Lancashire County Council

Scrutiny Committee

Friday, 19th June, 2015 at 10.30am in Cabinet Room 'B' - The Diamond Jubilee Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 17 April 2015**	(Pages 1 - 6)
4.	**Minutes of the Meeting Held on 12 May 2015**	(Pages 7 - 12)
5.	**Emotional Health and Wellbeing including Specialist Child and Adolescent Mental Health Services Report**	(Pages 13 - 88)
6.	**Workplan and Task Group Update**	(Pages 89 - 92)
7.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	
8.	**Date of Next Meeting** The next meeting of the Scrutiny Committee will be held on Friday 17 July 2015 at 10:30am at the County Hall, Preston.	

I Young
Director of Governance,
Finance and Public Services

Lancashire County Council

County Hall
Preston

Lancashire County Council

Scrutiny Committee

Minutes of the Meeting held on Friday, 17th April, 2015 at 10.30 am in Cabinet Room 'B' - The Diamond Jubilee Room, County Hall, Preston

Present:

County Councillor Bill Winlow (Chair)

County Councillors

C Crompton	J Shedwick
Dawson	V Taylor
C Henig	C Wakeford
R Newman-Thompson	D Watts
Mrs L Oades	G Wilkins
A Schofield	

County Councillor Clare Pritchard was replaced by County Councillor Bernard Dawson, County Councillor Alyson Barnes was replaced by County Councillor Chris Henig, County Councillor Miles Parkinson was replaced by County Councillor Cynthia Dereli and County Councillor David O'Toole was replaced by County Councillor Alan Schofield for this meeting.

1. Apologies

None were received.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None were disclosed.

3. Minutes of the Meeting held on 13 March 2015

Resolved: That the minutes of the meeting held on 13 March be confirmed and signed by the Chair.

4. Environment Agency: Bathing Water Quality and Alt-Crossens Land Drainage

The Committee considered a report setting out responses from United Utilities and the Environment Agency in relation to bathing water quality on the Fylde coast and the proposals for the Alt-Crossens secondary pumping stations. These responses followed the Agency's attendance at the Committee meeting on 13 February 2015 to discuss these matters, together with a letter from the Chair of the Committee to the Agency setting out the Committee's concerns.

Members stated their wishes for United Utilities to commit further than specified in their response to the Committee by extending the real time spill warning system to all eight of the bathing waters on the Fylde Coast for the 2015 season, rather than the five specified in their response. Members noted that the Fairhaven treatment works could not cope in periods of heavy rain and therefore effluent had been contaminating the beaches in the area. It was suggested that the Committee should write to United Utilities and the Environment Agency expressing its concerns and requesting assurances that all eight of the bathing waters would be included in the implementation for the 2015 season.

The Committee also expressed concerns around the response from the Environment Agency to their recommendations for addressing the issues in the Alt-Crossens catchment area and, in particular, the proposals to switch off the secondary pumps.

Ian Welsby, Head of Flood Risk Management, attended and reported that an email had been received from the Lancashire Association of Local Councils (LALC), which articulated their anxieties regarding a lack of progress with the Alt-Crossens Flood Catchment issue. The LALC, within their email, explained that a proposed independent group would look at the establishment of a local water level management board which had been convened known as the Alt-Crossens Intermediate Drainage Group. The group had resolved that representatives and officers from West Lancashire Borough Council, Lancashire County Council, Sefton Borough Council, the NFU, the Environment Agency, utilities companies, and agricultural sector would be invited to attend meetings in order to exchange information and explore ways that the matter could be progressed.

Members enquired what level of influence the newly formed Alt-Crossens Intermediate Drainage Group had. Members were informed that it would be the Advisory Group and the Regional Flood and Coastal Committee (RFCC) which would deliver any recommendations, stating that the focus of the Drainage Group was upon information gathering.

Members who were aware of the Alt-Crossens Intermediate Drainage Group suggested that involvement from the County Council would provide a platform for potentially assisting the group's influence and the Committee was supportive of the County Council exploring options for involvement in the Group.

The Committee voiced concerns around the narrow remit of the Environment Agency, as defined by DEFRA, making particular reference to the Agency's priorities centred upon the protection of human life and residential areas. Members highlighted that the remit did not include human livelihood, and noted that the area was a rich source of food and of local, regional and national importance in terms of agriculture, in addition to being key to the local area in terms of employment and the local economy. It was felt that DEFRA should be asked to consider revising the remit of the Environment Agency and its priorities.

Members similarly suggested writing to United Utilities regarding their remit. It was expressed that their remit should reflect the importance of maintaining the pumping system as an integral part of the water management serving the Alt-Crossens

catchment area. Concerns were expressed regarding the role of United Utilities in relation to the management of surface water, as United Utilities collected a charge from residents to have surface water removed, but no longer admitted to any responsibility for this service.

The Committee suggested a proposal for a Notice of Motion to Full Council to be drafted requesting that the Chief Executive writes to DEFRA regarding the proposals to switch off the secondary pumps at Alt-Crossens, the narrow remit of the Environment Agency and the role of United Utilities in relation to the management of surface water.

Resolved: That;

i. The Committee writes to United Utilities requesting a firm commitment towards the implementation of the real time spill warning system across all eight bathing waters on the Fylde Coast for the 2015 bathing season, in order to alleviate issues with bathing water quality and effluent contaminating its coastlines.

ii. The County Council gives further consideration to being represented on the recently established Alt-Crossens Intermediate Drainage Group.

iii. A Notice of Motion for Full Council be drafted requesting that the Chief Executive writes to DEFRA;

   a. Outlining the County Council opposition to the proposals to switch off the secondary pumping stations at Alt-Crossens and to request that DEFRA revises the remit of the Environment Agency in respect of flood risk management priorities to include the protection of agricultural land where it contributes significantly to the economy of the area.
   b. To express to DEFRA the Committee's concerns regarding the role of United Utilities in relation to the management of surface water.

iv. In the meantime, the Committee writes to DEFRA outlining its concerns as set out at (iii) above.

5. Lancashire Enterprise Partnership - Assurance Framework Responses

Martin Kelly, Director of Economic Development, attended and responded to the comments of the Committee in relation to the Lancashire Enterprise Partnership's Assurance Framework which, it was specified, would be reviewed and refreshed on an annual basis.

Members were informed that some of their recommendations were met with full agreement from the LEP board. For example, whilst the detailed arrangements

were still subject to agreement, the proposal for all 15 local authorities to scrutinise the LEP collaboratively was welcomed. It was expressed that efforts had been made within the revised framework to demonstrate to Members that their recommendations had been subject to consideration.

Regarding the membership of the LEP Board, Members stated that the credentials of the people situated on the LEP Board could be explained further within the document. Members were informed that Government had provided a permissive framework under which to operate, and had specified that LEPs should be directed by skilled members of the business community who would make up the majority of LEP Board members. Members were reassured that appointments were made via assessment of needs and the corresponding skillsets required to undertake any particular role to drive the LEP's plans forward.

Members enquired whether information relating to the LEP Board's meetings were available to the public, either in an observer capacity at meetings or, for example, publishing reports on their website. Members were informed that reports without elements of confidentiality were uploaded to the internet. It was explained that their meetings were not held in public but requests by individuals with a genuine reason to attend in an observer capacity were often granted.

