier 4 discharge plans the in-patient unit at Ash Villa is reporting reduction in in-patient stays, again the Home Treatment Team are looking at collating data to demonstrate this.
**Crisis Presenting Needs**

Figures 4 and 5 show the reasons for referral for CYP to the Crisis Team. Due to pathways and services developing over the two year period they cannot be shown alongside each other and the data is not comparable. However, self-harm and suicidal ideations remain the main reason for referral for a crisis assessment.

<table>
<thead>
<tr>
<th>Fig. 4: Crisis - Presenting Need</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>80</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>35</td>
</tr>
<tr>
<td>Low Mood</td>
<td>6</td>
</tr>
<tr>
<td>Safety Assessment</td>
<td>3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>14</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>4</td>
</tr>
<tr>
<td>Behavioural Problems</td>
<td>6</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Anorexia</td>
<td>1</td>
</tr>
<tr>
<td>Child - Eating Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Skills Assessment</td>
<td>0</td>
</tr>
<tr>
<td>ADHD</td>
<td>1</td>
</tr>
<tr>
<td>First Episode Psychosis (Suspected)</td>
<td>0</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Elated Mood</td>
<td>0</td>
</tr>
<tr>
<td>Harmful Behaviour Assessment</td>
<td>1</td>
</tr>
<tr>
<td>Harmful Behaviour Intervention</td>
<td>1</td>
</tr>
<tr>
<td>Psychosomatic Disorder</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>156</td>
</tr>
</tbody>
</table>
### Fig. 5: Crisis - Presenting Need

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>5</td>
</tr>
<tr>
<td>Safety Assessment</td>
<td>6</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>3</td>
</tr>
<tr>
<td>Behavioural Problems</td>
<td>0</td>
</tr>
<tr>
<td>Low Mood</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Child - Eating Disorder</td>
<td>12</td>
</tr>
<tr>
<td>Harmful Behaviour Assessment</td>
<td>16</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Sensory Assessment</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>82</td>
</tr>
</tbody>
</table>

A calculation of the total number of combined referrals to the Crisis Team for either year as it has been recognised that at the point of a Crisis referral, it is often difficult to ascertain one diagnosis and CYP are often considered to be more than one category until further assessment can be undertaken.
Re-referral rates

Target for re-admission rates is less than 15% of all admissions are re-referrals from children and young people previously discharged from CAMHS within the previous 6 months.

Figure 6 shows the returns for 2016-17 and 2017-18 for the percentage of re-referrals; the average for the year being 7.6% and 10.4% respectively, both below the 15% target.
Volume on Pathways

The service has evidence-based care pathways. Following assessment, all referrals are allocated a pathway. At the end of Q4 2017-18, 87.3% of open cases had been assigned a pathway, 7.3% over the target. Some of the care pathways offer group interventions as the first course of treatment. In Q4 the CBT groups underwent a review; this included engaging young people in this process through the CAMHS involvement network. The redesigned evidence based CBT groups began in March 2018. The service will start to review the care pathways over the next year and will ensure that they remain in line with national guidelines and also are linked to patient-related outcome measures.

<table>
<thead>
<tr>
<th>Fig. 7: Pathways</th>
<th>Number on pathway for referrals that are open during the period 2017 - 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr</td>
</tr>
<tr>
<td>Anxiety: OCD &amp; BDD - Mild to Moderate</td>
<td>39</td>
</tr>
<tr>
<td>Anxiety: OCD &amp; BDD - Moderate to Severe</td>
<td>21</td>
</tr>
<tr>
<td>Attachment Difficulties</td>
<td>36</td>
</tr>
<tr>
<td>Behaviour: Level four</td>
<td>17</td>
</tr>
<tr>
<td>Behaviour: Level Three</td>
<td>24</td>
</tr>
<tr>
<td>Depression - Mild to Moderate</td>
<td>142</td>
</tr>
<tr>
<td>Depression - Moderate to Severe</td>
<td>73</td>
</tr>
<tr>
<td>Eating Disorder: Anorexia Nervosa</td>
<td>31</td>
</tr>
<tr>
<td>Eating Disorder: Atypical</td>
<td>26</td>
</tr>
<tr>
<td>Eating Disorder: Binge Eating</td>
<td>1</td>
</tr>
<tr>
<td>Eating Disorder: Bulimia</td>
<td>3</td>
</tr>
<tr>
<td>General Anxiety - Mild to Moderate</td>
<td>175</td>
</tr>
<tr>
<td>General Anxiety - Moderate to Severe</td>
<td>88</td>
</tr>
<tr>
<td>Harmful Sexualised Behaviours: Mild to Moderate</td>
<td>5</td>
</tr>
<tr>
<td>Harmful Sexualised Behaviours: Moderate to Severe</td>
<td>4</td>
</tr>
<tr>
<td>Learning Disability: Anxiety</td>
<td>14</td>
</tr>
<tr>
<td>Learning Disability: Challenging Behaviour/Self-harm</td>
<td>4</td>
</tr>
<tr>
<td>Learning Disability: Depression</td>
<td>2</td>
</tr>
<tr>
<td>Psychosis</td>
<td>9</td>
</tr>
<tr>
<td>PTSD: Longer Term</td>
<td>33</td>
</tr>
<tr>
<td>PTSD: Short Term</td>
<td>22</td>
</tr>
<tr>
<td>Self-Harm: Low Risk</td>
<td>26</td>
</tr>
<tr>
<td>Self-Harm: Medium Risk</td>
<td>17</td>
</tr>
<tr>
<td>Social Anxiety - Mild to Moderate</td>
<td>65</td>
</tr>
<tr>
<td>Social Anxiety - Moderate to Severe</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>914</td>
</tr>
</tbody>
</table>
Open Cases within the Service

The average number of cases seen within one month is 70.8%. The open cases include those referrals that are open for consultation only and also group referrals which will impact on the percentage of cases seen in one month. The service provides patient-focused care plans where the time of interventions are agreed collaboratively with the young person and family agreement.

<table>
<thead>
<tr>
<th>Open Cases with contact in the period 2017 - 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Cases</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Face to Face/Telephone contact in month</td>
</tr>
<tr>
<td>Percentage with contact</td>
</tr>
</tbody>
</table>

Patient Experience

Patient Experience has been gathered using the CHI throughout 2017-18; this is gathered at reviews and also at the end of treatment. In October 2017 the reporting system changed to Health Care Communications. The new system was not able to report accurately for both Q3 and Q4 and the data submitted was from a manual count. From Q1 (2018/2019) the system will produce full reports relating to patient experience. In March 2018 the CHI was reviewed and some questions removed as they were historic service additions to the standardised questionnaire. The new questionnaire which will be used from Q1 (2018/2019) will be known as the ESQ (Experience of Service Questionnaire). The ESQ will also contain the Friends and Family Test. The service will work over the next year (2018/2019) to improve the amount of ESQ’s that are completed by installing IPAD’s in waiting areas in all four Core CAMHS teams, making the feedback process more accessible for young people and families.
**Professional Advice Line (PAL)**

The PAL continues to be well used and feedback about its use is positive. Over the reporting year 2017-18 there were a total of 1491 calls, an average of 124 calls per month. The average length of the call is 10 minutes and 30 seconds. The percentage of calls from each agency is shown below:

<table>
<thead>
<tr>
<th>Caller</th>
<th>Amount of call over the Year (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Help</td>
<td>4%</td>
</tr>
<tr>
<td>Grief &amp; Loss</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>0.7%</td>
</tr>
<tr>
<td>GP / Nurse Practitioner</td>
<td>13.2%</td>
</tr>
<tr>
<td>LCC Children’s Services</td>
<td>10.7%</td>
</tr>
<tr>
<td>School / School Nurse / College</td>
<td>31.9%</td>
</tr>
<tr>
<td>YOS</td>
<td>0.7%</td>
</tr>
<tr>
<td>Residential Home</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

Commissioners have noted the increase in use of the PAL by those professionals who are not required to do so as part of a referral route such as GPs and Social Workers, reportedly this is due to those professionals valuing the advice and guidance provided by the PAL clinicians and in this way we are further able to demonstrate increased confidence and skills in the wider workforce.
Healthy Minds Lincolnshire – October 2017 to June 2018:

- 779 professionals across Lincolnshire schools and academies, including teaching and support staff, Initial Teacher Trainees (ITT), and Children's Services front line staff accessed training.
- 2,511 referrals accepted for interventions (1:1 and group support)
- 68.2% of referrals accepted were from schools or GPs (37.8% schools; 30.4% GPs)
- Referrals accepted across all age ranges and key stages with the highest number of referrals accepted from key stages 2 and 3
- Approximately 10.7% of referrals were from CAMHS
- 8,731 intervention sessions (1:1) delivered to children and young people
- Wide range of concerns supported – top 3 concerns being anxiety, behavioural concerns and low mood

Kooth Online Counselling Service – April 2017 to March 2018:

- 2,485 new registrations: highest % aged 13 to 17 years
- 2,616 young people logged into Kooth on 21,351 occasions
- 667 young people accessed 1,507 online counselling sessions and 1,500 young people exchanged 12,351 counselling text messages
- 1,874 young people accessed relevant articles or online forums to support their emotional wellbeing/mental health concerns
- 21 young people signposted to CAMHS and 5 young people signposted to CAMHS crisis team
- Top 3 concerns supported by the Service – anxiety/stress, family relationships and friendships
- 98% of young people said they would recommend Kooth to a friend

Since the service was recommissioned from April 2018:

- 662 new registrations: 60% between ages 13 to 16
- 870 young people logged into Kooth on 6,172 occasions
- 190 young people accessed 395 online counselling sessions and 496 young people exchanged 3,600 text messages with counsellors
- 665 young people accessed relevant articles or online forums to support their emotional wellbeing/mental health concerns
- 3 young people signposted to CAMHS and 1 young people signposted to CAMHS crisis team
• Top 3 concerns supported by the Service were anxiety/stress, depression and family relationships
• 97% of young people would recommend Kooth to a friend

Data flow for Kooth:
Kooth are planning to start flowing data to MHSDS. During September and October 2018, Kooth will test data flow through two sites in Cambridge & Peterborough and Essex. Following on that, the team at Kooth are planning to flow data nationally, starting with October data due to be submitted to MHSDS on 30 November.

Joint conversations have been underway with the team at Kooth, national data leads and clinical advisors, as well as colleagues at NHS Digital to ensure that data being submitted by Kooth aligns to the CYP access metric, especially with regards to what counts as a meaningful therapeutic contact.

Below is an agreed definition of a therapeutic message:
This involves a practitioner providing therapeutic content to a message. It is usually much longer and more detailed than an administration message. Crucially it involves a level of therapeutic assessment both in the consideration of response, and the requesting of further information for more assessment to take place. A therapeutic message is one informed and consistent with a model of counselling/intervention, is directly related to the identified/coded problem, and is intended to change behaviour. All three elements have to be present.

Service Improvement Trajectories
At the time of the 2018 LTP refresh, Lincolnshire Commissioners and CAMHS provider are in discussion with NHS England representatives to get a clearer understanding of the reporting of the Service Improvement Trajectory data.

Following meetings in December 2018, this Section of the LTP will be updated.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Actions to Date</th>
<th>Future Actions Required</th>
<th>Target date</th>
</tr>
</thead>
</table>
| 9.1 Does the LTP recognise the requirement for all NHS-commissioned (and jointly commissioned) services, including non-NHS providers, to flow data for key national metrics in the MH Services Data Set (MHSDS)? Does it set out clear expectations on all commissioned providers to flow data directly or via a lead information provider? | *Yes - CAMHS is flowing data to the MHSDS  
  • Non-flowing eligible services are currently working with NHS Digital and Regional teams to enable data flow to commence.  
  • Data quality issues have been addressed with the support of NHS Digital and effective data quality processes are in place. | To ensure that eligible services are supported to flow data to the data set.  
  • To enable Local Authority CYP IAPT staff to flow data. | April 2019 |
| 9.2 Does it set out the extent and completeness of MHSDS submissions for all NHS-funded services across the area, and where there are gaps set out a plan of action to improve that data quality? | *Yes - Routine outcome measures are being used collaboratively with CYP to co-produce interventions in all services where CYP IAPT training has been accessed.                                                                                                                                 | To develop a plan to increase the wider use of outcome measures, in addition to increasing the % of paired outcomes throughout the system. | Mar 2020 |
| 9.3 Is there evidence local areas are implementing routine use of outcomes monitoring as recommended by CYP IAPT principles? And is there evidence of a plan to increase the number of paired scores in the MHSDS? | *Yes  
  • local access rates are monitored through performance and contract management processed  
  • access rates are also cross-referenced with the MHSDS to identify where there may be any data quality issues |                                                                                                                                               |                 |
<p>| 9.4 Is there evidence in the LTP that data on key ambitions like access (and ED) are routinely monitored and used? | *Yes |                                                                                                                                               |                 |
| 9.5 Is there evidence of the use of local/regional data reporting and use to enhance local delivery e.g. local CYPMH dashboards? | *Yes - The MHSDS is used to monitor progress against Regional and National data.                                               | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Is there evidence the Clinical Network or other expertise have been part of discussions on improving data and reporting?</th>
<th>*Yes - Attendance at NHS Digital Data Quality Workshops is referenced as part of the data improvement plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.6</td>
<td>Does the LTP include evidence that all providers commissioned by the CCG are flowing accurate data?</td>
<td>* Yes - All CCG commissioned providers are flowing data.</td>
</tr>
<tr>
<td>9.8</td>
<td>If not is there a plan described to ensure this happens?</td>
<td>Not applicable</td>
</tr>
</tbody>
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Lincolnshire CAMHS Crisis & Home Treatment Services (C&HTS)

The functions of the C&HTS are:

- Admission avoidance
- To facilitate early discharge from inpatient services
- Providing crisis response and crisis support
- Intensive Home Treatment
- Assertive Outreach (support to Core CAMHS and CAMHS EDS with urgent concerns)
- Support to CAMHS EDS home care
- To undertake a gatekeeping function for admission to inpatient services
- To work with patients in crisis with a diagnosis of a learning disability and or autism spectrum disorder (ASD).

The service is available 7 days a week, between 8.45am until 7pm, 365 days per year. Outside of these hours, cover is provided for advice, crisis intervention and emergencies by on call staff.

To ensure good wraparound care, the C&HTS is based in the CAMHS hubs at Lincoln and Boston. In terms of young people in a crisis the C&HTS operates two levels of response:

**Emergency**

The Emergency response target is a 4 hour telephone response and *24 hour face-to-face response.*

This is for young people actively displaying:

- suicidal ideation or suicidal attempts
- severe symptoms of depression with suicidal ideation
- life threatening harm to self
- harm to others as a result of a mental health concern
- acute psychotic symptoms
- presentation of anorexia with severe physical symptoms.
*24 hour response rate:* originally the target response rate for face-to-face response was set at 13 hours. However, feedback from families was that in some cases, this was too soon and families were requesting that they have a longer period of time to "recover" from a crisis... Therefore the Service target was re-aligned to be Service User led rather than Service led. In the majority of cases, CYP are still seen within 13 hours.

**Urgent**

For urgent; a face to face appointment within 72 hours.

This is where children or young people present as a risk to themselves or others but are currently safe and contained, to include:

- Severe symptoms of depression
- Symptoms of anorexia with BMI below 18 or above but with low physical observations
- Serious incident of self-harm that is not life threatening
- Severe, unexplained deterioration in emotional state and behaviour at home and school, not thought to be due to substance or alcohol misuse or physical illness
- Symptoms suggestive of emerging psychosis
- Follow-up after assessment for self-harm at A&E.

**Patient, family and other service feedback:**

**Patient comments:**

- ‘Thank you for your help, team are like fairy godmothers.’
- ‘I enjoyed having the support of the team and the texting system really works.’
- ‘I will always remember you, the help and support you have given me have been the help and support that saved my life.’
- ‘I really enjoyed having appointments at home as it made me feel more relaxed and at ease and wasn’t as clinical. I felt more accepted and understood.’

**Parent’s comments:**

- ‘Thank you for all your support on Rainforest ward.’
- ‘Thank you for your help you have done a great job, thank all the others who have seen him too.’
• ‘Thanks to the team for all your help, not only for * but the whole family as well.’
• ‘I felt as though we all had a part in her care, and what was best for her. Very grateful the help and support was available as quickly as it was.’

Professional Feedback

NHS choices feedback: ‘I trust the CAHMS crisis team; they listen to me and continue to help me. Each one of them is different and each has their own way. And I don't mind that. They make me laugh when I see them or speak to them. They mean a lot to me and I don't think they realise that they do. They have helped me with so much and I don't ever want to forget them or see them leave, as that will be too hard to see that happen.’

ULHT Paediatric matron feedback: ‘Grateful thanks to the whole team for the difference they have made to children and young people, the staff are now no longer left to deal with difficult patient alone and have the support of the team.’

Police liaison feedback: ‘Really good working together on such a difficult case- keep up the amazing work.’

Letter from ULHT about the reduction of admissions to A&E/Paediatrics and the rapid assessment process of sending young people home more timely.

C&HT Service Developments

• Emotional first aid group - EFA was developed by the team and started in March 2017. This group now runs weekly in Lincoln and Boston as a rolling programme for CYP who need crisis support with regulating their emotions and learning new skills.
• Pets as therapy, Marley - Staff member awarded innovation fund to have training and implement Marley attending EFA group in both areas as a 6 month pilot. This is to support facilitation of the group and encourage attendance. We are awaiting data following the pilot to be collated to evidence success with this new role.
• Learning disability and ASD contract - The teams were awarded extra money in March 2017 to recruit 2 new staff in both teams to work with CYP in crisis who have a diagnosis of a learning disability and or ASD.
• Home treatment pathways - Team away days to develop home treatment pathways- Hearing voices/ Low mood/ Anxiety/ Self harm and suicide/ LD and ASD.
• Education and training of other services - C&HTS interface with numerous services educating them on MH issues and crisis work. A&E teaching sessions, police liaison
meetings, schools and colleges, crisis care concordat, Social workers, GP’s/Practice managers, Suicide awareness and e-learning package.

- Training of staff - Risk assess in children and adolescents, CBT and DBT essentials, Theraplay, EMDR, DBT group, Lucy Faithful foundation training, CYP IAPT CBT and systemic.
- Link roles - Team members have link roles for liaison with different agencies to enhance multi-disciplinary working.
- Local protocols - Developed over the year to improve joint working, team confidence and systems. EG- SPA, Phone triage protocol, A&E pathways, internal referral pathways, Lone working, Standard operating procedure written and reviewed.
- Ash Villa in-reach - Attendance By C&HTS to weekly MDT meetings and weekend working from the building to enhance relationships.
### 11. Urgent & Emergency (Crisis) Mental Health Care for CYP

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<tr>
<td><strong>10.1</strong> Does the LTP identify (a) that there is a dedicated 24/7 urgent and emergency mental health service for CYP and their families in place or (b) that there is a commitment with an agreed costed plan, clear milestones, and timelines in place to provide a dedicated 24/7 urgent and emergency mental health service for CYP and their families?</td>
<td>* Yes - Details of the structure and delivery of the UE Service for CYP is included in the plan, including agreed projected spend.</td>
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<td><strong>10.2</strong> If no, does the LTP identify that there is a commitment with an agreed costed plan, clear milestones, and timelines in place to provide a dedicated 24/7 urgent and emergency mental health service for CYP and their families?</td>
<td>Not applicable</td>
<td>* As part of the New Models of Working, further develop this area of the service and reduce the need for inpatient provision.</td>
<td>Mar 2020</td>
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| **10.3** Is there evidence that reasonable adjustments are being made to ensure there is appropriate urgent and emergency (crisis) mental health care for disabled children and young people particularly those with learning disabilities, autism or both? | * Yes - The plan includes details of additionally funded provision for:  
  - LD in CAMHS Core and Crisis Services.  
  - Youth Justice Hub |                                                                                       |             |
| **10.4** Is there evidence that the urgent and emergency mental health care for CYP has locally agreed KPIs, access and waiting time ambitions and the involvement of CYP and families, including monitoring their experience and outcomes? | *Yes - The plan includes detailed information on UE MH Service provision including KPIs, access and waiting times and how service user feedback is gained and is utilised to inform service development, as well as data, recovery stories are included. |                                                                                       |             |
Transitions out of Children and Young People’s Mental Health Services CQUIN

The national Commissioning for Quality and Innovation (CQUIN) aims to improve young peoples:

- experience of transition from services for children and young people to services for adults
- outcomes following transition young people, parent and carer involvement.

For those transitioning through inpatient care:

- To ensure the safe transfer of care for young people
- To reduce the number of delayed transfers of care from inpatient services and impact on length of stay
- To maximise the effective utilisation of inpatient capacity

What ‘good’ looks like for inpatient transition:

1. This should involve the inpatient provider and community mental health provider and any other agencies (such as social care and education). For young people approaching transition age this must involve the appropriate adult community mental health service as well as the referring CAMHS team. There must be active involvement in the CPA process by the adult service provider together with allocation of a care coordinator by the adult service. This should occur in all cases including in cases where it is anticipated that the young person will not be ready for discharge on reaching transition age. The joint planning is a shared responsibility between the young person’s referring community CAMHS team, the inpatient team and the adult mental health service provider and other agencies.