Members noted that the relationship between the LEP and the accountable body, the County Council, was complex. The Committee made reference to section 4.9 of the Assurance Framework and requested for this to be reworded as the word "comply" was deemed to be too dictatorial towards the accountable body. The Committee was reassured that this would be raised with the LEP.

Members reiterated their recommendation that the need for independent scrutiny over the allocation of funds decided by the LEP's Skills Board remained an issue. Reference was made to the membership of the Skills Board consisting of professionals from further education establishments, and that this could lead to a perception that decisions were being made to benefit specific institutions, rather than the wider sector, though members were advised that the majority of Board members are drawn from the FE college community. Reference was also made to the Memorandum of Understanding with the Skills Funding Agency (SFA) and the Skills Board's adherence to their Conflict of Interest Protocol, stating that this could only be judged by the SFA themselves. Members were informed that their concerns were understood, however, they were reassured that the members of the Skills Board were committed to driving forward the skills agenda across Lancashire and that the members represented their sector and not their establishments. Key investment decisions, the Committee was informed, are signed-off by the LEP Board, with strict adherence to Government set criteria, with their business cases also assessed by the LEP and Government officials and agencies.

It was suggested that the wording of Section 4.9 of the document, relating to conflict resolution, be raised with the LEP Company Secretary as it was felt that some of the wording used could be revised.

The Committee asked that quarterly update reports on the LEP be submitted and suggested that representatives of the LEP Board could be invited to future meetings. Also, Members requested a series of Bite Size Briefings which would help all Members to understand developments with the LEP's work and provide the opportunity for information to be disseminated.

The Chair thanked Martin Kelly for attending and expressed the Committee's appreciation for the engagement now being offered.

Resolved: That;

i. The Committee note the LEP's response to its recommendations.

ii. Consideration be given to further representation from non-education sector representatives on the LEP Skills Board.

iii. Quarterly update reports be submitted to the Committee, and that representatives of the LEP Board be invited to attend Committee meetings, as appropriate.

iv. Martin Kelly discuss the wording relating to conflict resolution in section 4.9 of the Assurance Framework with the Director of Governance, Finance and Public Services.

6. Work Plan and Task Group Update

An update was provided on the Committee's work plan and current task groups.

It was noted that the work plan had been revised to accommodate new items, such as Road Safety which came out of Budget Scrutiny Working Group, and the rescheduling of the report on Transforming Social Care from Newtons.

Resolved: That the current work plan and task group update be noted.

7. Urgent Business

No urgent business

8. Date of Next Meeting

It was noted that the next meeting of the Scrutiny Committee would be held on Friday, 15 May 2015 at 10:30am and would be a visit to the Multi-Agency Safeguarding Hub (MASH), Accrington.

Details of the visit were provided to the Committee, and a draft programme was circulated.

It was noted that a minibus was to be provided on the day, which would leave Bow Lane, Preston, at approximately 09.30 and would travel directly to MASH, Accrington. This would include a return journey for any Members who wished to use the service.

I Young
Director of Governance, Finance and Public Services

County Hall
Preston

Lancashire County Council

Scrutiny Committee

Tuesday, 12th May, 2015 at 10.00 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No. Item

1. Apologies

No apologies were received.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

County Councillor Crompton declared a non-pecuniary interest in Item 3 as a member of Preston City Council.

3. The Harris Museum and Art Gallery (The Harris) – Shared Services Initiative

The Committee considered the request made by five Members of the County Council that the decision made by the Cabinet Member for Environment, Planning and Cultural Services on 28 April 2015 on the Harris Museum & Art Gallery Shared Services Initiative, be "Called In".

The Committee welcomed County Councillor David Smith, County Councillor Albert Atkinson and County Councillor Anne Cheetham, presenting their reasons for the decision to be reconsidered.

The Committee also welcomed County Councillor Marcus Johnstone, Cabinet Member for Environment, Planning and Cultural Services; Louise Taylor, Corporate Director, Operations and Delivery; Phil Barrett, Director, Community Services and Julie Bell, Head of Service, Libraries, Museums, Culture and Registrars.

Councillors Smith, Atkinson and Cheetham outlined their reasons for supporting the request for the decision to be reconsidered. They queried whether there was a statutory requirement for LCC to have involvement with the project, and

expressed concerns that it appeared the proposal hadn't been detailed within the County Council's Budget, and therefore the method of funding.

It was voiced that the proposed £40,000 contribution to the managerial post per year, for three years, was excessive given that the Authority had been, and would continue to be, in a period of transformation which involved downsizing the organisation.

It was argued that the proposal was more advantageous for Preston City Council than for the County Council, and Members queried what the long term implications would be for the County Council with regard to staffing arrangements at the Harris Museum.

The Councillors presenting in support of the Call-In acknowledged the advantages of partnership working and the opportunities it could provide. However, concern was raised that the project appeared to be based upon aspiration without assurance that the cited figures from the Heritage Funding Agency could be attained, along with further cited sources of funding. It was also elucidated that the proposal could set a precedent resulting in District Council's requesting assistance with their own museums if the decision was not reconsidered.

The Committee then invited County Councillor Marcus Johnstone, Cabinet Member for Environment, Planning and Cultural Services, to speak. He referred to the three elements to the argument in favour of the "Call-In"; unbudgeted proposals, that the Harris Museum was the responsibility of Preston City Council, and a lack of detail around the staffing structure.

Regarding unbudgeted proposals, the Committee was informed that there was external funding available in the regenerate program for refurbishments, and in the Arts Council Resilience Fund. It was explained that these 'earmarked reserves' had been cited in the original report.

Concerning the perspective that the Harris Museum was Preston City Council's responsibility, it was emphasised that the Harris Museum was a very significant building in the North West of England, with 450,000 people visitors in 2014, and was considered to be a flagship landmark in the region, with comparisons made to St. George's Hall in Liverpool and Manchester Town Hall. The Committee was informed that the library service had been in situ at the Harris Museum since its inauguration, originally under the auspices of Preston Town Borough, and since 1974 under the auspices of the County Council in partnership with Preston City Council. Due to Preston City Council's budget constraints, it was expressed that assistance was necessary from the County Council.

The Heritage Lottery Fund, it was voiced, expected the demonstration of a robust partnership between the County Council and Preston City Council to receive funding and that the stance suggested by the opposition would be detrimental to any bid if moved.

Regarding the final element, a lack of detail around the managerial position and staffing, the Committee was informed that details had been outlined in the original report. The post holder, it was noted, would be responsible for drawing down additional funds, thus generating income for the Harris Museum, and increasing efficiency. The post holder would be responsible for developing and implementing a vision, and that this was the fundamental aspect towards securing funds from the Heritage Lottery Fund and Government to improve the Harris Museum. It was explained that the County Council, due to their own staffing levels, was unable to undertake this task, hence the necessity for a dedicated post.

The Committee highlighted a task group that had investigated issues around Arts funding in Lancashire, which had concluded that issues lay within the difficulty organisations had acquiring relatively small sums from the County Council. The Cabinet Member stated that it was imperative to ensure the correct groups received the funding, hence the stringency of the process. This was stressed to be increasingly important with consideration of funding reductions in recent years.

The Committee noted that the managerial post was overseen by PCC but paid, equally, by LCC, and therefore, queried whether paying for the managerial post would lead to input into the museum from LCC going forward. It was conveyed that LCC was working in partnership with PCC around the detail of the job description and would be working together through the shortlisting and appointment process. The manager would report to a joint officer board who would report to the Preston Collaboration Board, at which the Leaders and Deputy Leaders of both Councils attended.