2. In situations where the young person will not be ready for discharge at the point of reaching transition age that there is liaison with the appropriate service for adults which includes full discussion of care needs. The relevant NHS England case manager should have been alerted to the likely need for a transfer of care to a service for adults as soon as it is anticipated that this will be required. Wherever possible the young person and their parents/carers should receive information about the receiving service in advance of the transfer.

3. Young people are involved in all discussions and decisions as far as possible.

4. Involvement of parents/carers in all discussions and decisions subject to the consent of the young person.
5. Check the numbers of delayed discharges and delayed transfers of care and the reasons these have occurred.

It is anticipated that this indicator would be incentivised initially for a two-year period, 2017-19, to enable changes that are required to systems and processes in Mental Health Trusts to become business as usual.

**Lincolnshire Transition CQUIN**

Work is continuing to facilitate collaborative decision making with young people over the age of 17.5 years needing to access support for mental health conditions.

A collaborative approach between CYPMHS and Adult services underpins the transition process within Lincolnshire. The use of clear treatment pathways facilitate the identification of ongoing need, ensuring that the ongoing needs of young people can be aligned to the multiple provision options within adult services. An internal meeting, known as the interface meeting oversees all internal movement of people accessing our mental health and learning disabilities services. At the point of the identification of a young persons need for continuing intervention by adult services, their case will be taken to the interface meeting to ensure that they are transitioned to the most appropriate adult team and care pathway. In order to facilitate the 6 months transitions period, discussions with the young person regarding transition commences at age 17.25yrs or as soon after, as the need is identified. Early identification of ongoing need allows for the case to be taken to the interface meeting for allocation to a team by the time the young person reaches approximately 17.5 yrs.

The numbers requiring transition in Lincolnshire are low due to most young people aged 17.5yrs and over successfully exiting treatment whilst remaining within CAMHS. The successful exit without the need for transition is facilitated by young people being able to remain within CAMHS up until the age of 19yrs in order to complete their treatment episode.

The expected numbers undergoing transition are 2 to 3 per months. Discharge data analysis of young people 17.5yrs plus shows: 11.6% requiring transition; 79% being successfully exited without the need for transition with a third of these being over 18yrs; and 9.4% exiting in an unplanned way.

Implementation of the three performance indicators in line with the milestones has been varied and only partially achieved. Transition planning is currently in the lowest threshold, with pre and post transition surveys in the second to lowest threshold. Work is currently being undertaken on clinical systems to develop live monitoring of the indicators. The recovery plan for these indicators is to move up a minimum of one threshold in each
indicator every three months until achieving the top threshold for all indicators. The achievement of the CQUIN will be monitored by the overarching transition steering group between CYPMHT and adult services.

**Collaborative work with Adult Services Mental Health Services to develop better transitions**

At the commencement of the CQUIN an overarching steering group was established to oversee transition processes. The core membership of the group is the service managers of all CYPMHS and community adult mental health and learning disabilities services and the meeting is chaired by one of the Trust Quality Improvement and Assurance Leads. The meeting membership also includes adult service managers from inpatient service, who attend on a needs led basis. The steering group meets monthly with its core purpose being:

- Oversee the implementation of NICE Guidelines ‘Transition from children’s to adults’ (NG43) services for young people using health or social care services’ across services within LPFT.
- Oversee the introduction of the trust’s transition protocol into full working practice within LPFT and partner services.
- Oversee and monitor progress against the National transition CQUIN ensuring that all key milestones are met and lessons are learnt from any variance from these milestones.

The meeting reviews any pathway or process issues in the implementation of the transition protocol. Service manager’s problem solve issues and look to find quick resolution to presenting process issues. The meeting looks to ensure that pathways are aligned between CYP and adult services and there is a clear understanding over any variance in pathways. Service manager’s cascade any issues or developments to their local managers of services and feedback to the steering group from the local services. The meeting reviews an overarching action plan and provides sign off of key milestones in the implementation of transitions across the organisation.

A joint meeting has taken place, in May 2018, between CYPMHS and Adult Service managers and team managers to improve communication and gain a consistent understanding of the transition process. Key learning from the meeting was around timely allocation of receiving service worker and being clear about the ongoing need of the young person in order to ensure that the young person is transitioned to the most appropriate service.
The need for people with a learning disability to start transitions early has been a key focus of learning. The CYPMHS and adult learning disabilities services have collaborated in implementing a new post for a CAMHS Transitions and Team Coordinator, to sit within the CYP services but to have close links with the adult team. This post will not only provide management and leadership to the learning disability specialist within the core CAMHS service but will also oversee and support the transition process of individual over an extended transition period from aged 16yrs upward.

**Collaborative work done with CYP to develop better transitions**

Work was undertaken with a focus group of young people to develop the transition plan and pre and post transitions surveys. The CYP peer and involvement lead facilitated the focus group and worked with the young people over the design and wording of the paperwork.

The organisation is planning to undertake a follow up survey of young people who have undergone transition post 3 months to gain reflective learning about transitions.

Inpatient CAMHS services have established a transitions group for all young people post 17yrs to look at the wider issues of transitions into adulthood rather than between services. Learning from this group will be fed back into the Transition Steering group to ensure that the transition process is responsive to the wider needs of young people becoming adults.

**Evidence to meet the requirements of the 2017-19 Transition CQUIN**

Overview of patients over the age of 17.5 years who were discharged from CAMHS during Quarter 4 - 2017/18.

The hypothesis for the limited number of transitions to adult services identified in the CQUIN audit was due to a; the move to short term intervention and completion of time limited treatment programmes in line with NICE guidance, and b; the assertion from clinicians that where treatment completion was within sight, young people were kept on the caseload until treatment was successfully concluded beyond their 18th birthday, thus preventing disjointed care and interruption in therapeutic alliance.

The evidence below supports this hypothesis and confirms that over 75% of young people who are still in CAMHs on their 18th birthday will continue in CAMHs until completion of their treatment.

Of the 10 potential transitions identified on the system only 7 resulted in a need for transition to adult mental health services. The pre and post transition survey was signed off
at end of quarter 3 and therefore work is ongoing to ensure this is embedded, of the two cases where this was undertaken the feedback was positive and both patients felt appropriately supported.

**Transition Protocol**

The transition steering group is meeting monthly to oversee the implementation of the transition protocol across the organisation. Proactive tracking of those starting transition has been identified as an issue as this cannot be currently provided by the clinical system. The clinical system can identify those who have transitioned once closed to CAMHS and opens to Adult services but not at the start of the transition process 6 months prior to the actual transition. A process of reviewing all young people discussed at the interface meeting is in place; this has been piloted and reviewed by the steering group. Given the volume of referrals and transfers going through the eight interface meetings across the county, it is proving an inefficient way to track transitions at the point of referral. The CAMHS service manager has agreed to review a process within CAMHS to identify all individuals referred to adult services. CAMHS will bring the names of individuals to the steering group to ensure the group has robust oversight of each individual that is going through transition.

The Audit team have developed an audit tool in line with the CQUIN requirements.

The transition steering group continues to meet monthly to oversee the transition process within the Trust. The meeting reviews all process within the transition CQUIN and oversees the development of the tools to undertake the implementation and auditing of the CQUIN. The meeting is attended by both sending and receiving service managers and all issues over process and potential barriers are discussed within the meeting.

Following a review of the membership of the steering group, it was decided that due to issues around transition for patients in inpatient environments at the point of transition, that the Service Manager - Urgent Care Pathway should become an 'as required' member of the group. The Service Manager - Steps2Change should change from full member to 'as required' as CAMHS patient should not be regularly transitioning to adult IAPT pathways as this is not a secondary care pathway. The Head of Adult Clinical Psychology and Psychotherapies will no longer be required as a member due to access to adult psychology pathway moving to the CMHT managed by the Service Manager - Adult Community who already is a member of the group.

The steering group reviewed the protocol and the existing protocol was sent out to the divisions for comments and amendments. No suggested changes to existing pathways and descriptions within the protocol. However, the review suggested that there should be additional pathways added to the protocol for young people in inpatient care at the point of
transition. The pathways need to focus both, those in local inpatient care and those in out of county placements or requiring out of county placements.

Currently the only availability for tracking transitions is via a manual process. CAMHS will keep a spreadsheet for all young people aged 17.25 with a view to monitoring where people are in the transition process. As LPFT move toward a new clinical system the services will work with clinical systems to develop alerts and tracking of transitions on the system.

Appendix 7 provides a detailed record of the CQUIN Implementation and progress to date.

A copy of the Lincolnshire Transition Protocol is included in Appendix 7a.
## 12. Integration

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<tr>
<td>Does the LTP include local delivery of the Transition CQUIN and include numbers of expected transitions from CYPMHS and year on year improvements in metrics?</td>
<td>*Yes - CQUIN plan and progress are included.</td>
<td>• Complete analysis of support for mental health conditions post 17 to identify what services young people are accessing and if these are meeting needs.</td>
<td>Dec 2018</td>
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The dedicated Early Intervention in Psychosis Team is a countywide team in Lincolnshire. The service is delivered through a multi-disciplinary team which provides comprehensive assessments; intensive treatment and support for people aged 14-65 who are experiencing a First Episode Psychosis (FEP).

CAMHS psychosis pathway is delivered to young people under the age of 16 years old, or any young person already under the care of the service.

Both services offer NICE recommended treatment pathways. These include CBT for psychosis, Behavioural Family Therapy and medical interventions.

The pathway for CYP mirrors that of the dedicated Early Intervention in Psychosis Team; any young person is offered the same pathway and treatment options. Both services are monitored to meet the EIP access to wait standards; there is no specific monitoring for CYP.

The CYP provision offers NICE recommended treatment pathways. These include CBT for psychosis, Behaviour Family Therapy and medical interventions. The pathway for EIP is such that if a young person is seen within the CAMHS pathway they would be transitioned to adult mental health if they still require a service after 2-3 years intervention.

Where a young person under 18 presents in crisis, the first contact would be with the CAMHS crisis team where a full assessment would then inform the service that would meet the young persons need.

Lincolnshire Partnership NHS Foundation Trust has a transition protocol which is followed where a transition between CAMHS and AMHS is required. The links between CAMHS and EIP provide for the two services to interface upon receipt of a referral for a CYP under 16 years old and would joint assess if a young person in under 16 years old.

When necessary the Crisis and Home Treatment Team will support the young person and provide interventions in the home.
### 13. Early Intervention in Psychosis (EIP)

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<td>Does the LTP identify an EIP service delivering a full age-range service, including all CYP over the age of 14 experiencing a first episode in psychosis and that all referrals are offered NICE-recommended treatment (from both internal and external sources)?</td>
<td>*Yes - the plan outlines the transformed provision for CYP who present with acute psychotic symptoms and interventions are aligned with NICE recommended pathways. In addition, the Crisis and Home Treatment Service has clear links with adult services to ensure smooth and robust transition to services, as well as links to early intervention in psychosis teams.</td>
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<td>If so, does this include the full pathway for all CYP, including those who present to the specialist CYPMH service? Is there a commitment to specifically monitor CYP access?</td>
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The Government Response to the Consultation on Transforming Children and Young People’s Mental Health Provision: a Green Paper and Next Steps (2018) described opportunities for CCGs and Local Authorities to submit bids to be considered for trailblazer pilots. The White Paper indicated that only those areas selected by NHS England would be invited to submit an expression of interest (EOI) for a trailblazer opportunity.

Unfortunately none of the Lincolnshire CCGs were invited to submit an EOI; however, it was agreed by the Future in Mind steering group that the model that Lincolnshire had prepared in readiness for the national trailblazer would still move forward.

Building on the existing Care2Learn programme, which supports schools to provide a nurturing environment and where foster carers champion education, resources and developments already in place have been further expanded to form the Caring Schools Award framework, enabling educational settings to bring about the cultural change needed to support children and young people with their emotional and wellbeing development.

The Caring School toolkit has been developed in association with Caring2Learn and Partners in Practice.

**What is Caring2Learn?**

Caring2Learn is a research project funded by the Department for Education through the Partners in Practice programme. The overall aim of the project is to improve a wide range of outcomes for Lincolnshire’s looked after, previously looked after and other vulnerable children and young people. With the aim for all Lincolnshire education settings to be confident in nurturing vulnerable children and young people so they achieve better than expected progress and we want carers, foster carers and residential care workers, to champion education in the home. A key objective of the programme is to ensure that all Lincolnshire looked after children and young people feel safe and have a sense of belonging in their home and school, in order to provide them with a solid foundation to have the confidence to go on to learn, be aspirational and achieve their full potential.

The project aims to:

- improve the learning outcomes for all Lincolnshire looked after, post-looked after and other vulnerable children through knowledgeable Care and Learning communities in which our children and young people feel safe and believe they belong
• upskill and support our Carers and Educators to help them better support children and young people, in and out of their education setting, to improve learning outcomes
• promote good practice to support the wellbeing, emotional and mental health of all vulnerable children at home or in their education setting
• encourage active participation in education and improve the attendance of Lincolnshire looked after, post-looked after and other vulnerable children
• reduce the number of fixed-term and permanent exclusions of vulnerable children by creating more effective and nurturing learning environments, policies and procedures which meet the needs of individuals
• have fewer Post-16 looked after young people in Lincolnshire who are not in education, employment or training (NEET) by promoting higher aspiration and self-esteem.

What is a Caring School?

A Caring School can be any type of education setting; early years, primary or secondary, maintained, academy or independent, mainstream, specialist or alternative provision. It is an education setting where the nurture and well-being of all pupils and in particular the most vulnerable is as high a priority as their academic achievement. It is a place where the holistic needs of a child are addressed and their mental health is supported and enhanced so that they can achieve to their full potential.

The Caring Schools Award Toolkit provides educational settings with a framework of indicators that will support them to meet either a Bronze, Silver or Gold standard of practice in relation to their emotional wellbeing and mental health provision.

Areas of practice highlighted in the toolkit include; ethos and leadership, a child centred approach and working with families and other agencies.

It is anticipated that "Gold" schools will be "Centres of Excellence" and act as local hubs to provide peer support to other schools or clusters of schools.

Funding for the Caring2Learn project has been agreed until March 2020 with sufficient funding to run the Caring Schools Award with the revised criteria.

Consideration is being given to looking at the option of packaging up the Caring2Learn project so that this can be sold to other local authorities; this would build in future sustainability of the Caring Schools Award.
**Take up of Mental Health First Aid Training for Schools in Lincolnshire**

The Youth Mental Health First Aid in Schools training has been well-received by schools in Lincolnshire with 47% of eligible schools accessing the training in the first eighteen months of the programme; from April 2017 to October 2018.

Feedback from schools on the training included:

- "Very useful. It will be useful back in school with students and staff"
- "Very well delivered and allowed for group discussion/comments"
- "A positive course that made links with other training I have been on"
- "I felt there was a relaxed atmosphere in the room which really helped. [the instructor] was really easy to talk with"

Mental Health First Aid England reports that Lincolnshire has the highest uptake of the training in the East Midlands region and that they continue to value Lincolnshire's proactive approach to the programme.

It is expected that if uptake in Lincolnshire continues at the same rate, that at the end of the programme approximately 80% of Lincolnshire secondary schools will have at least one MHFA Champion.
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<tr>
<td>13.1 Has the site applied to be a trailblazer site?</td>
<td>* No - Due to the distance needed to travel to the training provider, Lincolnshire was considered ineligible for the trailblazers.</td>
<td>• To complete and evaluate the local trailblazer programme for 2018-19 that is detailed in the LTP.</td>
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<td>13.2 If not, is there a plan to apply in future years?</td>
<td>*Yes</td>
<td>• To ensure that there is local provision of training to allow inclusion in trailblazer programmes.</td>
<td>Mar 2019</td>
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<td>13.3 Is there evidence of how this will integrate with the existing transformation plan?</td>
<td>*Yes</td>
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### Section 15: Other Developments

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| 14.1 The LTP is a five-year plan of transformation. Does the plan include:  | *Yes - CYP were engaged in service development sessions and rather than have a road map developed a pictorial representation of their vision for service development that is included in the plan.  
- Examples of innovative projects include Peer Supporters, dedicated CYP website and extension of the Youth Offending Service mental health offer. |                                                                        |                          |
| - a transformation road map                                               |                                                                                                                                                                                                                                                                                                                                                  |                         |             |
| - examples of innovative and key enablers for transformation               | *Yes - Risks and mitigation are reported e.g. MHSDS data flow and recruitment.                                                                                                                                                                                                                                                                  |                         |             |
| - examples of how commissioning for outcomes is taking place?              | *Yes - The development and implementation of the Emotional Wellbeing and Mental Health online pathway, with expected outcomes is given.                                                                                                                                                                                                             |                         |             |
| 14.2 Does the plan highlight key risks to delivery, controls and mitigating actions? E.g. workforce issues, procurement of new services not being successful or delayed, issues related to MHSDS and flow of local data? Where risk had been identified is it highlighted within this plan? |                                                                                                                                                                                                                                                                                                                                                  |                         |             |
| 14.3 Does the plan highlight innovation that can be shared as 'best practice'? In particular: digital innovation that is used with CYP, parents and carers, schools and colleges and other partners as a tool for tackling stigma, and promoting MH prevention and treatment? | *Yes - The Future in Mind Steering Group provides a governance over the progress of the plan, including the finance and spend in relation to service development and outcomes.                                                                                                                                                      |                         |             |
| 14.4 Does the plan state how the progress with delivery will be reported, encouraging the transparency in relation to spend and demonstration of outcomes? | *Yes - The Future in Mind Steering Group provides a governance over the progress of the plan, including the finance and spend in relation to service development and outcomes.                                                                                                                                                      |                         |             |
| 14.5 Does the plan show how funding will be allocated throughout the years of the plan? | *Yes - Funding allocation is provided.                                                                                                                                                                                                                                                                                                                                                               |                         |             |
CAMHS: Impact of Service Outcomes

Complaints and Compliments – 2017-18

Each quarter the service has submitted details of complaints and compliments that have been received. Throughout the year there have been a total of 16 complaints received. On average there is 922 open cases each month, the number of complaints received is only 1.73% of total young people open at any one time. None of these complaints have been upheld, but 4 have been partially upheld. However there have been a total of 341 compliments received and reported over the year. The patient feedback (CHI) and Friends and Family Test has been submitted quarterly. In both Quarter 3 and 4 there were some reporting difficulties due to the change of the reporting system. The new reporting system will be accurately reporting the results of the ESQ formally known as the CHI for the next reporting year (2018/2019).

Outcome Measures

The use of outcome measures is core to the service delivery. Lincolnshire CAMHS uses the ‘My Outcomes’ system to measure the session by session rating scales (SRS) and the outcome rating scales (ORS). All other outcome measures are recorded using the clinical system (Silverlink). A range of outcome measures have been identified by LPFT that are being used, these include: RCADS: The Revised Children’s Anxiety and Depression Scale, EDEQ: Eating disorders examination questionnaire, SDQs: Strengths and Difficulties Questionnaire, ORS: Outcome Rating Scale, SRS: Session Rating Scale, SLDOM: Sheffield Learning Disabilities Measure, SCORE 15: Score Index of Family Functioning and Change, CRIES 8: Children’s Revised Impact of Events Scale.

On the My Outcomes system the outcomes can be inputted directly or indirectly by the young person or during their appointment and the progress tracked and shared with the young person and their family.

All other PROMS (Patient related Outcome measures) are used at point of assessment, at review (where applicable) and at discharge. The use of PROMS is varied and this is dependent on clinical need/presentation.

The service renewed its subscription with the My Outcomes system in February 2018. The renewal included additional licences so all clinical staff had access to the systems. One of the services ambitions for 2018/2019 will be to encourage the use of the My Outcomes systems which will both support clinical practice but also evidence the positive impact of the interventions delivered. Throughout Q1 and Q2, clinicians will be allocated a licence and each team will deliver localised training in the use of outcomes.
Online Counselling Service – April 2018 to March 2021

Planned outcomes for service users include:
- emotional wellbeing and/or mental health concerns are identified earliest opportunity and concerns are prevented from escalating
- emotional wellbeing and mental health improves as a result of accessing a service
- opinions feed into continuous service development
- aggregated improvement in mental health outcomes from start of counselling to completion

KPIs include:
- A positive therapeutic alliance (TA) between counsellors and service users
- Demonstrating improved mental wellbeing of service users through the submission of case studies on a quarterly basis.

Healthy Minds Lincolnshire – October 2017 to September 2020

Planned outcomes include:
- Improved emotional wellbeing and mental health of CYP in Lincolnshire
- CYP empowered to develop resilience and positive emotional wellbeing and mental health and have improved self-confidence and self-regulation
- More CYP are better supported by the workforce within their school

KPIs include:
- Sufficiency of interventions for children and young people
- Sufficiency of school workforce training to develop skills and capability of the workforce to support the emotional wellbeing concerns of CYP and their families
Appendix 1: Financial Commitment

Key stakeholders remain committed in ensuring that the service receives continued financial support including the Local Transformation Planning monies to maintain the restructured service to enable improved outcomes for young people.