Reference was made by the Committee to staff members of the Harris having received briefings on the proposed arrangement and queried what the collective feeling was from staff members. The Committee was informed that PCC and LCC staff had been briefed, and there had been no objections to the proposal. It was noted that the joint venture would provide an opportunity to analyse the staffing structure, including working hours and the use of space, which allowed for efficient and effective deployment of staff. It was expressed that this could lead to savings for both LCC and PCC, which would offset the cost of the contribution towards the managerial post.

It was asked if the project could be considered to be a pilot for other cultural facilities within Lancashire. It was conveyed to the Committee that the project was innovative and, if successful, could lead to the implementation of analogous arrangements at other cultural facilities. It was explained that, historically, LCC had worked creatively in partnership with Districts, such as in the joint arrangements with Lancaster City Council for the operation of Lancaster Maritime Museum. It was emphasised that new ways of working and the identification of efficiencies would become increasingly important in the coming years.

The Committee noted that encouragement was taken from the possibility that the project could be perceived to be a pilot. Reference was made to how the Fylde Parks Initiative, which had brought in significant funding for the area, had demonstrated how joint working could benefit the community. The Cabinet

Member agreed that this was a good example of how an authority was able to improve and enhance a facility by working outside of the normal channels.

Clarification was sought around the responsibilities of the managerial position by the Committee. It was explained that the manager would be responsible for; implementing a vision for obtaining the Heritage Lottery Fund capital investment, for operating the building efficiently, for the regeneration of the building, for managing the staff members of PCC and LCC employed at the Harris, and to maximise the use of the Harris, for example, reopening the café, which would generate income.

Following the debate, the Committee was invited to vote on whether the decision made by the Cabinet Member for Environment, Planning and Cultural Services on the Harris Museum & Art Gallery Shared Services Initiative, should be reconsidered.

Resolved: that the Cabinet Member should not be asked to reconsider his decision made on 28 April 2015 on the Harris Museum & Art Gallery Shared Services Initiative.

4. Urgent Business

No urgent business.

5. Date of Next Meeting

It was noted that the next meeting of the Scrutiny Committee would be at 10.30 on Friday 19 June at County Hall, Preston.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Scrutiny Committee
Meeting to be held on 19 June 2015

Electoral Division affected:
All

Emotional Health and Wellbeing including Specialist Child and Adolescent Mental Health Services
Appendices 'A' - 'D' refer

Contacts for further information:
Dave Carr, (01772) 532066, Head of Policy, Information and Commissioning (Start Well)
Nicki Turner, 07786 197011, Integrated Health Officer
Mark Warren, (01772) 538788, CAMHS Co-ordinator

Executive Summary

In January 2014 Local Authority and NHS commissioners attended a meeting of the Scrutiny Committee alongside Child and Adolescent Mental Health Services (CAMHS) providers to provide an update on specific actions being taken to improve CAMHS services in Lancashire and to provide information on wider developments of emotional health and wellbeing services for children and young people.

This report provides information on a number of issues as requested by the Committee and a brief overview of wider developments relating to emotional health and wellbeing including CAMHS.

Recommendation

The Committee is asked to:

(i) Note the report and update provided;
(ii) Note the progress made and comment as appropriate.

Background and Advice

In January 2014 Local Authority and NHS commissioners attended the Committee alongside Child and Adolescent Mental Health Services (CAMHS) providers to provide an update on specific actions being taken to improve CAMHS services in Lancashire and to provide information on wider developments of emotional health and wellbeing services for children and young people.

The Committee asked for information to be brought to a future meeting on a number of issues including:

- The results of the successful Preston pilot scheme to develop new ways of working for 16-18 year olds;
- Examples of improved involvement and interactivity with schools;
- Case studies in terms of the integrated activity with other services and any feedback from the service from the people who were using it;
- Examples of work relating to the emotional health response for Children Looked After;
- Financial facts of what funding was needed for the future and was it funding for staff or facilities that was needed;
- National comparable data when available.

This report provides an update on each of the areas requested and a brief overview of wider developments relating to emotional health and wellbeing including CAMHS.

The results of the successful Preston pilot scheme to develop new ways of working for 16-18 year olds

A programme to incentivise service development within Preston was agreed with commissioners and Lancashire Care Foundation Trust, as the service provider.

The pilot has concluded and is now rolled out across the county. Key successes of the pilot included:

- Excellent feedback from training sessions provided to Adult Mental Health Service (AMHS) workers to raise awareness of growing adolescent brain and impact of trauma;
- Establishment of a single Health Care Record, improving working between AMHS and CAMHS;
- Positive feedback from CAMHS workers regarding the establishment of practitioners who were nominated to receive extra training and to receive all referrals of 16/17 year olds;
- Positive feedback from AMHS workers who have Young People on their caseload and receive clinical supervision from CAMHS practitioners to help guide their interventions and practice;
- Improved information sharing with the Accident and Emergency (A&E) Liaison Team based at Preston hospital attending the A&E Safeguarding meetings along with CAMHS. The meeting considers the pathways for children and young people (up to 18 years old) attending A&E including those young people who self-harm and those that are experiencing mental health difficulties;
- Positive feedback from parents/carers in respect of AMHS sessions to improve young person and carer's experiences of care and recovery through greater family and systemic interventions and through wider application of Common Assessment Framework (CAF) processes;
- Children and Young People reported that they felt listened to, were able to talk about issues they wanted to talk about, understood the things said in the meeting and felt that the meeting gave them ideas for what to do.

The importance and success of the new arrangements for A&E Safeguarding Meetings was commented on in a recent Care Quality Commission (CQC) inspection as an example of good practice. Furthermore, this was also recognised as Winner of the Teamwork category in the 2014 Lancashire Teaching Hospital Quality Awards.

The pilot highlighted a continued need within AMHS and CAMHS to improve knowledge of services. This continues to be addressed through training, joint Steering Group and invitations to adult team members to join CAMHS staff during their assessment to create an opportunity for experience and learning to be shared.

The Preston Pilot Evaluation Report is attached as Appendix 'A'.

Examples of improved involvement and interactivity with schools

CAMHS providers have provided examples of interagency work and ongoing schools liaison. These are included in Appendix 'B'. The examples highlight:

- The use of prevention and early help approaches
- Use of family therapy and video interaction guidance
- Multi-agency joint working
- Targeted work with schools
- Improved access to support and advice to schools

Service specifications include a "reach down" from Tier 3 services in to universal and targeted settings to provide advice, consultancy and training to enable those settings to better support those cases where the referral is not accepted by CAMHS.

Case studies in terms of the integrated activity with other services and any feedback from the service from the people who were using it.

Examples of integrated activity and feedback from service users are included within Appendix 'C'. The case studies highlight a range of activities, including the journey of a young person through the Youth Offending Service Integrated Mental Health Team.

Examples of work relating to the emotional health response for Children Looked After.

Over the last two years the SCAYT+ service has worked with 548 children and young people Looked After and Adopted and seen an increase in numbers year on year with 167 new referrals in the last two quarters. This indicates an average demand of around 340 per year.

CAMHS are commissioned to work with Children Looked After that need a more specialist intervention.

East Lancashire CAMHS usually work with 70-110 case per year and Lancashire Care Foundation Trust reported 92 referrals 2014/5. Both these services collect data on children who are and have been looked after.