**CAMHS pooled funding**

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Contribution</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincolnshire County Council</td>
<td>£724,589</td>
<td>£724,589</td>
<td>£724,589</td>
</tr>
<tr>
<td>Lincolnshire East CCG</td>
<td>£1,641,604</td>
<td>£1,641,604</td>
<td>£1,641,604</td>
</tr>
<tr>
<td>Lincolnshire West CCG</td>
<td>£1,369,338</td>
<td>£1,369,338</td>
<td>£1,369,338</td>
</tr>
<tr>
<td>South Lincolnshire CCG</td>
<td>£937,143</td>
<td>£937,143</td>
<td>£937,143</td>
</tr>
<tr>
<td>South West Lincolnshire CCG</td>
<td>£777,313</td>
<td>£777,313</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>£5,449,987</td>
<td>£5,449,987</td>
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<tr>
<td><strong>CQUIN Contribution</strong></td>
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<tr>
<td>Lincolnshire East CCG</td>
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<tr>
<td>Lincolnshire West CCG</td>
<td>£34,233</td>
<td>£34,233</td>
<td>£34,233</td>
</tr>
<tr>
<td>South Lincolnshire CCG</td>
<td>£23,429</td>
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</tr>
<tr>
<td>South West Lincolnshire CCG</td>
<td>£19,433</td>
<td>£19,433</td>
<td>£19,433</td>
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<tr>
<td><strong>Total</strong></td>
<td>£118,135</td>
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</tr>
<tr>
<td><strong>Transformation Plan Funding</strong></td>
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<tr>
<td>Lincolnshire East CCG</td>
<td>£493,154</td>
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<tr>
<td>Lincolnshire West CCG</td>
<td>£419,499</td>
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<tr>
<td>South Lincolnshire CCG</td>
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<td>£294,994</td>
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<tr>
<td>South West Lincolnshire CCG</td>
<td>£233,395</td>
<td>£233,395</td>
<td>£233,395</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£1,441,042</td>
<td>£1,441,042</td>
<td>£1,441,042</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td>£7,009,164</td>
<td>£7,009,164</td>
<td>£7,009,164</td>
</tr>
<tr>
<td><strong>Additional funding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transformation underspend</td>
<td>£69,600</td>
<td>£69,600</td>
<td>£69,600</td>
</tr>
<tr>
<td>Lincolnshire County Council</td>
<td>£84,334</td>
<td>£84,334</td>
<td>£84,334</td>
</tr>
<tr>
<td>Support to LD</td>
<td>£195,000</td>
<td></td>
<td>£195,000</td>
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<tr>
<td><strong>Total CAMHS Pooled Fund</strong></td>
<td>£7,163,098</td>
<td>£7,358,098</td>
<td>£7,358,098</td>
</tr>
</tbody>
</table>
Funding for wider system services:

**Healthy Minds Lincolnshire**

A review of children’s public health services identified that emotional wellbeing support was a key area that children, families and professionals require specific help with. On 1st November 2016 the Council’s Executive agreed to the recommended new children’s health services model which incorporates the commissioning of a new emotional wellbeing service. A budget of £1 million per financial year had been allocated from Lincolnshire County Council’s Children’s Services and following further discussions it was proposed that a further £1 million per financial year be allocated from the High Needs budget of the Designated Schools Grant to further enhance the Service. This proposal was supported by Lincolnshire Schools’ Forum on the 12th January 2017.

*The Healthy Minds Lincolnshire Service commenced 1st October 2017 and therefore commenced mid-way through the 2017/18 financial year.

<table>
<thead>
<tr>
<th>Healthy Minds Lincolnshire</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincolnshire County Council Children's Services</td>
<td>-</td>
<td>£1,000,000</td>
<td>£1,000,000</td>
</tr>
<tr>
<td>Lincolnshire County Council High Needs budget of the Designated Schools Grant</td>
<td>£960.810</td>
<td>£1,000,000</td>
<td>£1,000,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><em>£960,810</em></td>
<td><strong>£2,000,000</strong></td>
<td><strong>£2,000,000</strong></td>
</tr>
</tbody>
</table>

**Kooth – Online Counselling**

The review of children’s public health services also included the online counselling service and on 1st November 2016 the Council’s Executive agreed to the online counselling service contract at the time being varied to 31st March 2018 and an online counselling service being procured through open competitive tender, with services being operational from 1st April 2018.

<table>
<thead>
<tr>
<th>Online Counselling Service</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincolnshire County Council Children's Services</td>
<td>£200,000</td>
<td>£200,000</td>
<td>£200,000</td>
</tr>
</tbody>
</table>
## Appendix 2: Key Performance Indicators (KPIs)

Detailed below are the minimum KPI’s that will be monitored during the delivery of the CAMH Service.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTCOMES &amp; STAKEHOLDER FOCUS</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| **O&S 1. NHS Outcomes Framework** | The Trust can evidence conformance with, and improvement aligned with the CAMHS relevant objectives set out within the NHS Outcomes Framework. The NHS Outcomes Framework for Children and Young People will be referred to throughout the KPIs where another KPI relates to them.  
NHS1) More children and young people will have good mental health  
NHS2) More children and young people with mental health problems will recover  
NHS3) More children and young people with mental health problems will have good physical health, and more children and young people with physical ill-health will have better mental health  
NHS4) More children and young people will have a positive experience of care and support  
NHS5) Fewer children and young people will suffer avoidable harm  
NHS6) Fewer children and young people and families will experience stigma and discrimination | | |
| **O&S 2. Timely Complaints Resolution (NHS4, NHS5)** |  
- Widely disseminated complaints policy available to professionals and Service Users and is written in such a way that it is appropriate and accessible for all children, young people and their families  
- 100% complaints resolved in line with the Trust’s Complaints Policy timelines  
- Areas for improvement are identified and acted upon  
- Review of year on year volume of complaints (as a percentage of service users)  
Complaints are reported quarterly, grouped into themes with tracking of improvement and actions taken | Quarterly |
| **O&S 3. Formal Compliments Received (NHS4)** |  
• The Trust shall maintain a compliments evidence portfolio that is available for inspection by the commissioner  
• Compliments are reported quarterly, grouped into themes  
• The Trust shall record and present the number received during the contract year and as a % of Service users | Quarterly |
### O&S 4. Annual Stakeholder Survey

- The Trust completes an annual stakeholder survey (to be included within the annual Trust Performance Report)
- The Trust conducts a regular, planned programme of service evaluation
- The Trust provides evidence of systematic and continuing process of consultation with a broad range of stakeholders, including service users
- Areas for improvement are identified and acted upon in a "you said, we did" approach
- The annual stakeholder survey shall include a particular focus on the views of CYP. The Trust shall jointly develop this work with the Lost Luggage group or other forums as it deems appropriate to listen to the views of CYP as to how best to capture the feedback of the CYP.
- The annual stakeholder survey shall offer an opportunity for front line practitioners and Clinicians to have access to Commissioners and may utilise mechanisms such as shadowing, attending team meetings, case studies or the attendance of a service user at a contract management meeting. The Council welcomes the feedback of diverse metrics for measurement in the annual survey from front line practitioners who are experts in measuring the journey undertaken from different service user groups. The Council supports the Trust in being creative and innovative through this process.

### O&S 5. Voice of the Service User (NHS4)

- The Trust provides evidence of systematic and continuing process of involvement with Children & Young People (CYP) regarding areas for service improvement & adding value (including a cross section of all key service use groups e.g. LD, LAC etc.)
- The Trust is to demonstrate how key stakeholder feedback from CYP has been utilised in improving the service delivered
- The Trust is to empower YP to provide feedback on their experiences through suitable language and mediums, such as CYP friendly versions of key documentation
- Parent and Carer and Children and Young People questionnaire results to be presented along with Performance Information. Results should be tracked to enable identification of trends
- Questionnaires should show 95% of service users that remain with the service after assessment have received a copy of their care plan / multi-agency risk management plan.

**2018-19 KPI Development:**

<table>
<thead>
<tr>
<th>Quarterly</th>
<th>Annually</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>O&amp;S 6. Demonstrable Commitment to the Participation Charter (NHS4)</td>
<td>Evidence to include CHI ESQ responses, report that shows how these are captured</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>
| The Trust is to demonstrate commitment to the four key principles of the Participation Charter:  
  - Children have equal opportunity to be involved  
  - Children are valued  
  - The involvement of children is a visible commitment which is properly resourced which can be evidenced through contract management  
  - The involvement of children is monitored, evaluated, reported and improved  
**2018-19 KPI development:**  
This indicator can also be evidenced through the Peer support qualitative work and cross-referenced to KPI IO25. The Participation Champions work will also be considered as evidence for this KPI in addition to KPI IO25 | |
| O&S 7. Standards for the Service (NHS4) | The Service will be commissioned through the principles of No Surprises. The Trust shall inform the Council within five (5) working days of any recommendations from statutory bodies and within one (1) working day of any reputational issues that would directly affect the Council and the Trust. This Principle to include all CAMHS services within the County and for the benefit of Commissioners, this could include You're Welcome, QNCC and CQC. | Quarterly |
| O&S 8. The Trust has a model in place to measure how users outcomes have been achieved (NHS2, NHS4) | - Model to measure progression of outcome is in place, which includes recording of outcome measures for each CYP  
  - Desired outcome is identified at start of engagement and evaluated at point of transition – and recorded at both points  
  - Routine use of Patient Rated Outcome Measures (PROMS). These should include, as a minimum Goal Based Outcomes, SDQ’s; session by session monitoring and symptom trackers.  
  - Results of outcomes measures will be shared with children, young people and their families (where appropriate) to involve them in understanding their progress, to empower the service users and to help service users and their families understand and decide what further intervention they need  
  - Symptom trackers will be linked to the Care Pathways to enable effectiveness of care Pathways to be monitored | Quarterly |
| O&S 9. Average aggregated improvement in service user mental health outcomes from start of provision to discharge (Individual Patient) (NHS1, NHS2, NHS4) | 1. The service standard is that the Trust shall commence engagement outcomes measurement for 95% Service Users on the first assessment. However, the Council recognises that the Service User may not wish to participate or the Clinician may not deem this to be appropriate. In either case, this will be recorded on the patient notes.  
2. Where measures are undertaken, the Trust shall record number of Service Users outcomes reported where clinically viable at first appointment, discharge and any measure-specific time-intervals.  
3. Aggregated score shows improvement in outcomes for Service Users. | Quarterly |
| O&S 10. Outcome measures evidence improvement in mental health risk (NHS1, NHS2) | The Trust shall use an accepted risk assessment tool. The Trust shall evidence that mental health risk scores are being captured for 100% of Service Users at assessment, 1st contact and discharge (excluding discharges due to Service User disengagement) as a minimum. As a result of service access, there should be a measurable improvement in the mental health of the Service Users at the point of discharge. The Trust shall evidence that Staff are trained and have the required competencies to undertake risk assessments. | Quarterly |
| INPUTS & OUTPUTS | There is a performance monitoring system in place for recording and reporting contract related management information.  
- Monitoring information is provided in line with the measures agreed and is to schedule  
- Performance Reports are accurate & are provided by 28th of the month in July, October, January and April  
- Contract management meetings to be held in August, November, February and May.  
- Significant over or under-achievement of measures required are to be highlighted *excluding significant changes or requests made by the Commissioner – alternative timescales will be agreed where this occurs* | Quarterly |
| I&O 1. Contract Performance Monitoring System Effectiveness | Prior to the signing of the new Agreement, the Trust has conducted a gap analysis on current services versus the requirements detailed within the service specification. The Trust has developed an action plan with key dates, milestones and acceptable tolerances for the transition of services to the required specification that is agreeable to the Council. The progress of change against this agreed action plan shall be reviewed on an agreed basis with the Council. It is the expectation of the Council that the Trust shall continue to monitor the identified actions, timescales and required quality. Mechanisms of this include, but are not limited to, implementation meetings, mobilisation project plans, and | Quarterly |
Both Partners shall need to work together through change management. Once the implementation process is complete and the transition to the new service is embedded, this measure shall draw to a close.

<table>
<thead>
<tr>
<th>I&amp;O 3a</th>
<th>CAMHS Advice Line For Professionals (PALS)</th>
<th>Quarterly</th>
</tr>
</thead>
</table>
| The Trust shall deliver a Professional Advice Line service for professionals to obtain general mental health advice, support and guidance, including referral guidance. The CAMHS/LPFT led PAL will work towards reporting (as per the KPI schedule review in Q1 2017/18):
  - Volume of calls (in the month)
  - Length of calls (average in the month)
  - Consultation sent (Yes/No)
  - Caller agency (main agencies and other to be agreed)
  - Services signposted to (main resources and other to be agreed). |

<table>
<thead>
<tr>
<th>I&amp;O 3b</th>
<th>Screening Response Speed (NHS2, NHSS)</th>
<th>Quarterly</th>
</tr>
</thead>
</table>
| The Trust shall deliver high quality consistent prioritisation of children and young people’s mental health needs following the screening process for new referrals. CAMHS/LPFT led screenings shall be conducted and an accept/reject response given within 24 hours of initial referral for routine referrals. Emergency and urgent referrals will be processed as a priority, in line with their target timescales.  

**Screening Outcome – Routine Referral Accepted**
If appointment is offered then this will initially be followed up by telephone to the referrer/parent (as appropriate) within 24 hours, to offer two appointments. If the referrer is uncontactable then a letter will be sent with an appointment time within 5 working days.  

**Screening Outcome – Routine Referral Declined**
Within five (5) working days a letter shall be sent to the referrer/parent as appropriate. The content of the letter should include:
  - A clear explanation as to why the referral was inappropriate and
  - alternate services to be considered/signposting

*Examples of anonymised declined letters will be required at contract management.*

**2018-19 KPI development:**
Each of the access times and waits are shown on the report currently – and will be appraised separately rather than aggregated.

<table>
<thead>
<tr>
<th>I&amp;O 4.</th>
<th>Booking onto 1st Appointment</th>
<th>Quarterly</th>
</tr>
</thead>
<tbody>
<tr>
<td>A system is in place that supports expected service standard that 95% of Service Users are offered their 1st appointment following the screening process, if the screening process assesses the user as requiring CAMHS.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### I&O 5. Response Rates (Urgency)

**NB:** There are two response rate targets (Service and Presentation Type, and Urgency). The service user should always be subject to the quicker of the two response targets, based on their individual need.

(NHS2, NHS5)

95% of Service Users (assessed as requiring the Service) receive the following response within the target timescales (below) based on the urgency of their need. Urgency waits include the following classifications:

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

- **Urgent**
  - Face to face within 72 hours

- **Routine**
  - Face to face within 6 weeks

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

- Self-Harm Assessment and Intervention Service with presentation at A&E: 24 Hours
- Specialist CAMHS Support to LAC: 4 weeks
- Young people in contact with the YJS: 3 weeks

Community Eating Disorder waits are subject to an alternate wait time.

- Face to Face emergency response: 24 hours
- Face to Face urgent response: 72 hours
- Treatment start: within 1 week for urgent cases and 4 weeks for routine

Although a target of 95% has been set for whole service response rates, it is the view of the Commissioner that 100% of Service Users should receive a response within the targets set. Therefore all waits for a response that exceed target should be reported as an exception, regardless of whether they push the overall service response rate below 95%.

### I&O 6. Response Rates (service & presentation type)

**NB:** There are two response rate targets (Service and Presentation Type, and Urgency). The service user should always be subject to the quicker of the two response targets.

95% of Service Users (assessed as requiring CAMHS) receive an appointment within the following timescales:

- **24 hours**
  - Any presentation that would be applicable under Crisis and Home Treatment Service

- **3 weeks**
  - Youth Offending/CAMHS Nurse Specialist Service

- **4 Weeks**
  - Specialist CAMHS Support to LAC

- **6 Weeks**
  - Targeted CAMHS Support to Universal Services and Local Integrated Teams

Quarterly
<table>
<thead>
<tr>
<th>I&amp;O 7. Booking 1&lt;sup&gt;st&lt;/sup&gt; ‘Core’ appointment (first session of treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Clinician undertaking assessment may or may not be the subsequent deliverer of care. Although treatment may be identified as appropriate, it may be undertaken by another Clinician or the Service User may be suitable for group work. Where it is the case that;</td>
</tr>
<tr>
<td>• a Service User has been identified during their 1&lt;sup&gt;st&lt;/sup&gt; Assessment as being suitable for treatment <strong>and</strong></td>
</tr>
<tr>
<td>• the Clinician shall be the deliverer of Care it is the expectation of the Council that 95% of Service Users are booked onto a 1&lt;sup&gt;st&lt;/sup&gt; ‘Core’ intervention during the Assessment appointment.</td>
</tr>
<tr>
<td>Where it is the case that;</td>
</tr>
<tr>
<td>• a Service User has been identified during their 1&lt;sup&gt;st&lt;/sup&gt; Assessment as being suitable for treatment <strong>but</strong></td>
</tr>
<tr>
<td>• the Clinician undertaking assessment shall not be the deliverer of Care</td>
</tr>
<tr>
<td>It is the expectation of the Council that it shall be standard service performance to update 95% of this cohort either to the</td>
</tr>
<tr>
<td>• next available group session or,</td>
</tr>
<tr>
<td>• the 1st Core Appointment with the alternate identified Clinician within 7 working days</td>
</tr>
<tr>
<td>• Total number of CYP who are waiting for 1st treatment sessions and their wait in weeks (average, maximum, minimum)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I&amp;O 8. Care Pathways (NHS2, NHS3, NHS4, NHS5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust shall support the development, creation and maintenance of effective key multi-agency pathways based on best practice by agreeing the CAMHS part of the pathway and ensuring adherence to this is monitored and reported to Commissioners. The Trust shall establish pathways, in partnership with other agencies, for the following presentations within three (3) months of the Commencement Date: Self-Harm and Transitions to Adult Services; Children and young people with dual diagnosis (substance misuse and mental health concerns). The CAMHS element of the pathway will be reflected in their ‘Care Pathways’. The Trust shall play a key role as highlighted in the Behaviour Pathway. The Trust will report any issues with these developments in the contract review meeting.</td>
</tr>
</tbody>
</table>
| I&O 9. DNA Rates | The Trust will actively manage DNA rates for all subsets of its services and service users (including YOS, LAC DNA rates). The Trust shall present the DNA information to the Council as a whole service equivalent as well as by Care Options. **DNAs (numbers and rates)** The Trust shall deliver a cumulative year on year reduction in DNAs rates (towards a target of less than 8% within the life of the contract):  
Year 1: less than 11%  
Year 2: less than 10%  
Year 3: less than 9%  
Year 4: Crisis and Home Treatment Service CAMHS less than 8%  
Year 4: core CAMHS less than 8%  
Where DNA rates are high (whole service or subset of service and service users) the Trust will seek to understand the root cause and initiate an appropriate solution. The Council may reflect on national, regional or historical benchmarking to inform the decision. | Quarterly |
<p>| I&amp;O 10. Inappropriate Referrals | The Partners shall work collaboratively together with referrers into the Service to achieve a year on year reduction in inappropriate referrals and referrals that do not ultimately receive an intervention (as a percentage of total annual referrals) | Quarterly |
| I&amp;O 11. Re-admission Rates | Less than 15% of all admissions are re-referrals from children and young people previously discharged from CAMHS within the respective six (6) months. The Trust will monitor and identify to the Council those that are repeat admissions for the CAMHS service and work collaboratively to understand the needs of this group to help reduce it. | Quarterly |
| I&amp;O 12. Open cases | 95% of all open cases should receive a face-to-face contact each month (as a minimum). This is to avoid non-active caseloads remaining open and drives focus on effective discharge. The Council recognises that monthly appointments may not be appropriate for those sat under an LD Consultant, DNA / transitioning out of care. The Trust does not need to provide further exception reporting for the CYP who fall under such headings. <strong>NB:</strong> The once a month measure is used in this KPI to distinguish between active and inactive open cases, and is in no way a target for intervention frequency. <strong>2018-19 KPI development:</strong> The current measure does not demonstrate what we need to know. Proposal: Do a snap shot of cases with activity, defined as 1 contact in the last 3 months and 6 months. Anyone that sits outside is a potential outlier and would need an explanation. Following this exercise, if the commissioners are assured of throughput, this can potentially move to an end of year. | Quarterly |</p>
<table>
<thead>
<tr>
<th>I&amp;O 13. Disengagement Rate (NHS4)</th>
</tr>
</thead>
</table>
| Less than 15% of all discharges are as a result of the service user becoming ‘disengaged’. Disengagement rates to be presented by Care Options, thereby showing LAC/YOS discharges. Looked After Children and those Young People engaged in Youth Offending Services shall be treated under core CAMHS in the new service. In response to scrutiny, as an interim measure, the Council would like to continue to monitor the quality of service and timescales LAC/YOS are in receipt of during service transformation. This will enable the Provider and the Council to respond to challenge around these identified vulnerable groups. For the first six (6) months, the service shall report;  
- disengaged YOS/LAC cases where discharge has been agreed by Service  
- All YOS cases transitioned to AMHS  
- All LAC cases accessing the service as part of the 18-24 year old age group  
| Quarterly |

<table>
<thead>
<tr>
<th>I&amp;O 14. Wide Access to Services (NHS1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a Lincolnshire County wide NHS service to all children and young people in need of a CAMHS prevision, irrespective of any socio-demographic background or protected characteristic. Ethnicity is recorded for 100% of children and young people who are receiving treatment in the service. All CAMHS staff are trained in cultural competence.</td>
</tr>
<tr>
<td>Quarterly</td>
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<table>
<thead>
<tr>
<th>I&amp;O 15. Volume on pathway and Average Core Sessions and 3rd Quartile Core Sessions</th>
</tr>
</thead>
</table>
| There is a shared understanding between the Partners that the average (mean) number of ‘core’ face-to-face sessions is no more than as outlined as service standard within the appropriate pathway. . As standard, the Trust shall inform Council as to the number of Service Users on each pathway. It is the expectation of the Council that when Pathways are referenced, the Trust shall produce information in relation to both elements of each Pathway (e.g. Mild – Moderate and Moderate – Severe)  
1. Depression- mild to moderate  
2. Depression- moderate to severe  
3. General Anxiety-mild to moderate  
4. General Anxiety- moderate to severe  
5. Social Anxiety-mild to moderate  
6. Social Anxiety- moderate to severe  
7. Anxiety: OCD & BDD-mild to moderate  
8. Anxiety: OCD & BDD - moderate to severe  
9. PTSD: short term  
10. PTSD: Longer term |
<p>| Quarterly |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>12. Self-Harm: Medium Risk</td>
<td>The Trust can evidence the delivery of a rolling programme of training to universal services based on a training needs analysis.</td>
</tr>
<tr>
<td>13. Eating Disorder: Anorexia Nervosa</td>
<td>An initial short term training plan should be shared with the Council within one (1) month of the Commencement Date. Training is a valued part of the TEAMHS offer and should reflect the requirements of a range of stakeholders. Information about training should be shared in an accessible way so that maximum numbers can attend.</td>
</tr>
<tr>
<td>14. Eating Disorder: Bulimia</td>
<td>Training on how to make an effective and appropriate referred to CAMHS will be well publicised and training will be provided when requested within schools and colleges. These staff will also be training in low level interventions and how to monitor improvements using goals-based outcomes.</td>
</tr>
<tr>
<td>15. Eating Disorder: Binge Eating</td>
<td>Targeted Services working with children and young people at greatest risk of mental health services will receive training in mental health. The Trust will provide up to 16 training days per year to the LA’s social workers, fosters carers, residential care home staff, leaving care workers and adoptive parents (pre-adoption).</td>
</tr>
<tr>
<td>16. Eating Disorder: Atypical</td>
<td>This provision of training will include promoting mental health, recognising and supporting children and young people with mental health problems, referrals and priorities of the integrated CAMHS, including an introductory module, followed by access to more advanced training around specific mental health problems and support strategies that can be used in Universal/Targeted Services.</td>
</tr>
<tr>
<td>17. Attachment Difficulties</td>
<td></td>
</tr>
<tr>
<td>18. Harmful sexualised behaviours: Mild to moderate</td>
<td></td>
</tr>
<tr>
<td>19. Harmful sexualised behaviours: Moderate to severe</td>
<td></td>
</tr>
<tr>
<td>20. Psychosis</td>
<td></td>
</tr>
<tr>
<td>21. Behaviour: Level Three</td>
<td></td>
</tr>
<tr>
<td>22. Behaviour: Level Four</td>
<td></td>
</tr>
<tr>
<td>23. Learning Disability: Depression</td>
<td></td>
</tr>
<tr>
<td>24. Learning Disability: Anxiety</td>
<td></td>
</tr>
<tr>
<td>25. Learning Disability: Challenging behaviour/ self-harm</td>
<td></td>
</tr>
</tbody>
</table>

The number of sessions required across the Service can vary significantly, therefore the Trust is only expected to report by exception those that exceed 25% further sessions than identified within their pathway. If more than 25% of all Service Users should receive more than this tolerance before discharge over a quarter the Trust shall seek to understand the root cause and initiate an appropriate solution.
Numbers of universal staff trained will be shared on a monthly basis during the implementation phase, broken down into locations/professions. Following the implementation phase this shall transition to quarterly performance reporting.

An audit will take place bi-annually (i.e. every two years) of a sample of universal staff to demonstrate evidence of ability to recognise and influence psychological well-being and early signs of distress. This will be led by the Trust.

**2018-19 KPI Development:**

Evidence of the training that the Peer support workers undertake will contribute to this indicator, i.e. whole school delivery, school assemblies etc. Can be included in this section, but needs to be pulled out into IO 16(B) measure to ensure this work is captured.

Will be itemised as part of Peer support Project (New-IO25) but referenced back to this entry.

| I&O 17. Care Pathway Development (NHS2, NHS4, NHS5) | The Trust shall develop ways of working that support the creation, maintenance and on-going development of effective evidence-based Care Pathways. The Trust shall evidence that a minimum of 50% of its caseload is being supported using a Care Pathway approach within six (6) months of the Commencement Date. The Trust shall evidence that a minimum of 80% of its caseload is being supported using a Care Pathway approach within twelve (12) months of the Commencement Date. The use of which PROMS, particularly symptom trackers, and when, will be identified in the Care Pathways in order to measure the effectiveness. | Quarterly |
| I&O 18. The creation of an effective Crisis and Home Treatment service (T3=) (NHS2, NHS5) | The Trust shall evidence the establishment of a Crisis and Home Treatment service (described in section 3.0) by the Commencement Date, which is to continue for the remaining duration of the Agreement. Reporting on the progress of this Service shall be in the contract review meetings. Reporting requirements, if different to those for the rest of the service, will be agreed between the Partners. | Quarterly |
| I&O 19. Crisis and Home Treatment Package response rates (NHS5) | Emergency wait times – 4 hour telephone response; 24 hour face-to-face emergency response and urgent within 72 hours. Intensive Home Treatment Packages should commence within 24 hours of acceptance by the service.  
- Number of Service Users accessing service for out of hours/crisis support and wait time (average, maximum, minimum)  
- Number of Service Users accessing service for intensive home treatment support and waits (average, maximum, minimum)  
- Duration of time Service Users in receipt of Home Treatment Service (average, maximum, minimum) | Quarterly |
| I&O 20. Tier 4 Inpatient Settings | Presenting need (e.g. ED, Self-Harm, LD, ASD)  
95% of all home treatment is to commence within 24 hours of acceptance This excludes referrals from inpatient mental health settings. |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| I&O 20. Tier 4 Inpatient Settings | The Trust shall inform the Council;  
- Number of Service Users referred to Tier 4 bed  
- Number of Service Users accepted on to a Tier 4 bed  
The Partners shall work together to evidence effectiveness of Crisis and Home Treatment Service in reducing volume of Lincolnshire CYP in entering NHS Tier 4 settings. This information may be requested from NHS England directly.  
**NB:** This measure is intended to understand the demand for inpatient settings and is no way a target to stop CYP from accessing a service they need. |
| I&O 21. Community Eating Disorder Services | A Community Eating Disorder Service (CEDS) to be delivered in line with Schedule 3. Lincolnshire is committed to national aim of 95% treatment of Eating Disorders being delivered to NICE pathway by 2018. In Q1, 2 and 3 the service shall focus on implementing the agreed pathway and by end of Q4 in 2016 a minimum of 60% of all Service Users presenting with an Eating Disorder shall receive treatment in line with this Pathway. |
| I&O 21. Community Eating Disorder Services | Notification to the Council of capacity and demand of the Pathway |
| I&O 22. Behaviour | Looked After Children and those Young People engaged in Youth Offending Services are treated under core CAMHS. However in order to respond to regulatory reporting requirements, the Council would like to continue to monitor the quality of service and timescales LAC/YOS are in receipt of. This will enable the Provider and the Council to respond to challenge around these identified vulnerable groups.  
The Trust shall report;  
- Presenting need  
- disengaged YOS/LAC cases where discharge has been agreed by Service  
- All YOS cases transitioned to AMHS  
- All LAC cases accessing the service as part of the 18-24 year old age group |
| I&O 25. 2018-19 KPI Development New Indicator | Reference evidence in KPI OS5. Consider impact on service and CYP  
1. The Service will demonstrate that the voice of the child is evident within service development: |
<table>
<thead>
<tr>
<th>Peer Support and Involvement</th>
<th>Peer Support and Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Report on the You Said We Did work</td>
<td></td>
</tr>
<tr>
<td>● Include any aspects of service development where relevant e.g. the self-referral project</td>
<td></td>
</tr>
<tr>
<td>● Newsletter can be used as evidence</td>
<td></td>
</tr>
<tr>
<td>2 Young people who want to become involved in participation are given support to engage in service development by developing positive relationships with PSW/Project lead that centre around their individual interests:</td>
<td></td>
</tr>
<tr>
<td>● Covered in the KPI OS5</td>
<td></td>
</tr>
<tr>
<td>● Involvement network evidence</td>
<td></td>
</tr>
<tr>
<td>3. Continued service response to reduce stigma related to children’s mental health in Lincolnshire:</td>
<td></td>
</tr>
<tr>
<td>● Evidence work with CYP to improve publications and leaflets, so that they are accessible and make sense to CYP</td>
<td></td>
</tr>
<tr>
<td>● Newsletter can be used as evidence</td>
<td></td>
</tr>
<tr>
<td>4. Continued improvement of access to mental health service by active engagement of young people who are having difficulty accessing service:</td>
<td></td>
</tr>
<tr>
<td>● Hand holding support, demonstrate impact through case studies (a few paragraphs not lengthy), include service user feedback</td>
<td></td>
</tr>
<tr>
<td>5. Continued support of young people when they transition into adult services:</td>
<td></td>
</tr>
<tr>
<td>● Where this happens, demonstrate impact through case studies (a few paragraphs not lengthy), include service user feedback</td>
<td></td>
</tr>
<tr>
<td>6. Continued development and updating of the content of the dedicated CAMHS website:</td>
<td></td>
</tr>
<tr>
<td>● Evidence of what has changed, been updated in the last Quarter, - can be reported as a null return for 2 quarters out of 4.</td>
<td></td>
</tr>
</tbody>
</table>

Quantitative measures –

1. The number of CYP contacts delivered by the peer support service as part of the CYP engagement in treatment
2. The number of other agencies receiving mental health awareness from Peer Support Workers; provided by the number and type of agencies; the number of CYP and the number of staff - this will be referenced in KPI IO 16(B)

<table>
<thead>
<tr>
<th>I&amp;O 26. Commissioning for Quality and Innovations (CQUIN’s)</th>
<th>2017-19 National CQUIN Transition from CAMHS (Child and Adolescent Mental Health Service) to AMHS (Adult Mental Health Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence that the project and reporting to NHSE is in-line with national reporting guidelines and timescales.</td>
<td></td>
</tr>
<tr>
<td>I&amp;O 27. 2018-19 KPI Development New Indicator Justice Project</td>
<td>The supplier will provide the following evidence:</td>
</tr>
<tr>
<td></td>
<td>1. Number of referrals in the month broken down by:</td>
</tr>
<tr>
<td></td>
<td>● Those leading to formal indirect case involvement</td>
</tr>
<tr>
<td></td>
<td>● Those leading to formal direct case involvement</td>
</tr>
<tr>
<td></td>
<td>2. Number cases in the month broken down by:</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
### Continuity Improvement

**C.I 1. Annual Self-Review of Safeguarding Arrangements in line with Section 11 of Children Act 1989. (NHS5)**

- The Trust is able to demonstrate and evidence compliance with Section 11 of Children Act 1989.
- The Trust is able to evidence that where areas for improvement are identified they are acted upon in a timely and appropriate manner.
- The Trust shall complete a self-review of Safeguarding Arrangements annually.
- The Trust shall use either the Lincolnshire LSCB template or the ‘Safe Network’ website as a means to evidence compliance and best practice.
- The Trust shall ensure 100% of staff have undertaken Safeguarding training.

**C.I 2. Trust actively manages delivery utilising an up to date risk register, to include a business continuity plan. (NHS4)**

- Risk Report: Any risks identified are managed and actions to mitigate risk are identified and implemented.
- Trust to manage, maintain and report by exception on contracts risk register.
- Business continuity plans are in place and available for review.
- Business continuity arrangements are in place and are regularly reviewed to ensure they remain fit for purpose. These could include:
  - Staff Shortage - illness, industrial action, severe weather.
  - Loss of premises - flood, fire, gas leaks.
<table>
<thead>
<tr>
<th>C.I 3. The Trust can demonstrate continuous improvement in the development of their workforce.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust can evidence that the following systems are in place and are operational and effective:</td>
</tr>
<tr>
<td>- Induction training is provided to all new starters</td>
</tr>
<tr>
<td>- All employees receive regular supervision</td>
</tr>
<tr>
<td>- All employees are subject to an annual appraisal with associated personal development plan</td>
</tr>
<tr>
<td>- Training, development and support standards are met and plans are in place and monitored to ensure that specific competencies for the various roles are achieved</td>
</tr>
<tr>
<td>- All employees are in receipt of all appropriate accreditation</td>
</tr>
<tr>
<td>- Teaching Agency requirements are met (previously referred to as the Children's Workforce Development Council)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.I 4. Breadth of Skills Base (NHS2, NHS4, NHS5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust can evidence the provision of a clinical workforce that are trained, certified and able to offer a wide range of evidence based interventions in line with local need and NICE Guidance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.I 5. Friends and Family Test (NHS4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust is to gather Friends and Family Test scores from all Service Users at discharge from the Service (in line with NHS England guidance) based on the following statement: ‘How likely are you to recommend our Child and Adolescent Mental Health Service to friends and family if they needed similar care or treatment?’ Scores shall be reported monthly for both ‘Recommended’ and ‘Not Recommended’ rates. CHI-ESQ Report Action Plan is agreed with the Council and recommendations are implemented (bi-annual reporting) The Trust shall deliver a year-on-year improvement in ‘recommended’ responses and a year-on-year decrease in ‘not recommended’ rates. Low ‘recommended’ response rates or high ‘not recommended’ response rates at a service, location, or service user group level shall drive further investigation and inform the continuous improvement of the service. Nationally, there is a target for 20% of all discharges to complete a Friends and Family questionnaire. The Provider is already reporting to their Board how CAMHS is progressing against this target on a monthly basis. Each Hub, alongside the EDS and C&amp;HTS Teams will be given the number of discharges from their service that month and the number of completed questionnaires,</td>
</tr>
</tbody>
</table>
which are subsequently converted into a percentage. To ensure that Friends and Family are encouraged to complete the benchmark, the Commissioner would like to see an increase to a consistent return of 15% on average across the service by end of Year 1. The Council would like to see an increase to 20% on average across the service by end of Year 2.

C.I 6. **Completed annual Contract Performance Report**

The Trust shall provide the Council with an annual Contract Performance Report that includes the following:

- A review of the year's performance, including any centrally imposed targets/expectations
- The annual stakeholder survey results and subsequent improvement actions taken
- Evidence that objectives, actions, tasks within the plan have led to actual service improvements
- The impact of the service outcomes is demonstrated and benchmarked against other services locally, regionally & nationally
- A service user engagement plan for the forthcoming year
- Evidence of the effective engagement of other services
- Value for money is demonstrated
- Areas for improvements that have been identified and acted upon
- Findings from Quality Assurance audits have resulted in positive changes to services (where needed)
- Demonstrable Outstanding delivery in line with Ofsted grade descriptors (where applicable)
- A forward look at how to improve service delivery during the following year including acting upon suggestions from children/young people

C.I 7. **Safeguarding Vulnerable Adults and Children ' Markers of Good Practice' RAG rating (NHSS5)**

Staff are trained in safeguarding according to the levels and competencies set out by the LCSB. LPFT are represented on the LCSB and attend 75% of meetings.

Staff have received training in safeguarding vulnerable adults according to the levels set out in the Safeguarding Adults Board.

Staff have received training in line with the Mental Capacity Act 2005.

The Trust is able to provide the following:

- Written evidence of implementation of local policies and procedures are in place
- Evidence that a named Nurse and named Doctor for safeguarding children is in post
- All DBS checks have been conducted and assurance received for all employees and volunteers
- The process for flagging children who miss appointments
- The system for flagging children for whom there are safeguarding concerns

Annually
- Evidence that there is role clarity and sufficient time and support for named professionals
- Safeguarding is led from Board & Executive level
- The board review of safeguarding occurs annually
- Robust and appropriate performance monitoring systems in place

NB: Reporting does not need to be completed in years when S11 Assessments are completed.

<table>
<thead>
<tr>
<th>Mental Health Minimum Data Set</th>
<th>LPFT to submit the required information to Minimum Data Set.</th>
<th>Quarterly</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP IAPT</td>
<td>The Trust shall continue to commit to the delivery of the CYP IAPT Programme in line with the jointly submitted bid to form part of the East Midlands Collaborative. The Trust shall provide summary updates at contract management meetings.</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**FINANCE & PRODUCTIVITY**

- NI/Pension Costs – provided as one amount as a broad average percentage applied and shown as a separate column
- Point of contact for Finance queries is Deputy Director of Finance
- Capital asset purchases shall be held in the NHS' balance sheet with notification of such capital purposes for our accounting treatment i.e. revenue purchases from capital. Any transfer in service back would consider such assets in NHS' balance sheet
- Recurrent expenditure shall be broken down into Team but not Hubs
- Recurrent expenditure shall be presented as Funded/Contracted and Pay/ Non Pay
- Data shall be presented as YTD and Forecast
- Up to date operational definitions shall be provided of any terms used to apportion cost, e.g. "indirect costs"
- A download of all YTD costs shall be provided on a separate tab for review. These YTD costs will show travel, training, mobile phones etc.
- Corporate overheads shall be attached as one whole cost
- The amount apportioned to surplus is to be identified. LPFT is expected to generate a 7% margin from all contracts as per NHSE guidance to achieve a suitable Financial Score. If a margin in excess of that is forecast then LPFT would initiate a discussion at the contract meeting on proposed reinvestment for the benefit of CAMHS patients.
- Operational Management costs to be identified
- 68% of budget to be apportioned to all CAMHS staff. 68% shall cover all staff groups and vacancies.

Quarterly
| F & P 2. Unit Costs | The Trust is aiming for 72% but below 68% will trigger a discussion at the contract meeting.  
- Direct Premises costs will be shown as one whole cost.  
A download of all direct costs will be submitted as part of the quarterly report. | Quarterly |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Vacant Posts        | Details of vacancies are to be provided through contract management. This shall include number of days that posts are vacant (cumulative) and percentage of full capacity workforce that is vacant on a month by month and annual basis.  
The Trust ensures vacancies are filled quickly to reduce the reliance on agency staff and to minimise the impact on service  
The Trust ensures any negative impact to the service user while a role is vacant is minimised | Quarterly |
| Clinical Staff as a percentage of Budget | A minimum of 68% of the overall budget shall be apportioned to all Lincolnshire CAMHS-staff. 68% shall cover all staff groups and vacancies.  
The Trust is aiming for 72% but below 68% will trigger a discussion at the contract meeting. | Quarterly |
| Absence             | Number of Days and % of contract time lost to sickness kept to a minimum (Cumulative).  
1) The data shall be presented as a percentage and shall be contract specific, not overall sickness of the Trust  
2) The % shall be tracked against target of the overall target of the Trust so that trends can be identified | Quarterly |
| Out of area LAC provision | The Trust is to provide timely and accurate information in relation to provision of services to Looked After Children from other Local Authorities (monthly) to enable recharge to other services for this provision. | Quarterly |
| Risk Report         | The Trust is to manage, maintain and report by exception on contract risks, including contingency plans. | Quarterly |
Community CAMHS Annual

Contract Performance Report

2017/2018

Amy Butler – Community CAMHS Service Manager

April 2018
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Report Overview

The Community Child and Adolescent Mental Health Service (CAMHS) Annual Contract Performance Report will review the years (2017/2018) performance, highlighting the achievements and challenges faced by the service.

The report will also show the objectives and actions over the year which has led to service improvement, and an evaluation of the impact of these actions.

The report will also showcase the achievement with service user engagement, focusing on the participation and involvement project. The report will include the results of the annual stake holder engagement survey and an analysis of these results.

The service ambitions for the next year 2018/2019 will be outlined, these will include what children and young people would like from children mental health services in the future.
Review of the Year’s Performance 2017/2018

The service has submitted quarterly reports detailing the year performance to date.

In April 2017 the service retained its CQC rating as ‘Outstanding’. Only 9% of all specialist community CAMHS services have received an ‘Outstanding’ rating from the CQC (CQC, 2017).