Case studies from both CAMHS providers and SCAYT+ are attached at Appendix 'D'. The case studies provide further examples of feedback.

Financial facts of what funding was needed for the future and was it funding for staff or facilities that was needed and National comparable data when available

Robust national comparative data was expected in April 2014. However, the national programme to deliver this information was suspended, to enable the issues to be considered as part of a wider Mental Health Services Data Set (MHSDS). This new dataset is not expected to be made available until 2016.

NHS England has indicated that they expect the Increased Access to Psychological Therapies (IAPT) outcome recording system will be incorporated into the CAMHS dataset by September. However, the CAMHS dataset is not fully embedded nationally and IAPT recording is only currently used by one of the local CAMHS providers.

A Joint Commissioning Strategy for Children and Young People with Emotional Health and Wellbeing Needs in Lancashire has been developed and shared with key partnership groups. The Strategy broadly identifies and defines the joint resources and support for children and young people with emotional health and wellbeing needs, identifies a set of commissioning proposals aimed at prioritising our limited resources and contains key partnership actions to improve outcomes for children and young people with emotional health and wellbeing needs.

Comparative data on funding within Lancashire, highlights that the mean spend on CAMHS services per head of population of the 0-18 population for Lancashire is £29.46 compared to that of England £59.35 (Chimat 2015).

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

The County Council provides £34.5m net funding for all age mental health services, which includes over £1.1m annually for specialist CAMHS. The CAMHS contract expects a "reach down" from Tier 3 CAMHS which is intended to provide universal and targeted settings with advice, consultancy and training to enable those settings to better support those cases where the referral is not accepted by CAMHS. Concerns remain about the outcomes achieved through this contribution and there have been challenges in obtaining information from providers to enable us to manage performance and decisions regarding ongoing investment.

Future service development

In October 2014 the Lancashire Health and Wellbeing Board received a report on Children and Young People's Emotional Health and Wellbeing which identified a

number of key issues and areas for improvement in relation to the current partnership and commissioning arrangements. In summary these include:

- Limited strategic governance arrangements;
- Lack of a coordinated approach around promotion and prevention (Tier 1) to capitalise on the role of universal services;
- Inequity of provision/ lack of capacity in targeted and specialist services (Tiers 2,3, 4);
- Joint commissioning arrangements which are neither robust, nor sustainable due to funding pressures and procurement regulations.

Equally concerns have been raised by Lancashire Safeguarding Children's Board and from the findings of serious case reviews which support the case for change.

The Health and Wellbeing Board agreed to strategically lead a joined up approach across partners and provides the mechanism for us to hold each other to account. The recommendation of the Board was that a task and finish group is established which:

- Is chaired by Dr. Ann Bowman, with project management support provided by the local authority and/or the Clinical Commissioning Groups (CCGs');
- The Chair of the task group writes to each CCG requesting a contribution towards project management support;
- Reviews current commissioned provision and develop future possible models for consideration by the Board in April 2015, whilst taking account of the work already done by the CCGs;
- Following agreement by the Board, work to jointly implement the chosen model by April 2016;
- In addition to the redesign, oversees the implementation of an action plan which captures all partnership actions to support the achievement of the eight outcomes detailed in the report;
- Provides quarterly monitoring updates to the Board and biannual progress updates to the Scrutiny Committee;

The Health and Wellbeing Board will consider the findings of the initial phase of the review and plans for further working in June 2015. However, the review to date has not met the expectation of developing possible future models and not set out what a "good" service would look like.

The review has made the following recommendations:

- Each Clinical Commissioning Group to increase investment in Children and Young People's mental health disorders to meet the Department of Health ambition to spend at least 8% of the total spend on adult mental health disorders on services for children and young people;
- Plan to include CAMHS services in the increase in finance to meet the mandate for parity of esteem for children;

- To robustly contract monitor CAMHS within the existing contract monitoring arrangements in the three separate areas to inform future service development;
- Integrated commissioning approach under the Better Care Fund (virtual-pooled budget) umbrella whilst a more robust system is put into place;
- To develop appropriate contracting and governance arrangements through, for example, a S75 agreement.

Current proposals are for a multi-agency Systems Board to be established, which will undertake a further review of arrangements. Importantly, the recommendations have not been agreed by all partners.

The Systems Board is proposed to be accountable to the Lancashire Clinical Commissioning Board. We are not confident that this further review will lead to the rapid change that is needed to ensure that we are able to offer the best possible service to children and young people. Whilst we will continue to influence and help shape change across all tiers of service our future commitment within the County Council will be to the development of a wellness service, which removes duplication within existing prevention and early help services, and strengthens our preventative offer within Lancashire.

A verbal update on the outcomes of the Health and Wellbeing Board discussion will be available to the Committee at the meeting on 19 June.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The joint, multi agency, development and maintenance of emotional health services is a key component in ensuring that Lancashire is able to make the best use of the resources available in this area. The Committee is asked to note the vital role that joint commissioning and relationships with provider services has in responding to current challenges.

List of Background Papers

Paper	Date	Contact/Tel
Report to Scrutiny Committee – 'Emotional Health and Wellbeing Including Specialist CAMHS'	17 January 2014	Mark Warren (01772) 538297

Evaluation of the Pilot in Preston for Improving Adult Mental Health Services for Young People and Roll-Out Plan for LCFT

Contents


Steering Group
Training Subgroup
Training Design
Evaluation
Delivering Training
Outcomes Subgroup
Data Comparison Q4s
Inter- team Survey
Pathways
Out of Hours Guidance
Transition Guidance
Joint Case Management
Improving Support
Meriden (Systemic Intervention) training
Supervision from CAMHS
Young Peoples Champions
Working with Young People Training
Access to ECR
Feedback forms

Background

Case reviews and inspection reports undertaken in Lancashire had highlighted a lack of equity for young people (aged 16-17 years) in accessing mental health provision and suggested, despite recognition, young people require developmentally appropriate responses to their mental health need. It was noted that some young people were offered interventions that were rooted in adult mental health practice.

A review of the admissions pattern to inpatient beds for young people suggested that more developmentally appropriate interventions provided, particularly, out of hours could have had a significant impact upon keeping young people out of hospital.

A CQUIN programme to incentivise service development within a pilot area had been agreed with commissioners and LCFT, as the service provider, were to meet measures associated with the programme.

The objectives of the pilot were fivefold –

- Improve care for young people (aged 16-17 years) presenting with mental health problems
- Improve out of hours responses
- Provide family centred/systemic interventions
- Improve young people and their carers satisfaction with the services they receive
- Provide evidence of improved outcomes

A critical success factor would be the commitment and involvement from all LCFT teams including – CAMHS, Step 2/3 AMH, Step 4 AMH and Step 5 AMH.

This paper will evaluate the pilot and recommend a roll out programme for the 8 other localities within Lancashire. –

- Lancaster and Morecambe
- Blackpool
- Fylde and Wyre
- Chorley and South Ribble
- West Lancashire
- Blackburn and Darwen
- Burnley and Pendle
- Hyndburn, Rossendale and Ribble Valley

Pilot Site

Preston was chosen as a pilot site as the Adult Mental Health Services (AMHS) and Children and Adolescent Mental Health Services (CAMHS) had good professional relationships and had worked closely through periods of transition for Service Users in the recent past.

Steering Group

As stated above it was critical that all service under AMHS and CAMHS were committed to this initiative and attended monthly development meetings. The steering group was chaired by the Step 4 Service Manager.

The following teams were represented:–

CAMHS – Transition Co-ordinator, Consultant Psychiatrist, Team Manager, Service Manager

Step 2/3 Services – Team Manager

Step 4 Services (CCTT) – Team Manager, Consultant Psychiatrist, Consultant Clinical Psychologist, Service Manager

Step 5 Services (CRHTT and A&E Liaison) – Team Manager, Service Manager.

Roll-Out Recommendations

Recommendation 1 – All Localities to have a Steering Group which meets monthly consisting of -

- **Service Manager (Chair)**
- **CAMHS Team Manager, CAMHS Consultant Psychiatrist**
- **Step 2/3 Team Manager**
- **Step 4 Team Manager, Lead Psychologist**
- **Step 5 Team Manager**

Evaluation of Objectives

1. Improve Care for Young People Presenting with Mental Health Problems

The goal of this objective was to improve the care given to young people presenting with mental health difficulties by raising awareness of growing adolescent brain and impact of trauma for staff working in AMHS namely in Single Point of Access, CCTT, CRHTT and A&E Liaison.

In order to achieve this the steering group developed a number of ideas –

(A) Develop a Training Package for AMHS Teams

A sub-group was formed to develop a training package for all AMHS teams within the pilot site. Initially it was expected that 80% of all staff within CRHTT, CCTT and SPA would receive this training. Outcome measures were developed to measure the effectiveness of this training including pre and post training questionnaires.

Initially there was information to fill 2 days' worth of training but that was condensed into 1 days training. A date was set for 13th December to cover the following topics –

- **Presentation 1** Confidence and fears of working with young people presented by CAMHS Transition Co-ordinator
- **Presentation 2** The physiology of the adolescent brain and the implications of practice presented by CAMHS Consultant Psychiatrist
- **Presentation 3** The REACH project, the impact of childhood adversity presented by a member of the project team.
- **Presentation 4** Working with young people who have ASD presented by Team Leader LD/Complex Needs Team (CAMHS)
- **Presentation 5** Introduction to systemic thinking presented by CAMHS Family Therapist
- **Presentation 6** The experiences of young people and their families in transition presented by CAMHS Transition Co-ordinator

Evaluation

24 AMHS staff attended the training and gave excellent feedback:-

Day 1

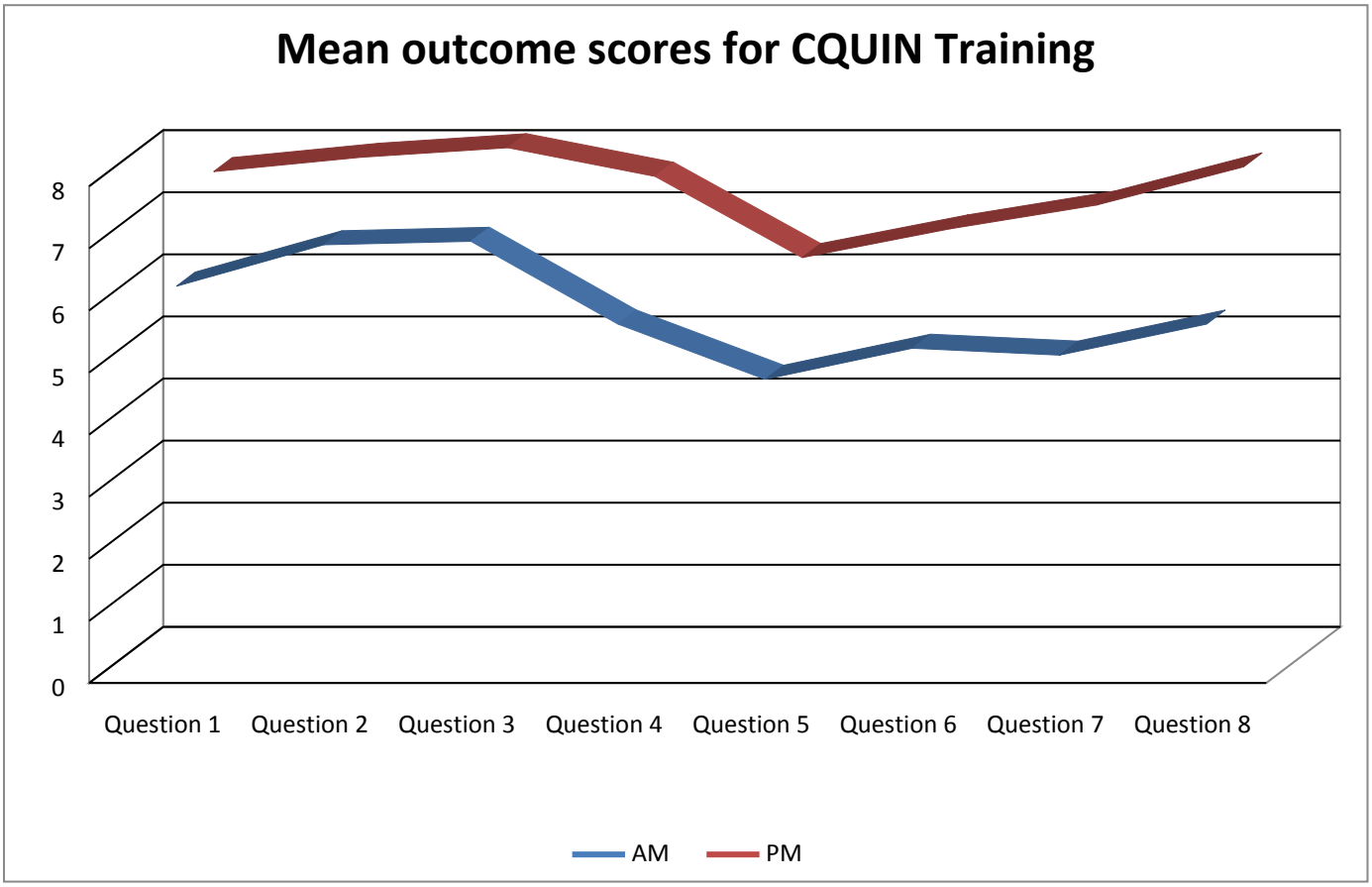
Response rate

AM – 17 PM – 13

Scoring

Questionnaire 1 (see appendix 1)