Patient Experience

Patient Experience has been gathered using the CHI throughout the year; this is gathered at reviews and also at the end of treatment. In October 2017 the reporting system changed to Health Care Communications. The new system was not able to report accurately for both Q3 and Q4 and the data submitted was from a manual count. From Q1 (2018/2019) the system will produce full reports relating to patient experience. In March 2018 the CHI was reviewed and some questions removed as they were historic service additions to the standardised questionnaire. The new questionnaire which will be used from Q1 (2018/2019) will be known as the ESQ (Experience of Service Questionnaire). The ESQ will also contain the Friends and Family Test. The service will work over the next year (2018/2019) to improve the amount of ESQ’s that are completed by installing IPAD’s in waiting areas in all four Core CAMHS teams, making the feedback process more accessible for young people and families.

Clinical Notes Audit

In January 2018 Community CAMHS including the CAMHS Crisis Team had a full comprehensive clinical notes audit. Twenty two notes were audited in total, fifteen from the core community teams and seven from the CAMHS Crisis Team. The audit consisted of seven sections:

- Section One – Assessment
- Section Two – Risk Assessment
- Section Three – Care Planning and Review
- Section Four – Core Records Standards
- Section Five – Safeguarding and Mental Capacity
- Section Six – Engagement where there is disguised compliance and poor or none engagement
- Section Seven – Summary

The audit evidenced that both Community CAMHS and CAMHS Crisis Teams use the clinical assessment template as the basis for the assessment of needs and risks which tied the records together well throughout the patients treatment. The Eating Disorder Service use of clinical letters to document the care and treatment plans were detailed and person centred. Not all CAMHS CH&T had
an initial assessment of need evident. Of the twenty-two notes audit, eighteen of them had a risk assessment completed on the clinical risk framework. Two of them had a risk assessment but not on the clinical risk framework, one of them had not engaged in the service and had therefore not been assessed by the service and one had not been assessed at the date of the audit. Therefore 100% of the all cases where an assessment had taken place had a risk assessment completed.

Screening Response Speed and Booking onto First Appointment

The service has a robust and effective process to manage the screening of all new referrals and ensuring a decision is made within 24 hours. Any emergency or urgent referrals are screened as a priority, in line with their target timescales. Each Core team has designated clinicians who screen new referrals daily; when a decision has been made the administrative team will book the first appointment with the family or young person. The current reporting is not a true reflection of how the service performs and therefore will become one of the service ambitions into 2018/2019.

Service Response Time

The service has specific waiting time targets to achieve. All routine referrals are to be seen within six weeks. The service has worked over the last year to meet the six week routine referral target. The service both reports on the number of young people seen for assessment with six weeks and the number of young people offered an assessment within six weeks (Earliest Date Offered). Lincoln CAMHS and Louth CAMHS have achieved their target of 95% of young people seen within six weeks for the year. Both Grantham CAMHS and Boston CAMHS have started to meet the target towards the end of this year. Grantham and Boston have experienced a higher turnover of staff which has significantly impacted on the waiting times. At the end of Q4 there was an improvement in the wait times across the service with 83.6% of new referrals being seen or offered an appointment within 6 weeks in February 2018. In addition at the end of Q4 all Core teams were offering routine assessment appointments within six weeks.

The CAMHS Crisis Team had an end of year average response time of 92.6%. The Eating Disorder Service (EDS) had not received any emergency referrals this year. The EDS urgent response rate at the end of the year was 93.3%. The routine response rate at the end of the year was 98.1%. The Looked after Children (LAC) response rate including the referrals where an earliest date offered at the end of the year was 95.1%. The Youth Offending Service (YOS) response rate including the referral where an earliest date was offered at the end of the year was 88.9%, only one referral was not seen or offered and assessment within response time.
Care Pathways

The service has evidence-based care pathways. Following assessment, all referrals are allocated a pathway. At the end of Q4 87.3% of open cases had been assigned a pathway, 7.3% over the target. Some of the care pathways offer group interventions as the first course of treatment. In Q4 the CBT groups underwent a review; this included engaging young people in this process through the CAMHS involvement network. The redesigned evidence based CBT groups began in March 2018. The service will start to review the care pathways over the next year and will ensure that they remain in line with national guidelines and also are linked to patient-related outcome measures.

Did Not Attend (DNA) Rates

The DNA rate over the year has reduced. The DNA rate at the end of the year was 13.9%. The service reviewed and implemented a DNA protocol, to effectively and safely manage frequent DNA’s and cancellations. In November 2017, a text reminder service for follow up appointments was also implemented.

Re-admission Rate

The re-admission rate at the end of the year was 10.2%, under the 15% target. The service has over achieved this target throughout the year

Open Cases

The average number of cases seen within one month is 70.8%. The open cases include those referrals that are open for consultation only and also group referrals which will impact on the percentage of cases seen in one month. The service provides patient-focused care plans where the time of interventions are agreed collaboratively with the young person and family agreement.

Disengagement Rate

Throughout the year the disengagement rate has been significantly below the 15% target.
External Training

The service offers training on request. The service has planned training on mental health awareness through the Lincolnshire Safeguarding Children’s Board (LSCB). Each Core hub also has a link with the Lincolnshire County Council (LCC) children’s residential homes, where training and consultation is offered on request. From Q3, the service has reviewed the inappropriate referrals received and identified those referrers who send a larger proportion of inappropriate referrals and written to them offering training. A full training plan outlining the external training for next year (2018/2019) is included in the service ambitions.

Youth Offending Service

The contract report from Q3 now includes a report from the Clinical Psychologist who works in YOS. The service jointly with LCC made a bid (Health and Justice) for the extension of the YOS/CAMHS team and was successful. The service has established quarterly interface meetings between CAMHS and YOS. An end of year report will be produced to show the performance of the CAMHS/YOS team in detail over the past year.

Workforce Development

Recruitment and retention of staff has been a challenge, particularly in the south of the county. Some long service staff have retired this year. The recruitment pool for CAMHS clinicians is small which is an ongoing challenge for the service. Grantham Core have been without a permanent full time Consultant Psychiatrist for a year, the cover has come from Locum Consultant Psychiatrists and the post continues to be advertised. In addition Psychology vacancies have been a challenge to recruit to and when newly qualified Psychologists are recruited there is often a delay in their start while they complete their course. However, during the course of this year we have successfully recruited 3 newly qualified Clinical Psychologists, 2 of them coming from our Lincoln based clinical psychology training course. We have also recruited a Highly Specialist Systemic Psychotherapist to replace the Systemic Psychotherapist who was leaving and this was done in a timely fashion with no gap in this provision.

The workforce has been developed by being offered a variety of training and development over the year.
• 21 CAMHS clinicians have attended Eye Movement Desensitization Reprocessing (EMDR) Levels 1 and 2 training which was arranged and provided locally.
• All clinicians that deliver CBT groups attended local training for the new CBT group content.
• A 3 day in service training “Introduction to CBT with Children and Young People” was provided to a total of 41 CAMHS and Healthy Minds staff.
• 4 clinicians attended DDP level 2 training.
• The 3 newly qualified Clinical Psychologists who joined the service during this year have been supported in attending a STAR supervisor training.

The service will review its Training Need Analysis for 2018/2019 and identify training for that year.
Evidence of Objectives and Actions

which have led to Service Improvement

Professional Advice Line (PAL)

The PAL continues to be well used and feedback about its use is positive. Over the reporting year there were a total of 1491 calls, an average of 124 calls per month. The average length of the call is 10 minutes and 30 seconds. The percentage of calls from each agency is shown below:

<table>
<thead>
<tr>
<th>Caller</th>
<th>Amount of call over the Year (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Help</td>
<td>4%</td>
</tr>
<tr>
<td>Grief &amp; Loss</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>0.7%</td>
</tr>
<tr>
<td>GP / Nurse Practitioner</td>
<td>13.2%</td>
</tr>
<tr>
<td>LCC Children’s Services</td>
<td>10.7%</td>
</tr>
<tr>
<td>School / School Nurse / College</td>
<td>31.9%</td>
</tr>
<tr>
<td>YOS</td>
<td>0.7%</td>
</tr>
<tr>
<td>Residential Home</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

The PAL Guidance and Log was reviewed and updated in Q4, this was to improve reporting and also ease of collecting data for the clinician. The review Guidance and Log can be found in Appendix 4 of this report.

CAMHS Crisis Team

The CAMHS Crisis Team has enhanced the CAMHS service. The CAMHS Crisis Team completed an end of year report for 2016/2017 which demonstrates the positive impact it has had to the service (Appendix 2 of this report). A similar report will be produced for 2017/2018.
CAMHS Eating Disorder Service (EDS)

The CAMHS EDS have also enhanced the CAMHS service. The team have been engaging in national training over this year. The team are now trained to offer Family Based Therapy (FBT), and Cognitive Behaviour Therapy-E (CBT-E), in line with NICE Guidelines. The team received 101 new referrals this year, 94 of them were accepted and offered an assessment. The team has also established a multi-disciplinary team (MDT) approach to assessment, a young person and family are seen for assessment and a full holistic assessment is completed with an MDT. The EDS team will also be completing a detailed end of year review.

Children and Young Person Improved Access to Psychological Therapies (CYPIAPT)

Six CAMHS clinicians completed the CBT CYPIAPT training in November 2017. Four of them returned to their posts within CAMHS, one moved to another CAMHS team within the service and another one has been seconded to the CYPIAPT enhanced evidence-based practice (EEBP) supervisor post. All the CYPIAPT CBT trained clinicians contributed to the review and implementation of the new CBT group packages and have also taken on CBT cases within their team to help them work towards British Association for Behavioural and Cognitive Psychotherapies (BABCP) accreditation; this is alongside their generic CAMHS caseload. Three CAMHS clinicians have started their CYPIPAT CBT training this year and are due to complete at the end of the year.

Six CAMHS Clinicians completed the Systemic Practice training in November 2017. Five of them returned to their post within CAMHS and one moved to the new Healthy Minds Service. The CAMHS Highly Specialist Systemic Therapist, with the CYPIAPT systemic clinicians, has established family practice clinics across Grantham, Boston and Lincoln this year. Louth will be establishing family practice clinics into next year, when a fixed term Family Therapist will become part of the Lincoln and Louth team (this post has been funded from maternity leave over the two hubs). Compared to neighbouring services, Lincolnshire CAMHS has a reduced systemic resource, the addition of the CYPIAPT systemic trainees and the addition of a fixed term Family Therapist post will enhance the systemic offer of the service considerably and should have a positive outcome. Two CAMHS clinicians have started their CYPIAPT systemic practice training this year and are due to complete at the end of the year.

In addition, two Team Coordinators completed their CYPIAPT Leadership Course this year and two CAMHS clinicians have completed the CYPIAPT EEBP course.
Transition to Adult Mental Health

Transition between CAMHS and AMHS is a CQUIN which will continue into next year.

LPFT implemented at new transition protocol this year. The protocol provides guidance on the transition process to improve the experience of the young person and also improve the overall outcomes (young person focused) of the transition.
Impact of Service Outcomes

Complaints and Compliments

Each quarter the service has submitted details of complaints and compliments that have been received. Throughout the year there have been a total of 16 complaints received. On average there is 922 open cases each month, the number of complaints received is only 1.73% of total young people open at any one time. None of these complaints have been upheld, but 4 have been partially upheld. However there have been a total of 341 compliments received and reported over the year. The patient feedback (CHI) and Friends and Family Test has been submitted quarterly. In both Quarter 3 and 4 there were some reporting difficulties due to the change of the reporting system. The new reporting system will be accurately reporting the results of the ESQ formally known as the CHI for the next reporting year (2018/2019). The use of the ‘You said, We did’ was changed to a new template in Q3, this can be found in Appendix 3.

Outcome Measures

The use of outcome measures is core to the service delivery. Lincolnshire CAMHS uses the ‘My Outcomes’ system to measure the session by session rating scales (SRS) and the outcome rating scales (ORS). All other outcome measures are recorded using the clinical system (Silverlink). A range of outcome measures have been identified by LPFT that are being used, these include: RCADS: The Revised Children’s Anxiety and Depression Scale, EDEQ: Eating disorders examination questionnaire, SDQs: Strengths and Difficulties Questionnaire, ORS: Outcome Rating Scale, SRS: Session Rating Scale, SLDOM: Sheffield Learning Disabilities Measure, SCORE 15: Score Index of Family Functioning and Change, CRIES 8: Children’s Revised Impact of Events Scale.

On the My Outcomes system the outcomes can be inputted directly or indirectly by the young person or during their appointment and the progress tracked and shared with the young person and their family.

All other PROMS (Patient related Outcome measures) are used at point of assessment, at review (where applicable) and at discharge. The use of PROMS is varied and this is dependent on clinical need/presentation.
The service renewed its subscription with the My Outcomes system in February 2018. The renewal included additional licences so all clinical staff had access to the systems. One of the services ambitions for 2018/2019 will be to encourage the use of the My Outcomes systems which will both support clinical practice but also evidence the positive impact of the interventions delivered. Throughout Q1 and Q2, clinicians will be allocated a licence and each team will deliver localised training in the use of outcomes.
Service User Engagement

Peer Support and Involvement Project

The peer support and involvement project was a significant achievement in 2017/2018. The yearlong project started fully in July 2017 when a project lead was appointed. The project lead has worked alongside the management team to change the culture within CAMHS towards positive involvement of young people in the service. The service advertised 4 full time equivalent peer support workers (PSW) in September 2017 and received 151 applicants, 6 PSWs were successfully recruited and began work in December 2017. The PSW’s along with their clinical supervisors attended accredited PSW training in February 2018.

In February 2018 the service hosted a participation and involvement event. This event celebrated the work of the involvement network to date and what projects young people wanted to be part of over the forthcoming year. This was a key event to engage young people in what they what they saw as the vision for children’s mental health in the future. The feedback was captured using creative design:

![Mind Map Image]
The project work has been a success and the service is a regional leader with its peer support and involvement network. The continuation of the Peer Support Worker and Involvement project into 2018/2019 are one of the service ambitions.
Effective Engagement with other Services

Annual Stakeholder Survey

The service conducted an annual stakeholder survey in March 2018. The survey was shared in either electronic format (email) or by letter. The following groups were asked to complete the survey:

- Early Help
- Team Around the Child (TAC) Team
- Family Assessment Support Teams (FAST)
- Public Health
- Looked After Children (LAC) Teams
- Youth Offending Service (YOS)
- Stakeholder Engagement Group
- Future in Mind Steering Group
- Lincolnshire Schools – via school news
- Mental Health Partnership Group
- Children and Young People’s Voluntary Sector Forum
- Healthy Minds
- Lincolnshire General Practitioners (GPs)

The response rate was 129 which was an excellent response rate in comparison to the previous year (2016/2017) where there was a response rate of 74. The survey consisted of nine quantitative questions and then a qualitative option at the end to leave a comment. The full results and comments of the survey can be found in the link in Appendix 1. The style and nature of the questions asked was different in comparison to the previous year (2016/2017), but a comparison will be made where possible.

Question One asked about the how easy it was to find information and make a referral to CAMHS

You found it easy to find information about how to make a referral to the child and adolescent mental health service?
128 people answered this question and 1 person skipped this question. 48.4% of people either strongly agreed or agreed and only 25.8% strongly disagreed or disagreed. There is some improvement in this in comparison to the previous year where when a similar was asked and 51.2% responded negatively. The service offers a referral form to support referrals into the service. The service also has information on referring into the service on the website ‘We Are CAMHS’. The results show there are some actions needed to support referrers to find information about how to make a referrals and the referral process itself, this will be addressed in the ‘future service ambitions’ section of the report.

Question Two asked about the professional advice line (PAL) and how helpful the advice given was.

![If you used the professional advice line, the advice offered was helpful?](image)

127 people answered this question and 2 people skipped the question. 40 people chose to answer as ‘not applicable’, which would suggest they have not used the PAL. Excluding those that answered not applicable 66.75% of people agreed or strongly agreed that the PAL gave helpful advice.

Question Three asked about referrals that are not accepted and if the signposting advice given was helpful.
128 people answered the question and 1 person skipped the question. 35 people answered ‘not applicable’, which could suggest they have not made a referral to CAMHS or had a referral rejected by the service. The results showed 32.3% either strongly agreed or agreed and 36.6% either disagreed or strongly disagreed, this was excluding those choosing ‘not applicable’. The advice offered by the service when a referral is declined will be addressed in the ‘future service ambition’ sections of the report.

Question Four asked where a referral was accepted by the service, was the response time satisfactory.

118 people answered this question 11 skipped the question. 42.37% neither agreed nor disagreed. However 49.83% responded that they strongly agreed or agreed. When compared to 17.79% who responded that they strongly disagreed or disagreed, the results show a majority of people are satisfied with the service response rate. The services performance relating to response time has been a challenge for the service of the year, particularly in the south of the core teams (Boston and Grantham). The service response time has improved and the service is now offering assessments within 6 weeks for routine referrals across the core teams.
The Fifth question asked about how informed the referrer felt at point of assessment, intervention and discharge.

120 people answered this question and 9 skipped the question. 36.67% neither agreed nor disagreed. 26.67% responded that they strongly agreed or disagreed. However 36.67% either strongly disagreed or disagreed. The results show that a majority of people do not feel they are kept informed; therefore this will be addressed within the service ambitions and action plan for the following year.

The sixth question that was asked was about the CAMHS Crisis Team and where they had been involved was the advice and support offered helpful. A similar question was asked in 2016/2017, the question asked where a young person was in crisis, was the service helpful when seeking help.

125 people answered the question and 4 skipped the question. 56% of those who answered the question replied not applicable, this could suggest they have not needed to use the CAMHS crisis service. Excluding those people who answered not applicable, 45.45% answered positively, that they either strongly agreed or agreed that the advice and support offered by CAMHS crisis team was helpful. Only 23.64% answered negatively, that the support and advice was not helpful (either strongly disagree or disagree). In comparison to the previous year this is an improvement where
35.19% responded that the service was ‘not at all’ useful when seeking advice and help. The results of the survey support the CAMHS crisis end of year report (Appendix 2) which shows the positive impact of the service.

The seventh question asked about the outcome of assessment and intervention. A similar question was asked in the 2016/2017 annual stake holder survey.

You are satisfied with the outcome of the assessment and intervention?

![Bar Chart](chart1)

120 people answered the question and 9 skipped the question. The results were mixed, with 32.5% answering that they either strongly agreed or agreed that they were satisfied with the outcome of the assessment and intervention and 30.83% answered that they either strongly disagreed or disagreed that they were satisfied with the outcome of the assessment and intervention. However, there is some improvement in this year's result in comparison to the previous year where 40.54% answered negatively that the service had achieved the outcome they hoped for.

The eighth question asked about whether the young person or family were satisfied with the outcome of the assessment and intervention.

You felt the young person or family was satisfied with the outcome of the assessment and intervention?

![Bar Chart](chart2)
123 people answered this question and 6 people skipped the question. The majority chose to answer that they neither agreed nor disagreed (38.21%). Only 23.57% answered that they either strongly agreed or agreed that the young person or family were satisfied with the outcome of the assessment and intervention. However 38.21% answered that they either strongly disagreed or disagreed that the young person or family were satisfied with the outcome of the assessment and intervention. This contradicts some of the information which is reported by the service, the amount of positive compliments is evidence of the positive impact and satisfaction with the service. In addition the amount of complaints received in comparison to the compliments is considerable lower. In quarter 3 and 4 the service began to use the new template for the ‘You said, We did’ (Appendix 3), which is now shown in all waiting rooms.

The ninth and final question asked about consultation and training that the service offered and if this was helpful and informative.

Only 20% responded that they either strongly disagreed or disagreed, in comparison 50% responded that they either strongly agreed or agreed that the consultation and training was helpful and informative. The results identify that, although the overall response was positive, there may be some stakeholders who have not accessed training and consultation that may have benefitted from this. Therefore the service will make training part of one of the service aspirations for the following year (2018/2019).
The stakeholder survey also gave the option for comments and feedback. 55 people chose to leave a comment. A majority of the comments that were left were negative; however there were some positive comments:

‘I have always found your help and support so useful. Thank you’

‘I have not had to use this service only in regards to leading a TAC meeting and the support I got was fantastic and when I closed it again the support was great’

There were themes in the comments given:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>13</td>
</tr>
<tr>
<td>Communication with professionals</td>
<td>11</td>
</tr>
<tr>
<td>Outcomes</td>
<td>8</td>
</tr>
<tr>
<td>Support in School</td>
<td>4</td>
</tr>
<tr>
<td>Training</td>
<td>3</td>
</tr>
<tr>
<td>Access to the service</td>
<td>2</td>
</tr>
<tr>
<td>PAL</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
</tbody>
</table>

Most of the comments were in relation to the service criteria and the general feeling that it is too high. There were no comments about the understanding of the service criteria, but there were comments about the challenges of accessing mental health support for young people when the referral criteria are not met. The introduction of the new Healthy Minds Service in October 2017 may be able to support those who have concerns about a young person’s emotional wellbeing. The service takes referrals from Healthy Minds where a young person meets the CAMHS criteria. The Q4 report shows that only 7% of all referrals sent to CAMHS from Healthy Minds did not meet the criteria for the service. The service also has the professional advice line (PAL) which gives advice and consultation for professionals looking to make a referral, which should provide support for those young people who do not meet the CAMHS criteria.