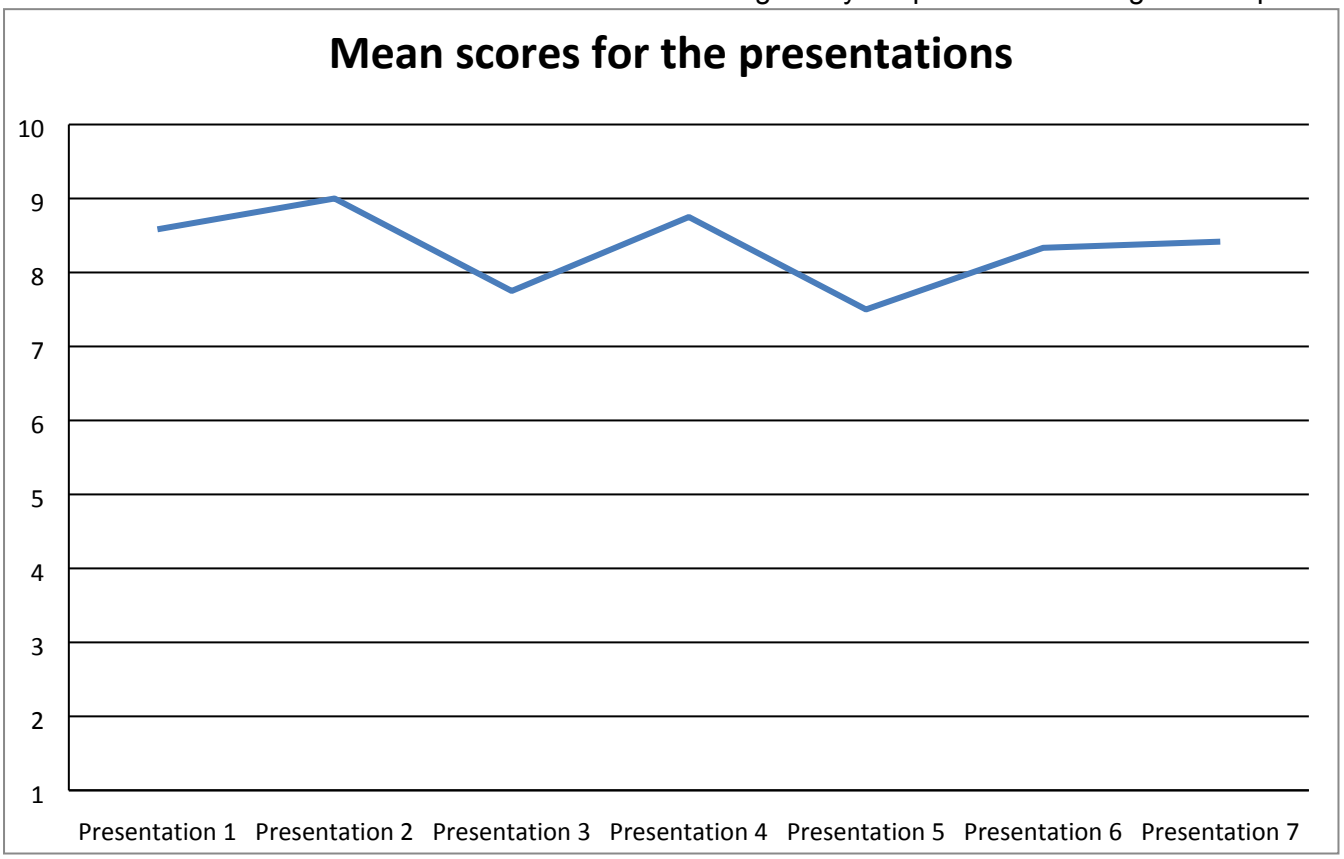
“Using a scale of 1 to 10, with 1 meaning low and 10 meaning high, please rate yourself on the following questions”.



Individual presentations (Appendix 2)

Scoring

"Please rate the individual sessions as below 10 being really helpful and 1 being not helpful at all"



Comments

What could we have done more of?

I found the information giving/review (physical and ASD) to be most helpful

More about what is present or likely to transfer straight to MH services (adult)

Would like to have more about the impact of substance misuse on the developing brain

Physiology

Make sessions more interactive

Biological difference and working with PDD

Physiology how the adolescent brain works

Handouts

Interactive working

Would be happy to learn more about brain development but it was generally really informative

Link to practical working etc

What we could have done less of?

All good

Shorter lectures in afternoon

More discussion group work

What could we have also have done?

Handouts to read to save taking notes

Risk Management

Given information re local services

Discussed management of deliberate self-harm and OD

Reflected on different scores in questionnaire training child services

Talked about changes in services

The staff questionnaire will be followed up in June (6 months after training) to assess longer term impact of the training for practitioners.

Following the training and reflecting on who it would benefit most the group decided that 80% of all staff was not required but felt that all staff within SPA, CRHTT, A&E Liaison should attend future training along with staff within CCTT who are working with young people.

It was also felt that as staff development is the driver for change the training package should also consider:-

Young Minds Guide to Transitions

Chapter 2 General Principles and Key Concepts

http://www.youngminds.org.uk/assets/0000/1331/YM_Prof_Transitions_Guide_email_version.pdf

"Turned Upside Down" – Mental Health Foundation Report

http://www.mentalhealth.org.uk/content/assets/PDF/publications/no_help_in_crisis.pdf?view=Standard

We also need ensure to ensure that the interventions delivered respond to the Young Person's needs, therefore we should also highlight the importance of Person Centred Planning

Your evaluation report clearly confirms the hypothesis that there are internal referrals and discharge issues that illustrate multiple systems within a larger LCFT delivery system rather than responding to a Young person's needs.

Perhaps the training also needs to highlight the importance of Person Centred Planning. Person-centred planning is based on learning through shared action, about finding creative solutions rather than fitting people into boxes and about problem solving and working together over time to create change in the person's life, in the community and in organisations. (Sanderson, 2000)

http://www.jrf.org.uk/system/files/9781859354803.pdf Chapter 2 and http://www.helensandersonassociates.co.uk/media/11242/personalisation-through-person-centred-planning.pdf

The group attempted to arrange further training sessions but due to clinical commitments of the presenters and difficulties with teams releasing staff the next session has been arranged for late June. Due to the these difficulties and the resources involved in the setting up and delivery of the training the following is recommended for roll-out.

Roll-Out Recommendations

Recommendation 2 – LCFT to approach an educational provider to facilitate a training package for the roll out 2014/15. We would also need to work with the commissioner to decide which elements of the training we would need to prioritise.

Recommendation 3 – The following staff need to attend the bespoke training on Young Person Development:-

- **All A&E Liaison staff**
- **All CRHTT Staff**
- **All SPA Staff**
- **CCTT Young People Champions**
- **CCTT MDT working with Young People**

(B) AMHS and CAMHS to Joint Work Where Appropriate

Following discussions within the steering group it was felt that at times Young People could receive interventions from AMHS whilst being case managed by CAMHS. This particularly applied to Young People who were coming up to their 16th birthday and were already under CAMHS and were assessed to require an IAPT intervention prior to discharge.

This was discussed at a meeting between CAMHS and Step 2/3 Services from AMHS and agreement was reached as how these referrals would made and processed. This will be reviewed after 6 months. For this cohort of Young People it was felt a conversation between CAMHS and Step 2/3 Team Managers would be the referral route.

In order for Step 2/3 Services to maintain their required reporting needs and maintenance of IAPT performance monitoring along with the principle that a Service User should have 1 Health Care Record the following was completed –

- GAD 7 and PHQ 9 assessment tools were added to CAMHS ECR
- All AMHS Step 2/3 staff were given access to CAMHS ECR by adding a dropdown option to their log in to ensure their activity was captured correctly.

Evaluation

So far 4 referrals have been made. However, as this was a late development in the project the young people have not been seen yet.

Roll-Out Recommendations –

Recommendation 4 – Each Locality to Develop and Implement a Referral Process for Referrals to Step 2/3 where CAMHS retain Case Management.

Recommendation 5 – All Step 2/3 Staff are given access to record on CAMHS ECR

(C) CCTTs to Nominate Young People Champions

The steering group quickly recognised that the needs of a Young Person under the care of CCTTs where different to those of Adults under their care. It was felt that in order for a Young Person to receive the most consistent and appropriate interventions for their age Young People Champions needed to be nominated for extra training and to receive all referrals of 16/17 year olds. Due to the relatively low numbers of referrals of Young People it was decided that Preston CCTT should nominate and develop 3 practitioners.

Evaluation

Since the inception of this idea 4 referrals from CAMHS have been allocated to the Young People Champions to Preston CCTT. There has been positive feedback from CAMHS about this initiative.

Roll-Out Recommendation

Recommendation 6 – All CCTTs should nominate 2 Young People Champions to receive all referrals aged 16/17.

(D) CAMHS Practitioners to Provide Clinical Supervision to AMH Practitioners

AMH practitioners who have Young People on their caseload should receive clinical supervision from CAMHS practitioners to help guide their interventions and practice. In Preston the CAMHS Transition Coordinator offered this input. This was initially offered to CCTT Care Coordinators but following discussions within the steering group it was decided that this should be extended to CRHTT.

Evaluation

1 face to face supervision has been completed. 1 email conversation but the clinician and the supervisor felt that they were doing OK and was receiving excellent support within the team.

Roll-Out Recommendation

Recommendation 7 – CAMHS should identify how each team will provide support from each locality to provide clinical supervision to the CCTT Champions and CRHTT. They will develop local protocols with the teams.

E) Developing better working relationships between teams and across networks.

A survey of inter-team relationships was developed and members of staff from all the adult teams and CAMHS were invited to complete it. (See Appendix 3).

Evaluation

Despite a small response the survey showed, as we suspected that the knowledge of other services is not as good as it should be. The training as planned was one way to address this. The development of the Steering Group also helped to improve relationships. Additionally, adult team members were invited to join CAMHS staff during their assessment to create an opportunity for experience and learning to be shared. However, at the time of this report this offer had not been utilised.

2 Improve Out of Hours Responses for Young People

The goal of this objective was to reduce the number of young people presenting in crisis out of hours who are admitted to inpatient beds by improving the understanding of adolescent behaviour and provision of age and stage appropriate interventions.

The steering group felt that the development of guidance for practitioners to follow when a young person presents out of hours would be able to supplement the training described in Objective 1. The following was completed –

(A)The Development of Guidance for Staff to Follow When a Young Person Presents Out of Hours

A sub-group was set up to produce this document for Preston services. The guidance developed into a document that could be used upon the presentation of young people to AMHS in and out of hours. (see appendix 4).

The guidance shows potential referral sources, points of contact in AMHS and crucially age specific actions if admitted into AMHS including –

- Most appropriate person to allocate to
- Where to obtain previous records
- Telephone number of CAMHS to obtain either consultation or support
- Social Inclusion guidance
- Age appropriate interventions
- Medication advice
- Prompt for completion of CAF if required
- Advocacy prompt
- Young Person's organisations
- Carers assessment requirements

The guidance also gives discharge guidelines.

Attached to this is the CAMHS to AMHS transition guidance and the LCFT Procedure for safeguarding young people admitted to Adult Wards.

Evaluation

The guidance was completed recently and circulated to CRHTT and A&E Liaison Teams. We await feedback of its use but initial responses indicate this is a very useful document.

Roll-Out Recommendation

Recommendation 8 – Each locality to produce local guidance for teams when a Young Person in in contact with AMHS using the template developed by the pilot site.

(B) A&E Liaison to Attend A&E Safeguarding Meetings

The steering group felt it would be good practice and useful for information sharing if the A&E Liaison Team based at Preston hospital attended the A&E Safeguarding meetings along with CAMHS. The meeting considers the pathways for children and young people (up to 18 years old) attending A&E including those young people who self-harm and those that are experiencing mental health difficulties. The meeting seeks to prevent missed onwards referrals and explores every missed referral with corrective action being taken. It is also an opportunity to share service developments so that there is always a clear understanding of changes that take place and amendments to pathways can be introduced ensuring that children and young people get referred to the right service, first time. Within the meeting initiatives relating to safeguarding within the area

are shared. The meeting is an opportunity to create and develop relationships between services. More recently attention has been given to the training needs of people who working with young people who self-harm or experiencing difficulties with their mental health. The importance and success of the meeting was commented on in a recent CQC inspection as an example of good practice. Furthermore, this was also recognised as Winner of the Teamwork category in the 2014 Lancashire Teaching Hospital Quality Awards.

Evaluation

Preston A&E Liaison team now regularly attends this meeting.

Roll-Out Recommendation

Recommendation 9 – All A&E Liaison Teams to attend their local A&E Liaison Meetings.

3 Family Centred /Systemic Interventions

The goal of this objective is to improve young person and carer's experiences of care and recovery through greater family and systemic interventions and through wider application of CAF processes.

It was accepted that Service Users remained longer in CCTTs than in other AMHS teams and therefore were afforded more time for family/systemic interventions to be completed. This was also to be evaluated using Carers feedback.

(A)Training of CCTT Practitioners in Systemic Interventions

It was decided that 2 practitioners from Preston CCTT should receive Meriden training which focusses on systemic interventions. Initially the practitioners were to attend the LCFT in house Meridian training offered by EIS, however due to the unavailability of the trainers they went to Birmingham to complete the course.

Evaluation

Following completion of the training one practitioner has been allocated a case and is joint working with the Clinical Psychologist in the team initially. They are also receiving supervision from the Clinical Psychologist. There is also a possibility that they can receive group supervision from the Meriden trained staff in EIS. The other practitioner does not have capacity to take a case but the Team Manager is aware of this and is looking at balancing the workload.