The communication between CAMHS and other professionals was also a key theme. This corroborates with the results found in question five of the survey. In particular there were 3 comments relating to CAMHS not always attending TAC meetings.
One of the other top things was about the satisfaction with the outcomes of the service. A lot of the comments indicated that respondents felt that CAMHS input was not helpful; again the service received large amounts of compliments each quarter which contradicts these results. However the comments also indicate some misunderstanding about what the service offers and this can be addressed with the training plan for stakeholders and also the action plan to review effective communications between professionals.

Some of the comments related the Healthy Minds Service and also to access to the right service. This evidences the need for a greater understanding and effective communication between the two services at the point of referral. This will be part of the service ambitions into 2018/2019, so that the service is easy to access and that the service works collaboratively with other services e.g. Healthy Minds.
## Future Service Ambitions (including those of Young People)

Throughout the Annual Report there has been service ambitions identified which have been summarised in the table below. These will from part of the improvements into the next year and will be evaluated next year in the annual report for 2018/2019.

<table>
<thead>
<tr>
<th>Ambition for 2018/2019</th>
<th>What is needed to achieve the ambition?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong> – For the new ESQ to be completed for all discharges</td>
<td>The service will be putting IPADS in the waiting rooms in all hubs to capture patient experience</td>
</tr>
<tr>
<td><strong>Screening response rate and booking onto first appointment</strong> – to report accurately and demonstrate the achievement of this performance indicator</td>
<td>Review of reporting for the performance indicator with LPFT informatics</td>
</tr>
<tr>
<td><strong>Care Pathways</strong> - To review care pathways to ensure in line with national guidelines</td>
<td>The service to review the care pathways over the next year – this can be completed within the CAMHS steering groups</td>
</tr>
<tr>
<td><strong>Peer support and involvement project</strong> - To continue into 2018/2019 with recurrent funding</td>
<td>Recurrent funding in place to support the projects achievements are sustained</td>
</tr>
<tr>
<td><strong>Outcome measures</strong> - All clinicians to have access to My Outcomes and access training locally on the use of outcome measures. The positive impact of the service to be reported using the My Outcomes system</td>
<td>Subscription renewed in February 2018. In Q1 all clinicians to be allocated a licence In Q1 and 2 staff to have access to local training around the use of outcomes measures</td>
</tr>
<tr>
<td><strong>YOS – End of Year report</strong></td>
<td>End of year report for 2017/2018</td>
</tr>
<tr>
<td><strong>CAMHS Website</strong> - to be completed and include referral information to support referrers when making a referrals</td>
<td>Current plan in place and due to complete in July 2018</td>
</tr>
<tr>
<td><strong>Self-Referral</strong> - to have self-referral as an option to improve access to the service for young people and their families</td>
<td>A process agreed where self-referrals can be made and then managed effectively by the service. As well as a young person engagement group to identify what they expect and hope from self-referral option</td>
</tr>
<tr>
<td><strong>External Training</strong> – a training plan which can be delivered by the service which will support referrers with the referral process but also</td>
<td>CAMHS external training plan:</td>
</tr>
<tr>
<td>Support to referrers when they are supporting a young person with mental health difficulties</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>CAMHS Crisis Team - End of year review</strong></td>
<td>End of year report for 2017/2018</td>
</tr>
<tr>
<td><strong>CAMHS EDS - End of Year review</strong></td>
<td>End of year report for 2018/2019</td>
</tr>
<tr>
<td><strong>Family Therapy - Continued development of family practice clinics across the service</strong></td>
<td>Support of fixed term Family Therapist to establish clinics in Louth hub and a full review of Lincolnshire CAMHS systemic resources</td>
</tr>
<tr>
<td><strong>Communication with referrers and other agencies - to improve our communication</strong></td>
<td>Review of current processes</td>
</tr>
</tbody>
</table>
References

CQC (2017) Review of children and young people’s mental health services: Phase one. October 2017

Appendix

Appendix 1

Annual stakeholder survey for CAMHS 17

Appendix 2

End of year report CAMHS Crisis and h

Appendix 3

You said we did background pub

Appendix 4

V4 Professional Advice Line Guidance
### Appendix 3. Review of LTP Ambitions

Following is a review of the progress on the ambitions that were set out for 2015/17 to support the implementation of the Lincolnshire Transformation Plan and the initial transformation of the CAMHS service specifically. The majority of these actions have now been successfully completed and are now monitored through robust quarterly contract management.

During the twelve month period from October 2016 to October 2017, the need to address Child and Adolescent Mental Health and Emotional Wellbeing through a whole system change was acknowledged and the approach was taken that will bring about sustainable improvement in both service provision and outcomes for young people. Going forward any remaining actions will transfer to Future in Mind Lincolnshire: Local Transformation Plan 2018-2020, (see Section 5: Our Plans for the Future 2018-20).

<p>| Ambition One: Improving public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled |
|---|---|---|---|
| Action | Timescale | Led By | Outcomes |
| 1 | Development of accessible information for service users and professionals to understand the specific needs of children and young people in regards to mental health and emotional wellbeing, including development of a dedicated CAMHS website, App and leaflets, driven by consultation with children, young people, parents and carers. | Additional work needed transferred to LTP 2018-20 | • Raise awareness of Mental Health specifically in regards to the needs of children and young people • Ensure service users feel comfortable talking about their needs with peers and in the School environment • Reduce the stigma associated with mental health • Ensure young people are able to recognise that they have a voice and that services are designed to respond to their specific needs • Ensure that service users have the information they need to confidently access support |
| 2 | Training days allocated within the CAMHS revised model to raise awareness with front line practitioners to increase their understanding of mental health issues specifically for children | Additional work needed transferred to LTP 2018-20 | Agencies identify key staff, LFT to deliver | • Increased awareness will lead to earlier intervention with service users, whilst their needs are at lower levels • C/YP feel more confident |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>and young people</td>
<td></td>
<td></td>
<td>to raise and discuss mental health with their peers but also parents, carers and professionals</td>
</tr>
</tbody>
</table>
| 3 Training, sharing of promotional materials and best practice with professionals across multi-agencies | Additional work needed transferred to LTP 2018-20 | All | • Raise awareness of issues and encourage cross-sector learning and peer to peer support so learning can continue outside of direct training days  
• Practitioners feel empowered and engaged and more likely to spot early signs of mental health needs and respond  
• Promote the Local Transformation Plan |
| Ambition Two: Timely access to clinically effective mental health support when Children and Young People need it | | | |
| 4 Maintain and improve reduced routine waiting times for CAMHS model resulting in a significantly shorter wait period for Lincolnshire YP than the national indicator recommends | Completed Responsibility moved to quarterly CAMHS contract management | LPFT, LCC | • Young People are seen as soon as possible to stop their issues from escalating  
• Ensure our waiting times are comprehensive and in line with national trajectory, including waiting times for Eating Disorders  
• Service users and their families, Practitioners and other stakeholders are clear about the service they can expect |
| 5 Delivery of emergency, out of hours and crisis support (Tier 3+) with continuing opportunities to further develop this aspect of the CAMHS according to emerging needs | Completed Responsibility moved to quarterly CAMHS contract management | LPFT, LCC | • The most vulnerable young people are supported as they receive emergency intervention when required  
• Young people receive community based support as close to home as possible, leading to a reduction in inpatients and out of county provision, a reduction in travel time for the service user and better outcomes as the young person can stay closer to |
<p>| | | | |</p>
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</thead>
<tbody>
<tr>
<td>6</td>
<td>Continue to monitor and track waits for the service and further refine robust contract management to ensure that transformation is embedded</td>
<td>Completed Responsibility moved to quarterly CAMHS contract management</td>
<td>LPFT, LCC</td>
</tr>
</tbody>
</table>
|   |   |   | • Any issues can be identified as soon as is possible, a plan for resolution identified and tracked  
• Any breaches in wait times can be understood and a plan put in place to monitor improvement  
• Service users, their families and stakeholders can be confident in the local CAMHS offer  
• Service is cost effective |
| 7 | Delivery of Professional Advice Line | Completed Responsibility moved to quarterly CAMHS contract management | LCC LPFT |
|   |   |   | • Professionals working with children and young people have access to advice and support prior to referral  
• Children and young people are supported by those professionals that already know them in surroundings that are familiar to meet their needs before they escalate  
• Increased knowledge and confidence for professionals in supporting children and young people who are experiencing challenges affecting their emotional wellbeing |
| 8 | Refinement of Single Point of Access | Completed Responsibility moved to quarterly CAMHS contract management | LCC LPFT |
|   |   |   | • Simplifying access to the service  
• Empowering self-referral  
• If professionals understand how to access the service they will feel more confident to use it and will access the service when needed  
• Access to the right service, first time  
• Greater understanding of peers, family and existing support networks  
• Reduction of more costly, out of county provision |
<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Description</th>
<th>Responsibility</th>
<th>Company</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Refinement of the dedicated community eating disorders service</td>
<td>Completed Responsibility moved to quarterly CAMHS contract management</td>
<td>LPFT, ULHT, LCC</td>
<td>• Access to a dedicated community service delivering evidence based care. • NICE concordant treatment to start within a maximum of 4 weeks from first contact</td>
</tr>
<tr>
<td>10</td>
<td>Utilise a wider breadth of service user groups that involve engagement with children and young people including Lost Luggage, Young Inspectors and further service user groups identified through consultation</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>LCC, LPFT</td>
<td>• Young People are experts by experience and there should be no service about them, without them. By listening to the views of C/YP we will ensure the Local Transformation Plan reflects the needs of our local population • We will increase the confidence of C/YP to challenge agencies when they aren't doing a good job and we can use this feedback as part of continuous service improvement</td>
</tr>
<tr>
<td>11</td>
<td>Empower Parents/Carers and families to understand the Local Transformation Plan by creating web based platform that explains the local universal services available</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>LCC, LPFT</td>
<td>• Parents and Carers will know where they can go to access support • Utilise digital tools effectively, offering people the opportunity to engage with services online rather than face to face as a first point of contact • Online content is available anywhere, anytime which could support working families</td>
</tr>
<tr>
<td>12</td>
<td>Work in partnership with C/YP, their Parents and Carers in reviewing care pathways (such</td>
<td>Additional work needed transferred to</td>
<td>LCC, LPFT</td>
<td>• Through participation, these views will be embedded into the</td>
</tr>
<tr>
<td></td>
<td>as Behaviour, Self-Harm and Transition pathways) and ensure these meet their needs</td>
<td>LTP 2018-20</td>
<td>service and as a result pathways can be improved</td>
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<td></td>
</tr>
<tr>
<td>13</td>
<td>Ensure services are joined up locally</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• This will lead to reduction in costly duplicate working and share best practice across agencies</td>
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<tr>
<td></td>
<td>• Service users will feel supported by a range of agencies</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Service users can expect consistency from whichever agency they feel most comfortable to approach</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Young people receive the support they need and there are no gaps in service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Having lead commissioning arrangements in every CCG area for C/YPs mental health and wellbeing</td>
<td>Completed</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• This will lead to joined up and effective commissioning across the County</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Further develop data collection and analysis of the transformed CAMHS model to include service user outcome measures monitoring such as CHI-ESQ MyOutcomes</td>
<td>Completed Responsibility moved to quarterly CAMHS contract management</td>
<td>LPFT</td>
</tr>
<tr>
<td></td>
<td>• C/YP will be active participants in their treatment</td>
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<td></td>
<td>• Clinical improvements will be measured</td>
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<td></td>
<td>• Rigorous measurement of outcomes becomes routine</td>
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<tr>
<td>16</td>
<td>The model will ensure an appropriately trained workforce reflective of C/YP IAPT is in place</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>LPFT</td>
</tr>
<tr>
<td></td>
<td>• Improved skill set of the workforce</td>
<td></td>
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<td></td>
<td>• Professionals working with C/YP are able to respond to a broader range of needs – a workforce will be developed with the right mix of skills and competencies to complement existing experience</td>
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<td>Led By</td>
<td>Outcomes</td>
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</tbody>
</table>
| 17     | Completed Responsibility moved to quarterly CAMHS contract management | LCC, LPFT | • Simplifying access to the service  
• Promoting universal services through web based platform which will help families and service users to understand what is out there to help them |
| 18     | Additional work needed transferred to LTP 2018-20 | LPFT, LCC | • Myth busting and reducing anxieties about the new service model  
• Promoting how to access the service will help professionals feel that it is more accessible |
| 19     | Additional work needed transferred to LTP 2018-20 | All | • Having named contacts will result in various outcomes; service users will know who to speak with, the point of contact will develop an overview of the service and any issues and therefore will be able to feedback key information, information can be quickly disseminated across agencies as the appropriate point of contact has already been identified  
• Having a commissioner contact ensures the professionals know who to go to in order to expedite matters |
| 20     | Completed Responsibility moved to quarterly CAMHS contract management | LCC, LPFT | • Practitioners who are unsure whether or not to make a referral can seek advice  
• Practitioners feel more confident about the service because they know who to contact  
• Practitioners can get some initial advice and |
<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
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</table>
| Refinement of Tier 3 + service that providing intensive home treatment | Completed Responsibility moved to quarterly CAMHS contract management | LPFT | • C/YP will receive intensive community based care that meet their wider educational and social care needs by ensuring all agencies work proactively together  
• Providing a crisis response which compliments response provided by the Community Team in hours  
• Reduce T4 Inpatient admissions  
• Provides a crisis response  
• Children can remain at home, close to family, friends and peers |
<p>| The Local Transformation Plan will work in conjunction with the Mental Health Crisis Care Concordat | Additional work needed transferred to LTP 2018-20 | All | • Children are treated at the right place, in the right timeframe as close to home as possible |
| Support the ongoing work stream on Section 136 Suites | Additional work needed transferred to LTP 2018-20 | LCC, Police | • No young person in Lincolnshire should be detained in a cell as a place of safety |</p>
<table>
<thead>
<tr>
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<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
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</thead>
</table>
| 24| Further development and refinement of pathways including Self Harm, Behaviour and Transition | Additional work needed transferred to LTP 2018-20 | LCC, Service Users | • Stakeholders and professionals are clear on what treatments are available and seamless experience for those accessing the service  
• Other services and agencies are involved in developing ways of working that support C/YP transitions between services according to their changing needs, e.g. BOSS, Early Help, YOS |
|   | **Ambition Seven:** Improving Access for Parents to evidence based programmes of intervention and support to strengthen attachment between parent and child |                         |                   |                                                                                                                                 |
| 25| Work in partnership with the Perinatal Support Team                    | Ongoing                  | CCG               | • Commissioned Perinatal Community Mental Health Team (PCMHT) provide a specialised service for the prevention and treatment of Serious Mental Illness in the antenatal and post-natal period supporting Mother and Baby |
| 26| Training and support for Parents                                       | Additional work needed transferred to LTP 2018-20 | LPFT, LCC Social Care Team | • LPFT to deliver attachment training programmes to enhance bond between parent and child, avoid early trauma and help build resilience and improve behaviour, this can be with parent groups or universal practitioners as a train to deliver model |
| 27| Portage                                                                | Ongoing                  | LCC               | • Portage services provide help to very young children, 0-5 delivering a home visiting educational service for pre-school children with special educational needs disabilities. |
### Ambition Eight:
**A better offer for the most Vulnerable children and Young People**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| 28     | Identify specific provision to support vulnerable groups including LAC and Care Leavers, those with a learning disability, those in contact with the youth justice system and those who have been sexually abused/exploited, | Additional work needed transferred to LTP 2018-20 | LPFT | - Children who have been sexually abused/exploited will receive comprehensive and specialist support  
- If we are able to get the support right for our most vulnerable young people, it is more likely we will get it right for all  
- Reduced wait times for our vulnerable groups so they are seen quicker |

### Ambition Nine:
**Improved Transparency and Accountability across the whole system**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Led By</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| 29     | Further development to ensure robust and transparent metrics in place and implementation of the Mental Health Services Data Set (MHSDS) | Additional work needed transferred to LTP 2018-20 | LCC, LPFT | - There are robust metrics covering access, waiting times, including referral to treatment and outcomes in the CAMHS contract which allow for benchmarking of services at local and national level  
- Service Users and their families can understand the service and level of care they can expect to receive  
- Robust targets enable monitoring and tracking of service provision  
- Breeches in targets can be identified and improved upon  
- Further development work to identify appropriate measures and monitoring for the PALS and SPR |
<p>| 30     | Financial transparency | Completed | LCC, CCG | - A clear financial breakdown of the monies contributed from the Local Authority and Clinical Commissioning Groups enables effective |</p>
<table>
<thead>
<tr>
<th>31</th>
<th>Set up local implementation groups to monitor progress against the Local Transformation Plan including risk</th>
<th>Completed</th>
<th>LCC, LPFT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Implementation meetings between the Provider, LCC and CCG's will ensure progress against delivery of plan is in line with timescales</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Any issues can be addressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Risks can be monitored and mitigated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32</th>
<th>Arrangements in place to hold multi agency boards for delivery</th>
<th>Completed</th>
<th>LCC, CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The appropriate monitoring mechanisms are identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The progress of the LTP is captured on agenda of multi-agency boards including the Women &amp; Children's Board and Health &amp; Wellbeing Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The progress of the transformation plan and services supporting the mental health and emotional wellbeing of children and young people is monitored and developed through the multi-agency Lincolnshire Future in Mind Steering Group</td>
<td></td>
<td></td>
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<tr>
<td>Action</td>
<td>Timescale</td>
<td>Led By</td>
<td>Outcomes</td>
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</tr>
<tr>
<td>Deliver training for Practitioners</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>LPFT, LCC, Agencies</td>
<td>• Practitioners need to raise through their Agency Lead (as identified in the Local Transformation Plan or Crisis Concordat) the training that they feel they will require. This should be amalgamated and time allocated for the most popular issues raised</td>
</tr>
<tr>
<td>Implement CYP IAPT Training – *First cohort identified and registered *Second cohort identified</td>
<td>Additional work needed transferred to LTP 2018-20</td>
<td>LPFT, LCC</td>
<td>• Practitioners can access the Professional Advice Line for quick queries • Practitioners understand the Single Point of Access process and feel confident to use it</td>
</tr>
<tr>
<td>Identify additional staff to undertake enhanced CYP IAPT training.</td>
<td>Completed</td>
<td>LPFT</td>
<td>• Recruit to train • Psychological Wellbeing Practitioners</td>
</tr>
</tbody>
</table>
Appendix 4. CAMHS Pathway Examples

Overview of LPFT’s CAMHS Pathways

<table>
<thead>
<tr>
<th>Treatment Pathways</th>
<th>Specific Support Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td>10. Learning Disabilities</td>
</tr>
<tr>
<td>2a. General Anxiety</td>
<td>10a. LD – Depression</td>
</tr>
<tr>
<td>2b. Anxiety – OCD &amp; BDD</td>
<td>10b. LD – Anxiety</td>
</tr>
<tr>
<td>3. Social Anxiety</td>
<td>10c. LD – Challenging</td>
</tr>
<tr>
<td>4. PTSD</td>
<td>Behaviour/Self-Harm</td>
</tr>
<tr>
<td>5. Self-harm</td>
<td></td>
</tr>
<tr>
<td>6. Eating Disorders</td>
<td></td>
</tr>
<tr>
<td>7. Attachment Disorder</td>
<td></td>
</tr>
<tr>
<td>8. Harmful sexualised behaviour</td>
<td></td>
</tr>
<tr>
<td>9. Specific support</td>
<td></td>
</tr>
</tbody>
</table>

Universal Services
1. Warm and welcoming
2. Carers are involved
3. Supportive and encouraging
4. Respectful, non-judgmental
5. Confidential and safe
6. Supportive to all

Referral to CAMHS team
- e.g. GP, Social Worker, Paediatrician, School Nurse, C&I

Assessment
- Clinical Interview, Clinical Assessment Tools

Mild - Moderate
- Guided Self-help and CBT group work or 1:1 if clinically indicated
- 6 - 12 weeks

Moderate - Severe
- Individual CBT, 1:1, or IPT
- 20 - 26 weeks

C&HTS
- Care planning
- Transition to Adult services
- Transition to CAMHS

Transition to CAMHS
- No further follow up
- Referral to Adult services
- Referral to CAMHS

where concerns about potential risk to self or others (behavioural disability) or concerns about risk.

- Consider CPA
- Crisis intervention
- Intensive home treatment
Appendix 5. Lincolnshire Multi-Agency 136 Pathway

IMPORTANT CHANGES TO THE MENTAL HEALTH ACT 1983

Sections 80 - 83 of the Policing and Crime Act 2017 make important changes to the Mental Health Act 1983. These provisions come into force on December 11th 2017. These changes amend s.135 Mental Health Act 1983 (power of the court to grant a warrant to search for and remove a mentally disordered person) and s.136 (power of a constable to remove a mentally disordered person to a place of safety).

Police determined that admission to the 136 suite be considered – *refer to Lincolnshire Police Mental Health Process

Under 18 pathway – refer to children’s 136 pathway

Options for consultation, in order:-
1. CAMHS Crisis and home treatment (CRHT) team (24/7)
2. Ascertain if the young person is known to Children’s Services
3. Section 136 Suite Duty Nurse (24/7)

Over 18 pathway – refer to adult 136 pathway

Options
1. Section 136 Suite Duty Nurse (24/7)
2. Police consult with Mental Health Practitioner based in Police HQ Control Room
3. Triage car

Can 136 suite admission be diverted and alternative options considered?

Yes

Under 18 - Options considered for diversion:-
1. Phone triage from C&HTS practitioner
2. A&E for face to face assessment after phone consultation
3. Planned appointment with CAMHS if known
4. If ‘at risk’ of significant harm, referral to Children’s Social care
5. If early help support required, undertake an early help assessment and arrange a team around the child meeting
6. Appointment with GP

Over 18 - Options considered for diversion:
1. Home treatment
2. Crisis House on informal basis
3. Planned appointment offered with CRHT *1
4. Appointment with GP
5. Other

No

Screened and deemed appropriate for admission for Section 136 detention

Refer to EMAS conveyance procedure

Refer to Lincolnshire Partnership Foundation Trust (LPFT) pathways

Refer to United Lincolnshire Hospitals Trust (ULHT) pathways

Places of safety options considered, in order of priority as directed by S136 suite duty nurse:-
1. 136 Suite Lincoln
2. A&E Lincoln / Boston - police to stay with patient
Call received in FCR or Officers alerted to someone having a mental health problem and in need of immediate care or control anywhere other than their private dwelling

Incident created – Officers deployed (if necessary)

Person displaying mental health behaviours – Officers attending considering detention under Section 136 MHA. Attending officer MUST consult a mental health professional and duty Sergeant BEFORE detention

Attending Officer obtains details (Name, Date of Birth and Address) and passes to FCR for incident log

Over 18
Call S136 Suite 01522 573699 or 07826 951392, FCR MHP or Triage Car

Under 18
Call SPA 0300 123 4000 for duty CAMHS crisis team

Are they known to the service?

Yes

Is there a crisis plan?

Yes

Implement the plan

No

Is there an appropriate alternative diversion?

Yes

Advice from S136 Suite Nurse as to diversion opportunity

No

Consider S136 as a course of action

Information received onto incident log

If detained under Section 136 MHA, person taken to a Health Based Place of Safety directed and co-ordinated by Section 136 suite duty nurse
Police determined that admission to the Section 136 suite be considered

Options for consultation:
1. Section 136 Suite Duty Nurse (24/7) Tel: 01522 573699 /07826 951392
2. Police consult with Mental Health Practitioner based in Police HQ Control Room during hours 12:00 - 20:00 Tel: 01522 947853
3. Triage car during hours 16:00 - 24:00

Can 136 suite admission be diverted and alternative options considered?

Options considered for diversion:
1. Home treatment
2. Crisis House on informal basis
3. Planned appointment offered with CRHT
4. Appointment with GP
5. Other

Screened and deemed appropriate for admission for Section 136 detention

Places of safety options considered, in order of priority, as directed by S136 suite duty nurse:-
1. 136 Suite Lincoln
2. A&E Lincoln / Boston- police to stay with patient

Refer to LPFT pathways

S136 suite duty nurse arranges AMHP, 1st psychiatrist & adheres to the memorandum of understanding S136 procedures

Assessment conducted (if practicable due to medication, condition/ treatment etc.)

Admission or discharge

AMHP completes documentation including Part 2 of monitoring form and GP discharge letter
**S136 Admission Process for Children**

Police determine that admission to the 136 suite or alternative be considered for children

**Options for consultation, in order:**
1. CAMHS Crisis and home treatment team (24/7) - on call after 7pm
   North team - Lincoln; South team – Boston via SPA 0303 123 4000
2. Ascertain if the young person is known to Children’s Services
   by ringing the CSC on 01522 782111 or if out of hours the children’s EDT on 01522 782333
3. Section 136 Suite Duty Nurse (24/7) 01522 573699 / 07826 951492

**No mental health disorder/diagnosis identified**

**Options considered for diversion:**
1. Phone triage from CAMHS practitioner
2. A&E for face to face assessment after phone consultation
3. Planned appointment offered with CAMHS (if known to service)
4. If ‘at risk’ of significant harm, referral to Children’s Social care
5. If early help support required, undertake an early help assessment and arrange a team around the child meeting
6. Appointment with GP

**Places of safety options considered, in order of priority, as directed by S136 suite duty nurse:**
1. 136 Suite Lincoln
2. A&E Lincoln / Boston- police to stay with patient

**S136 suite duty nurse arranges AMHP, 1st psychiatrist & adheres to the memorandum of understanding section136 procedures**

**Assessment conducted (if practicable due to medication, condition/ treatment etc.)**

**Admission or discharge**

**AMHP completes documentation**

**Can 136 suite admission be diverted and alternative options considered?**

- **Yes**
  - Screened and deemed appropriate for admission for Section 136 detention

- **No**

** 这一页的内容是S136儿童住院流程图，描述了警方确定需要将孩子送往136套间或替代方案的考虑。**
Emergency Department Place of Safety Process for Children and Adults

Pre-alert phone call received from S136 Suite duty nurse on ED ‘red phone’ direct dial:
Lincoln County Hospital: 01522 583555
Pilgrim Hospital, Boston: 01205 446823

ED shift coordinating nurse:
- Completes ‘handover checklist’
- Ensures appropriate cubicle / room is available and prepared
- Alerts receiving nurse, MHLT / CAMHS, medical staff and Site Manager (SDM) of estimated time of arrival

Patient arrives with police (24hr clock commences)

- Admitted to ED
- Nurse assessment & medical first assessment as per existing ED pathways and protocols including safeguarding
- Clinical needs identified & planned e.g:
  - Treatment / intervention for injuries, wounds
  - Treatment / intervention for existing medical condition
  - Hydration
- Personal care and comfort needs identified:
  - Nutrition
  - Elimination
  - Pain
  - Comfort
  - Warmth
  - Reassurance
  - Information

Place of Safety Handover Checklist to include:
- S136 Suite duty nurse name
- Patient details (if known)
- Current location
- Estimated time of arrival
- Level of risk & need:
  - Violent / aggressive
  - Compliant / calm
- Current situation, background, assessment, recommendation SBAR
- Estimated length of stay
  (S136 suite available at : hrs)

Is continued or further physical health intervention required?

- Yes
  - At least hourly joint ED / Police reviews
  - Discharge from ED care
  - Police continue to detain

- No
  - At least hourly joint ED / Police reviews
  - S136 assessment / alternative diversion available

Discharge handover to be on reverse side of initial place of safety handover as above and to include:
- Treatments given
- Treatments planned (e.g. OPD)
- Medications given
- Medications prescribed

Discharge / transfer to assessment bed
Co-ordinated by Police and S136 suite duty nurse
Transported by EMAS or Police
ULHT to provide a discharge handover of any health intervention
1: Recovery Story

Towards the end of 2014 I started to feel very unhappy and lonely for various reasons. I then started to feel unhappy about what I looked like. 

2015

The feeling unhappy went on for a few months and at the beginning of 2015 I started using food to cope. Whenever I restricted or did exercise it made me happy and gave me something to focus on and distract myself with.

For a long time I always wanted to recover and would really want to get better. But I just felt like the anorexia was in control and I just couldn’t do it. I felt stuck because there was the part of me that just wanted to be happy, gain weight and eat, but the anorexic voice would be too loud.

I always felt bad because my family were always so supportive and wanted me to get better. My mum would really help me and be there for me.

For year 11 at school I was taken out, so it was hard seeing all my friends go to parties and doing fun things but I would never go because of being too tired and scared about good/healthy. When I was underweight/not eating properly my physical health was not great. I would feel cold in the house and outside even when no one else was.
cold and said they was warm. I also had a lot of problems with low blood pressure and would faint a lot which is really scary looking back. There was one time when my blood pressure was really low and I kept on fainting, so the ambulance came and I was taken to hospital and had loads of tests on my heart. I would also be very low energy, so couldn’t enjoy days out because of being too tired.

2017
Towards the end of 2017 (September) I was going to be turning 18 and knew I might be leaving CAMHS which was really scary because the anorexia was still in control. So when I started the CBT-E I felt like it was my final chance to recover. I was motivated by the fact I was fed up of being miserable moving to London, wanting to travel and for my family. I felt like I needed to make the most of the CBT-E to start recovery.

During the first couple of months I really challenged myself to eat the ‘red foods’ on my ‘red foods list’ and to eat a more regular diet (3 meals and 3 snacks). Each meal was really hard and scary because it meant weight gain and giving up my coping mechanism. Weight gain terrified me, so I made loads of
motivational posters to help me remember the reasons to recover. When I started to accept that I would have to gain weight eating more got easier, but was still really hard. The 'red good list' really helped me get over my fear of certain foods as it showed me eating the goods listed wouldn't make me suddenly gain loads. I also did some exposure work which helped me overcome my fear of eating in public. Again it was really hard and the anorexic voice was really loud, but the more I did it the easier it got.

Once I was gaining weight and eating a balanced diet I found I had more energy, didn't get dizzy all the time, was a lot happier and could start to enjoy good more. It is still tricky but I have to keep reminding myself of my reasons to recover and I know it is worth it. This is the best I have felt in myself and around good in a 4 years. I no longer feel like the anorexia is in control. I am now able to work at a coffee shop because I have a lot more energy and don't get anxious like I did before. I also go out for drinks with my friends which again is a massive achievement because I wouldn't have been too anxious to do that before. I also go out for meals with my mum and sister and get things like pizza and pancakes which I never thought was possible.
**Case Study 1**

**Case Background**

Male, aged 14, presented first to core CAMHS, symptoms of excessive OCD – rigid showering/Handwashing/Ordering. As part of compulsions, food control, body image issues, thoughts of feeling fat, reduced food intake, refusal of food water, referred to Rainforest paediatric ward for stability. Diagnosis of Atypical Eating Disorder including traits of Anorexia Nervosa alongside some Obsessive Compulsive behaviours. The first initial assessment with family was with Mum, Dad and Brother. List of physical symptoms including tiredness, dehydration, pain throughout the body, and muscle wastage.

**Offered Intervention/ Formulation**

As limited insight/motivation to change from young person FBT was offered to promote family empowerment/weight restoration. This promoted families feeling they are in control of the eating difficulty and that they could implement boundaries around this when young person was unable to do this for themselves.

**Outcome**

This young person began FBT treatment in January 2018 and was discharged at 93% WFH in July 2018. Although ideally young person would have had the option for further therapy until her had reached at least 95% WFH, motivation was limited to attend sessions but family were aware of how to monitor weight/food intake if they had further concerns.

- Weight/Height/BMI/WFH on **Referral** - 35kg/171cm/12/62%
- Weight/Height/BMI/WFH on **Discharge** - 52.3/171cm/18/93%

---

**Graph to illustrate weight gain in KG and WFH % (Weight for Height) against number of FBT sessions dates offered**

![Graph](image-url)
**Case Study 2**

**Case Background**

Female, Aged 14, lost over 8kg in weight in a short time (2 months), controlling diet, vegetarian, refusing to eat dairy products. Ongoing image issues, thoughts of feeling fat, reduced food intake, refusal of lunch, portion reduction of evening meal. First initial assessment with Mum and Daughter (Dad was not involved in young person’s care). Physical symptoms of weight loss include tiredness, poor concentration and loss of energy.

**Offered Intervention/ Formulation**

Although ‘overweight’ vast weight loss was present alongside thoughts of being fat as well as ongoing food and water restriction which highlighted the need for therapeutic intervention. As the young person was very anxious to change and when asked if they felt they could change said ‘I can’t’ so was unable to actively make changes individually. FBT was offered to promote weight restoration and introduction of adequate portion sizing. This promoted a trusting relationship between mother and daughter to re-establish healthy eating patterns.

**Outcome**

Although young person was overweight on referral, symptoms were typical of Anorexia Nervosa. The aim of treatment was therefore to halt restriction, stabilise and then re-establish a healthy eating pattern.

| Weight/ Height/ BMI/ WFH on Referral | - 63kg/ 158cm/ 25/129% |
| Weight/ Height/ BMI/ WFH on Discharge | - 71.6/ 158cm/28/147% |

**Graph to illustrate weight gain in KG and WFH % (Weight for Height) against number of FBT sessions/dates offered**

![Graph showing weight gain and WFH % over time](image_url)
Case Study 3

Case Background

Female, Aged 13, presented with severe restriction of food over 3 months. History of bullying about physical image at school. Young person had poor body image, no purging but low mood. Lives with Mum and Mums partner. Biological Dad is an alcohol and limited understanding of young person difficulties.

Offered Intervention/ Formulation

Young person was feeling like she wasn’t part of her family – hiding eating difficulty made her more isolated from the family unit. Mum found out she was restricting food through her loss of weight and clothes becoming bigger. Young person did not want to change and felt like she wanted to lose 3 stones in weight. It was felt that FBT was the best approach as it would bring the family together to be involved in the treatment of the eating disorder.

Outcome

This young person began FBT treatment in October 2017 and was discharged at 101% WFH in August 2018. She was reporting feeling better in her mood and more confident to manage her own meal times.

- Weight/ Height/ BMI/ WFH on Referral - 56kg/ 161cm/ 21.6/ 112%
- Weight/ Height/ BMI/ WFH on Discharge - 54.0kg/ 161cm/ 20.8/ 108%

Graph to illustrate weight gain in KG and WFH % (Weight for Height) against number of FBT sessions dates offered
### Appendix 7 and 7a. CQUIN milestones and Transition Protocol

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Milestones</th>
<th>Responsible for delivery</th>
<th>Responsible for reporting</th>
<th>Target date</th>
<th>External Reporting (details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review Sending and Receiving Steering Group membership</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>1st April 2018</td>
<td>Following a review of the membership of the steering group, it was decided that due to issues around transition for patients in inpatient environments at the point of transition, that the Service Manager - Urgent Care Pathway should become an 'as required' member of the group. The Service Manager - Steps2Change should change from full member to 'as required' as CAMHS patient should not be regularly transitioning to adult IAPT pathways as this is not a secondary care pathway. The Head of Adult Clinical Psychology and Psychotherapies will no longer be required as a member due to access to adult psychology pathway moving to the CMHT managed by the Service Manager - Adult Community who already is a member of the group.</td>
</tr>
<tr>
<td>1</td>
<td>Set up Sending and Receiving Steering Group monthly meeting throughout the year</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>1st April 2018</td>
<td>Meeting dates scheduled monthly through 2019/19</td>
</tr>
<tr>
<td>1</td>
<td>Review TOR's for the steering group</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>31st April 2018</td>
<td>The ToR remains relevant for the group with only some minor amendments to the membership, as per above.</td>
</tr>
<tr>
<td>1</td>
<td>Steering group review lessons learnt from year one implementation and update the implementation plan</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>31st April 2018</td>
<td></td>
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<tr>
<td><strong>Transition Steering Group May</strong></td>
<td>Review the transition protocol</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>31st May 2018</td>
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<tr>
<td>1</td>
<td>Review processes for tracking young people going through transition</td>
<td>Amy Butler</td>
<td>Nige Dixon</td>
<td>30th June 2018</td>
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</tr>
</tbody>
</table>

The steering group reviewed the protocol and the existing protocol was sent out to the divisions for comments and amendments. No suggested changes to existing pathways and descriptions within the protocol. However, the review suggested that there should be additional pathways added to the protocol for young people in inpatient care at the point of transition. The pathways need to focus both, those in local inpatient care and those in out of county placements or requiring out of county placements. August's steering group will be a focus session on inpatient pathways and the protocol will be updated following this steering group. Revised document to be published on LPFT website and circulated to commissioners once complete.

Currently the only availability for tracking transitions is via a manual process. CAMHS will keep a spreadsheet for all young people aged 17.25 with a view to monitoring where people are in the transition process. As LPFT move toward a new clinical system the services will work with clinical systems to develop alerts and tracking of transitions on the system.
1. Review discharge codes being used.  
**Helen McDonald**  
**Nige Dixon**  
30th June 2018  
Cases from CAMHS at the point of transition should be closed using the transferred code on the system, all admin have been reminded of to use this code. However, a recent review of cases has evidence a number of codes are being used to transition a case to an adult mental health service. All future audits will also review the other codes on the as a part of the audit to ensure that all transitions are included in the audit even if the wrong coding has been used.

### 1. Report to Commissioners
Submit updated plan to commissioners with Q1 contract report. Highlight lessons learn from year one.  
**Nige Dixon**  
**Nige Dixon**  
27th July 2018  
Lincs CC contract report via DH  
27th July 2018

### 2. Transition Steering Group
**August**  
Focus session on reviewing pathways for young people in inpatient placements. Pathway review for people placed in CAMHS inpatient in county. Pathway review for people placed in CAMHS inpatient out of county  
**Nige Dixon**  
**Nige Dixon**  
31st August 2018  
Inpatient adult service managers attended the meeting. Agreement was made over the process for both young people in county and young people out of county who require an inpatient to inpatient transition. Updates on all young people 17.5yrs plus in inpatient care will be sent to adult bed managers following the CAMHS bed management meeting with NHSE.

### 2. Update transition protocol following August pathway meeting  
**Nige Dixon**  
**Nige Dixon**  
31st August 2018  
Update in progress

### 2. Work with LPFT clinical systems team to provide system alerts and tracking for transitions on LPFT's new clinical system.  
**Nige Dixon**  
**Nige Dixon**  
31st August 2018  
Following the introduction of the new RIO clinical system, Informatics department will meet with the transition steering group to review developing the functionality of the system to meet the transition process requirements. Booked to attend.
2  | **Report to Commissioners**  
1. Case note audit assessing those who transitioned out of CYPMHS from Q1 and Q2  
2. Assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q1 and Q2  
3. Assessment of post-transition questionnaire of those who transitioned to AMHS from CYPMHS through Q1 and Q2  
4. Provide a summary report of discharges during Q1 and Q2 for people 17.5 years and over.  
| Nige Dixon | Nige Dixon | 27th October 2018 | Lincs CC contract report via DH. See above | 27th October 2018  

3  | **Transition Steering Group October**  
review findings from quarter 2 audit and update action plan in response to findings.  
| Nige Dixon | Nige Dixon | 31st October 2018 |  

3  | Informatics to provide monthly transition reports following system developments.  
| Nige Dixon | Nige Dixon | 31st October 2018 |  

November’s steering group.
<p>| | | | | |</p>
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<tbody>
<tr>
<td>3</td>
<td>Submit updated action plan to commissioners.</td>
<td>Nige Dixon</td>
<td>Nige Dixon</td>
<td>30th November 2018</td>
</tr>
</tbody>
</table>
| 4 | **Report to commissioners**  
1. Case note audit assessing those who transitioned out of CYPMHS from Q4  
2. Assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q4  
3. Assessment of post-transition questionnaire of those who transitioned to AMHS from CYPMHS through Q4  
4. Provide a summary report of discharges during Q3 and Q4 for people 17.5 years and over. | Nige Dixon | Nige Dixon | 8th April 2019 | Lincs CC contract report via DH | 30th April 2019 |
Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services

**Transition Pathway**

Following 17th Birthday
Start discussions with the young person and where appropriate the family over the potential need to transition at their 18th Birthday

Service/Organisation identified for the young person to transition into

**CCG Commissioned Services** (not provided by LPFT)

- 9 Months Prior to Transfer
  - Service informed of the need for transition
  - Transition meeting date set for 6 months prior to transfer

**Internal LPFT Transition**

- 9 Months Prior to Transfer
  - Case taken to interface meeting
  - Receiving service identified
  - Transition process initiated
  - Clustering done

**Primary Care** (Non-CCG commissioned)

- 9 Months Prior to Transfer
  - Service informed of need for transition & invited to discharge planning meeting
  - Date set for 6 months prior discharge

**6 Months Prior to Transfer**

- First Transition Meeting takes place, involving sending and receiving services, the young person and (where appropriate) their parent/carer with young person’s consent.
- Transfer plan agreed and signed (use template).
- Named transition worker identified.

**Implementation of Transitional Plan**

This will include a joint session and may include further transitional meetings.

Sending providers must ascertain whether the young person feels prepared for transition at the point of discharge from CYPMHS.

Following transition the receiving services must ascertain whether the young person has met their personal transition goals agreed in their transition plan.

**Implementation of Discharge Plan**

Sending providers must ascertain whether the young person feels prepared for transition at the point of discharge from CYPMHS.
Children and Young People Improving Access to Psychological Treatment (CYP-IAPT)

PROJECT PLAN for IMPLEMENTATION OF CYP IAPT ACROSS LINCOLNSHIRE

Updated: April 2018
Guide to colour code used in template

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description</th>
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<tbody>
<tr>
<td>Green</td>
<td>action implemented/completed</td>
</tr>
<tr>
<td>Amber</td>
<td>action in progress and on track to be completed within the stated timeframe</td>
</tr>
<tr>
<td>Red</td>
<td>action has missed/ is likely to miss the implementation date</td>
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<tr>
<td>Item</td>
<td>Action</td>
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<td>------</td>
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</tr>
<tr>
<td>1.1</td>
<td>Named Project Lead</td>
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<tr>
<td>1.2</td>
<td>Local CYP IAPT Steering Group incorporated into Lincolnshire Future in Mind Steering Group</td>
</tr>
<tr>
<td>1.3</td>
<td>Lincolnshire CYP IAPT represented at Collaborative Project Leads Quarterly meetings and at Collaborative Meetings</td>
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<tr>
<td>1.4</td>
<td>CYP IAPT embedded within Service Transformation Plan; Local Transformation Plan</td>
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<tr>
<td>1.5</td>
<td>Accurate information submitted on a quarterly basis to CYP IAPT Collaborative meetings</td>
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<tr>
<td>1.6</td>
<td>Participation Lead identified</td>
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<tr>
<td>1.7</td>
<td>Children &amp; Young People’s council. Children &amp; Young People’s participation group set up</td>
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<tr>
<td>1.8</td>
<td>Parent support groups set up</td>
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<tr>
<td>1.9</td>
<td>Outcomes from participation is fed into service development and delivery</td>
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<tr>
<td>Item</td>
<td>Action</td>
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<tr>
<td>2.0</td>
<td>Children &amp; Young People are involved in staff recruitment training, supervision &amp; appraisal of staff</td>
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<tr>
<td>2.1</td>
<td>Children &amp; Young People carer involvement in: CAMHS Steering Group Future in Mind Steering Group</td>
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<tr>
<td>2.2</td>
<td>Core CAMHS, Healthy Minds Service and Children’s Services All staff are using feedback and outcome tools in their appointments with Children &amp; Young People.</td>
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<tr>
<td>2.3</td>
<td>Clinical and Line Management supervisors are looking at ROMs within supervisions to inform interventions</td>
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<tr>
<td>2.4</td>
<td>Demonstrate how intervention and treatment outcomes compare with other services within CYP IAPT programme</td>
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<tr>
<td>2.5</td>
<td>Evidence based care pathways in place for depression, anxiety, eating disorders</td>
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<tr>
<td>Item</td>
<td>Action</td>
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</tr>
<tr>
<td>2.6</td>
<td>Implementation of Self Referrals</td>
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<tr>
<td>2.7</td>
<td>Achievement of contracted waiting times CAMHS 4 weeks – LAC,YOS 6 weeks – standard</td>
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<tr>
<td>2.8</td>
<td>A range of interventions on offer</td>
</tr>
<tr>
<td>2.9</td>
<td>Services accessible to Child &amp; Young People taking into account of culture, gender, sexual identity</td>
</tr>
<tr>
<td>3.0</td>
<td>Staff training</td>
</tr>
<tr>
<td>3.1</td>
<td>Workforce Plan agreed</td>
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</table>
Workforce Planning

**Introduction**

This template has been devised as a guide to completing the workforce plan for your organisation/partnership, which encompasses seven areas of focus for CAMHS workforce planning. It provides a means to articulate the vision of how to meet the needs of CYP and families who require support from the CAMHS workforce.

1. **Workforce design and planning**

Having effective Workforce Design and Development practices in place combining need, service models to meet that need and workforce consequences across all agencies is fundamental to enable services to be staffed appropriately over the coming years.

2. **Recruitment and retention**

For mental health services to grow and develop, it is vital to recruit and retain good quality staff that reflects the make-up of the community they serve. Currently, mental health is not seen as an attractive place to work. We need to tackle this stigma by showing that it actually provides intellectual stimulus, good career opportunities, a fair rate of pay for the job and good support networks including a family friendly working environment. If there are insufficient staff we will continue to waste resources on agency and locum staffing, we will be unable to provide effective services for users and their carers and government targets will not be achieved.

3. **New ways of working**

New ways of working are essential because services are changing, are largely multi-disciplinary team based, with a need to provide a clear pathway/bundle/packages/integrated system for the service user and carer. The pressure from demand for services and insufficient supply of professionally qualified staff mean that traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

4. **New, emerging and developing roles**

We need to recruit from a different pool of people if we are realistically to expand the workforce to the extent required. Many of these potential recruits do not want to enter the traditional professions, but with the appropriate training and supervision could take on important roles in services to support and release time from professionally qualified staff based on an analysis of the capabilities required.
Appendix 9. Crisis Audit

Crisis Service Mapping Interview Schedule

Thank-you for agreeing to talk to us, we are undertaking some work on behalf of the Clinical Network.

Following on from the national audit for crisis provision, the Clinical Network would like to build a clearer picture of current mental health crisis services for Children and Young People across the region.

I have some questions to ask you, please also tell me anything else you think might also be helpful.

We are taking notes from this interview; the report will be produced and made available through the Clinical Network, to the FiM steering group. Whilst we may use information you give us about the services, we will not attribute anything to your personally without checking with your first.

LTP Area……………..Lincolnshire………………………………………………………………………………………………………

Provider Trust…………LPFT………………………………………………………………………………………………………………

Interviewee and role………..Local Authority Commissioner………………………………………………………………………………

<table>
<thead>
<tr>
<th>KLOE</th>
<th>Findings</th>
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<tr>
<td>1. Does your service operate a dedicated CYP Urgent &amp; Emergency service (UES)? If yes, do you have a clear service pathway/model? (Can we have a copy?) If not, what service protocols are in place to manage Urgent/Emergency demands?</td>
<td>Yes- Crisis and home treatment team 24 hours with an on call service from 7pm-9am 7 days a week. Response times are for urgent (face to face within 72 hours) and emergency (4 hours T/C and 24 hours face to face) Standard operating procedure details the above and ULHT pathways for CYP attending A&amp;E and how quickly we respond.</td>
</tr>
<tr>
<td>2. What’s the service called?</td>
<td>C&amp;HTS Crisis and home treatment service</td>
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<tr>
<td>3. How do children, young people and families find out about your service?</td>
<td>Online website Schools, GPs etc. Core CAMHS/EDS Leaflets for CYP and professionals Consultation with other agencies</td>
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<tr>
<td>4. Are Children, Young People and their</td>
<td>If they are known to the team (open referral or on</td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>1. Are parents/carers or support networks able to telephone your crisis service directly?  Are these telephone calls answered within 2 minutes?</td>
<td>alert) they can access and phone the team. If they are not known we do not currently accept self-referral in the service but are looking into implementing it in the future for CAMHS.</td>
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<tr>
<td>2. Do you have an alert system? If so, who can access and phone the team?</td>
<td>referrals per month per team and sources/per criteria/reasons Breaches Contacts On Call data- amount of referrals, time spent out of hours Inpatient admissions in and out of county Expressions of satisfaction, CHI- friends and family data, My outcome measures ULHT pathways/SOP/Phone triage protocol/end of year reports</td>
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<tr>
<td>3. What are the operating hours? If not 24/7, what how are urgencies/emergencies managed out of usual operating hours?</td>
<td>8.45am-7pm On Call 7pm-9am- responding to emergency services- A&amp;E/Police/Paramedic/S136</td>
</tr>
<tr>
<td>4. Where are these services located? E.g. Within existing CAMHS, Local hospitals etc.</td>
<td>Attached to existing core CAMHS- based in 2 of the hubs Boston and Lincoln but respond to CYP from other hubs at Grantham and Louth. 2 teams cover South and North of the county.</td>
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<tr>
<td>5. Please could we have a little more information regarding this service? What data do you collect? What are the KPI’s you report on? Do you have any service specifications, pathways or operational guidance, or evaluations you could let us include?</td>
<td>Referrals per month per team and sources/per criteria/reasons Breaches Contacts On Call data- amount of referrals, time spent out of hours Inpatient admissions in and out of county Expressions of satisfaction, CHI- friends and family data, My outcome measures ULHT pathways/SOP/Phone triage protocol/end of year reports</td>
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<td>8.45am-7pm On Call 7pm-9am- responding to emergency services- A&amp;E/Police/Paramedic/S136</td>
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<tr>
<td>8. What age ranges are catered for by this service? If there are age ranges NOT catered for what services are in place to respond to this client group?</td>
<td>Age 18 and under Flow chart for transition to adult services If 17 years and 9 months and not known to CAMHS Adult crisis team will pick up and see unless reason they need CAMHS instead.</td>
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<tr>
<td>9. How is your UES staffed? Numbers? Skill mix? Is specific training provided for staff? Would you say that staff are adequately trained and experienced to provide competent assessments and interventions?</td>
<td>1 Band 7 team co-ordinator 7 Band 6 practitioners 3 Band 5 practitioners 1 Band 3 admin worker The team is made up of Psychiatric Nurses, and Social Workers. The team can access a Psychiatrist or psychology support via the core CAMHS team. Specific training is provided for staff over the year and induction to the trust and CAMHS. Staff are supervised until they are adequately trained and experienced to provide assessment and intervention.</td>
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<tr>
<td>10. How does the team receive referrals? Who can refer? Does your service enable self-referral? How are referrals screened?</td>
<td>Direct referrals to the team via GP/Social worker/paediatrics/Emergency services Rest can refer via our Professional advise line Self-referral is being looked at and will be introduced at some point in the future</td>
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<td>Question</td>
<td>Answer</td>
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<td>Are referrals responded to within an hour? If Not..... In what timescales are referrals responded to?</td>
<td>Screening tool used in core CAMHS to see if risky then comes to C&amp;HTS for screening to see if meets urgent or emergency criteria. Referral then triaged over the phone and either signposted on or assessment arranged for face to face. Emergency referrals have a 4 hour telephone response time and 24 hour face to face response. Urgent referrals have a 72 hour face to face response time. Most if not all out of hours referrals are called within the hour.</td>
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<tr>
<td>11. Are assessments completed and actioned within 4 hours of a referral?</td>
<td>Emergency referrals have a telephone response within 4 hours and a face to face within 24 hours.</td>
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<tr>
<td>If Not...In what timescales are assessments completed and actioned? Should further assessments be identified are they occurring within 24 hours?</td>
<td>Yes we offer assessments at home, base, GPs, schools etc. Where ever meets the needs of the CYP and family best, considering lone working and safety of the staff</td>
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<tr>
<td>12. Are assessments available able to happen across a variety of locations? E.g. Service base, YP home, GP surgery, School, Local Hospital (A&amp;E Dep’t, Paediatric wards) Are efforts made to assess C/YP in their home? Or as close to their home as possible?</td>
<td>Yes we offer assessments at home, base, GPs, schools etc. Where ever meets the needs of the CYP and family best, considering lone working and safety of the staff</td>
</tr>
<tr>
<td>13. Should a C/YP require providing with a place of safety, where would this typically be? Following assessment, if required, is intensive community and home-based support/treatment provided? Does the team follow a specific model/approach for crisis support interventions? Is all necessary support and treatment provided actioned within 24 hours?</td>
<td>Place of safety is now identified at the Boston or Lincoln A&amp;E department (work is being done on one area to make it suitable) and we have an adult S136 suite in Lincoln which is used for CYP when needed or if A&amp;E is full. We have a protocol to manage any S136 detentions and work with multi agencies to prevent these whenever possible.</td>
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<td>14. Do you have links with local hospitals? Is there a SLA with local hospital services? Does your service provide urgent/emergency Mental Health, Self-Harm, Over-Dose assessments to CYP who present to local hospitals?</td>
<td>We have some links and provide consultation and training to the A&amp;E and children’s ward in both areas- although attendance is limited due to their resources and staffing levels. We provide intervention into hospital all hours</td>
</tr>
<tr>
<td>15. Are there existing collaborations between specialist community CYP mental health services? E.g. Between specialist community and inpatient CYP mental health services An integrated CYP mental health and social care model</td>
<td>Yes we all have the same line manager for complex CAMHS and work together to keep the CYP out of hospital or to get them home quicker. C&amp;HTS attend the ward weekly for MDT and patient reviews. C&amp;HTS are based in core CAMHS buildings and attend their team meetings when possible to</td>
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<tr>
<td><strong>Combined liaison and crisis mental intervention service for all ages</strong></td>
<td><strong>discuss referrals</strong></td>
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| **16. Does crisis management involve the full range of expertise and support from health and social care?**  
Can you describe this? Safeguarding / assessment and provision when required? | Social care support is limited and we do not have any specific service agreements. If we identify a SG issues we have to refer into early help workers like anyone else. Emergency Duty Team support out of hours is non-existent due to capacity and lack of mental health knowledge or understanding. |
| **17. How does your service minimise transitions between services?** | Screen referrals together so does not need re-referring or passing around  
Paediatric liaison meetings on a weekly/fortnightly basis.  
Shared team meetings to discuss referrals  
Transition protocol agreed with adult services to make transition smoother and timely |
| **18. What do you do in the event of a child or young person presenting with suicidal ideas?**  
**Self-Harm**  
If a child presents with self-harm is it recorded on your electronic patient record  
Do you know the number of CYP who present with self-harm to your services who are not admitted? If yes, please provide the last 12 months data and profile e.g. age, time of day  
Do all CYP who present in crisis with self-harm have a full safeguarding assessment completed before they are discharged in accordance with NICE guidance?  
Does your service have a self-harm pathway and/or offer specific interventions for self-harm?  
Do all CYP who present with self-harm follow the same pathway regardless of age / time of day they present? If not, please explain | Any contact or referral we get is recorded on electronic noting.  
Staff complete the child and young person safeguarding screening tool  
Self-harm/suicidal pathway for CYP attending A&E  
**Yes** |
| **19. Following assessment, if required, is intensive community and home-based support/treatment provided?**  
Does the team follow a specific model for crisis support interventions? If so, what model?  
Is all necessary support and treatment provided actioned within 24 hours? | No we have staffed skilled in different approaches-CBT/DBT/Emotional first aid/systemic work/human givens/Animal assisted therapy  
We follow a specific risk assessment which identifies the 5 Ps to formulate and agree risk and a safety plan with the CYP. |
<p>| <strong>20. Are assessments and correct interventions provided by adequately</strong> | Yes we have recruited all staff to the team who either had the skills in CAMHS and assessment when starting or we have trained them up to learn |</p>
<table>
<thead>
<tr>
<th><strong>trained, competent and experienced CYP mental health staff?</strong></th>
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<tbody>
<tr>
<td>How do you ensure staff are trained/competent? Do you have a workforce plan?</td>
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<tr>
<td>these skills by shadowing/induction and additional training. All staff when starting in the new teams had training on managing risk/self-harm in children in crisis before the teams started working with CYP.</td>
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<table>
<thead>
<tr>
<th><strong>21. Are there existing collaborations between specialist community CYP mental health services?</strong></th>
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<tbody>
<tr>
<td>E.g. Between specialist community and inpatient CYP mental health services An integrated CYP mental health and social care model (details of level of integration) Combined liaison and crisis mental intervention service for all ages</td>
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<tr>
<td><strong>Repeat of question 15?</strong></td>
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<tr>
<td>Yes we all have the same line manager for complex CAMHS and work together to keep the CYP out of hospital or to get them home quicker. C&amp;HTS attend the ward weekly for MDT and patient reviews. C&amp;HTS are based in core CAMHS buildings and attend their team meetings when possible to discuss referrals</td>
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<tr>
<th><strong>22. How do you ensure children and young people experience a smooth transition between services?</strong></th>
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<tr>
<td><strong>Repeat of question 17?</strong></td>
</tr>
<tr>
<td>Screen referrals together so does not need re-referring or passing around Paediatric liaison meetings on a weekly/fortnightly basis. Shared team meetings to discuss referrals Transition protocol agreed with adult services to make transition smoother and timely</td>
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<tr>
<th><strong>23. Do you have any current plans to enhance your current crisis provision?</strong></th>
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<tr>
<td>Any changes associated with LTP’s?</td>
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<tr>
<td>No we recently enhanced it by 2 staff per team (1 band 6 and 1 band 5) when awarded some money to work with CPY with LD and or ASD in a mental health crisis.</td>
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**Questions for Commissioners**

<table>
<thead>
<tr>
<th>KLOE</th>
<th>Findings</th>
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<tr>
<td><strong>24. What are your commissioning intentions for crisis provision and what strategic plans do you have in place?</strong></td>
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<tr>
<td>Are your plans consistent with your STP and LTP?</td>
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<tr>
<td>Are your plans a result of ‘joined-up’ multi-agency contribution?</td>
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<tr>
<td>To what extent have children and young people contributed to the development your plans?</td>
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<tr>
<td>When do you anticipate you will be fully compliant with the national standards?</td>
<td></td>
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<tr>
<td>There is consistency with the LTP; however, there is more work to be done to align STP and this piece of work. Crisis service is included in the current Community CAMHS specification and contract, in Lincolnshire this is jointly funded by the CCGs and Local Authority through a S75 agreement. Engagement events take place with children and young people bi-annually where the development of the whole service is discussed and fed into service development. In addition feedback on services through the Patient Experience Questionnaire and stakeholder surveys are used to inform service development. Currently the Local Authority is undertaking a full service review and as part of this work children and young people are</td>
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</table>
25. In respect of planning and developing crisis services, pathways and models:
Do your plans locate crisis within a clear pathway?
Do the plans capture the multi-agency contribution to crisis pathways?
Are the plans supported by workforce developing plans?
Are these plans fully funded?

<table>
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<tr>
<th>Question</th>
<th>YES</th>
<th>YES</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
</table>

26. How confident are you that local providers are or will be able to deliver your requirements?
Do they have a track record of working well together as partner agencies to support children and young people?

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>剥入。Due to the S75 agreement in place there are processes and opportunities already in place and embedded in practice to support collaborative working. This extends past the Local Authority to the Hospital Trust, Community Health providers, Police and Youth Justice, Education etc.</td>
<td></td>
</tr>
</tbody>
</table>

27. What are the barriers and facilitators in implementing these expanded services?
What support may you require from national or regional teams to successfully implement your plans?

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current the service is performing well and expected outcomes are being achieved, e.g. during 2017-18 ULHT reported that due to the work of the Crisis and Home Treatment Team hospital admissions for children and young people in the County reduced by 45%. However, there are some communication issues when Lincolnshire children and young people are transitioning back into county from out of county provision and it may be that regional discussions would be helpful.</td>
<td></td>
</tr>
</tbody>
</table>

Questions for Commissioners – the CCQI/NHSE audit survey had a glitch that prevented CCGs from entering more than one team in their pathway. Please ascertain the following information which ADS will pass to CCQI/NHSE to ensure consistency and completeness

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of dedicated teams in your pathway</td>
<td>1</td>
</tr>
<tr>
<td>Team 1 name</td>
<td>Crisis and Home Treatment Service</td>
</tr>
<tr>
<td>What kind of model does this team operate?</td>
<td>x Dedicated children and young people’s urgent and emergency teams/sub teams  □ Inpatient hub and spoke model  □ Integrated children and young people’s</td>
</tr>
</tbody>
</table>

being engaged to provide feedback on service development.
Service is compliant.
<table>
<thead>
<tr>
<th>Team 1</th>
<th>What function(s) does this team provide?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x  Support, advice and triage</td>
</tr>
<tr>
<td></td>
<td>x  Crisis assessment in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>x  Crisis assessment in the community</td>
</tr>
<tr>
<td></td>
<td>x  Crisis and brief response in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>x  Crisis and brief response in the community</td>
</tr>
<tr>
<td></td>
<td>x  Intensive home treatment (intensive intervention etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team 2</th>
<th>What function(s) does this team provide?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x  Support, advice and triage</td>
</tr>
<tr>
<td></td>
<td>x  Crisis assessment in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>x  Crisis and brief response in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>x  Crisis and brief response in the community</td>
</tr>
<tr>
<td></td>
<td>x  Intensive home treatment (intensive intervention etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Team 3 name</td>
<td>crisis &amp; recovery house</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| **What kind of model does this team operate?** | ☐ Dedicated children and young people’s urgent and emergency teams/sub teams  
☐ Inpatient hub and spoke model  
☐ Integrated children and young people’s mental health (CYPMH) and social care  
☐ Combined/ integrated services for all ages  
☐ Adult team responding to young people aged 16 years plus  
☐ Safe haven or crisis café  
☐ Short term in-patient mental health bed or crisis & recovery house  
☐ Other  
If other, please specify: |
| **What function(s) does this team provide?** | ☐ Support, advice and triage  
☐ Crisis assessment in A&E  
☐ Crisis assessment in the community  
☐ Crisis and brief response in A&E  
☐ Crisis and brief response in the community  
☐ Intensive home treatment (intensive intervention etc.)  
☐ Safe haven or crisis café  
☐ Short term in-patient mental health bed or crisis & recovery house |