Recommendation for Roll-Out

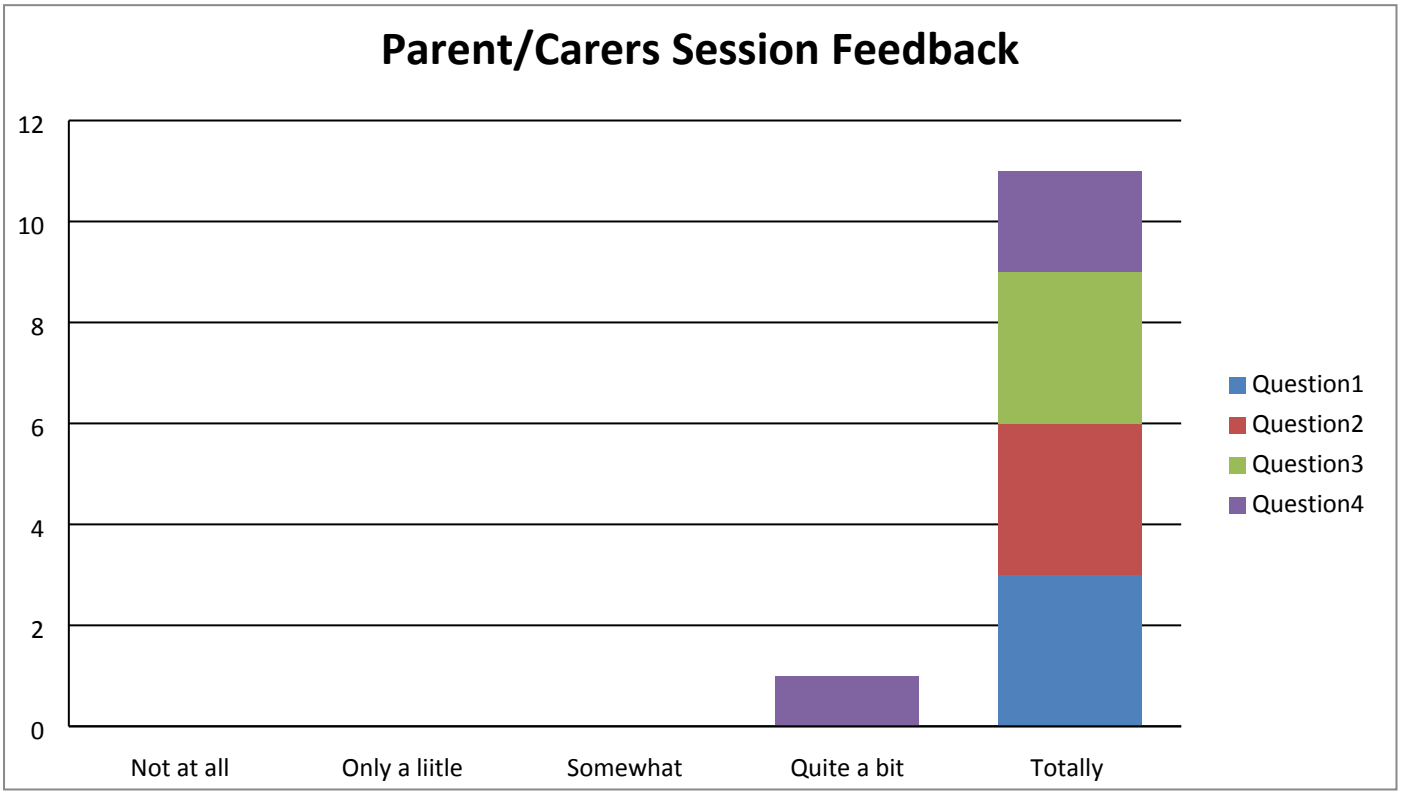
Recommendation 10 – 2 Practitioners for each CCTT to receive in-house Meriden (Systemic Intervention) training.

(B) Carer Satisfaction Survey

In order to evaluate the AMHS in relation to carers satisfaction the steering group agreed to use the CAMHS IAPT Questionnaire. (Appendix 5). It was suggested that questionnaires should be completed after each intervention. **Please note it was observed that the only difference between the child/young person (appendix 6) and family questionnaires are the colour and the title at the bottom of the page. It was therefore decided that the child/young person's form should be the only one issued to clinicians but used to gather the views of family members as well.**

Evaluation

There were 3 Parent/Carers questionnaires completed each a single appointment. The results were overwhelmingly positive about the sessions.



Recommendation for Roll-Out

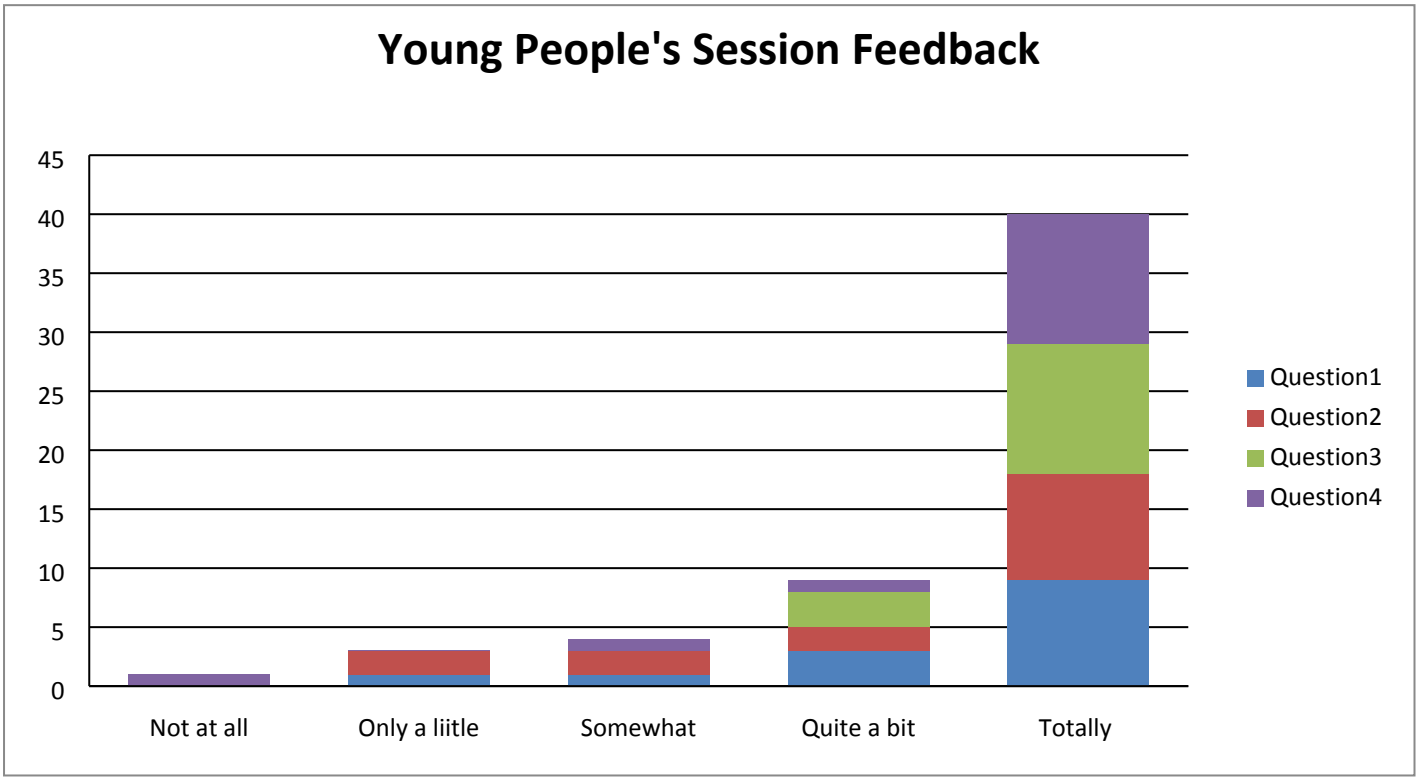
As the pilot site used a CAMHS questionnaire it was felt by the steering group that it would be for the AMHS network to decide how best they would like to capture Carer's feedback.

4 Improve Young Person's Satisfaction With Services Received

The goal of this objective was that the views and opinions of young people are routinely sought and used to inform service provision. It was agreed that the CAMHS IAPT Questionnaire would be used after every intervention. (Appendix 6).

Evaluation

There were 15 completed feedback forms from 5 young people. The least number of appointments the young person completed the forms for was 1 the highest number was 5 appointments.



Recommendation for Roll-Out

As the pilot site used a CAMHS questionnaire it was felt by the steering group that it would be for the AMHS network to decide how best they would like to capture Young People's feedback

5 Evidence of Improved Outcomes

The goal of this objective was for the CAMHS National Data Set is to be used to record all activity for young people up to their 18th birthday.

Alongside this a sub-group was developed to look at other outcome measures that could inform practice.

The CAMHS national Data set should include information about service demand and responses. However, to date we have been unable to secure that information.

However, we did complete a study of two periods (Quarter 4 2013 and Quarter 4 2014). This gave some baseline data in beginning to understand the needs of young people and their service usage.

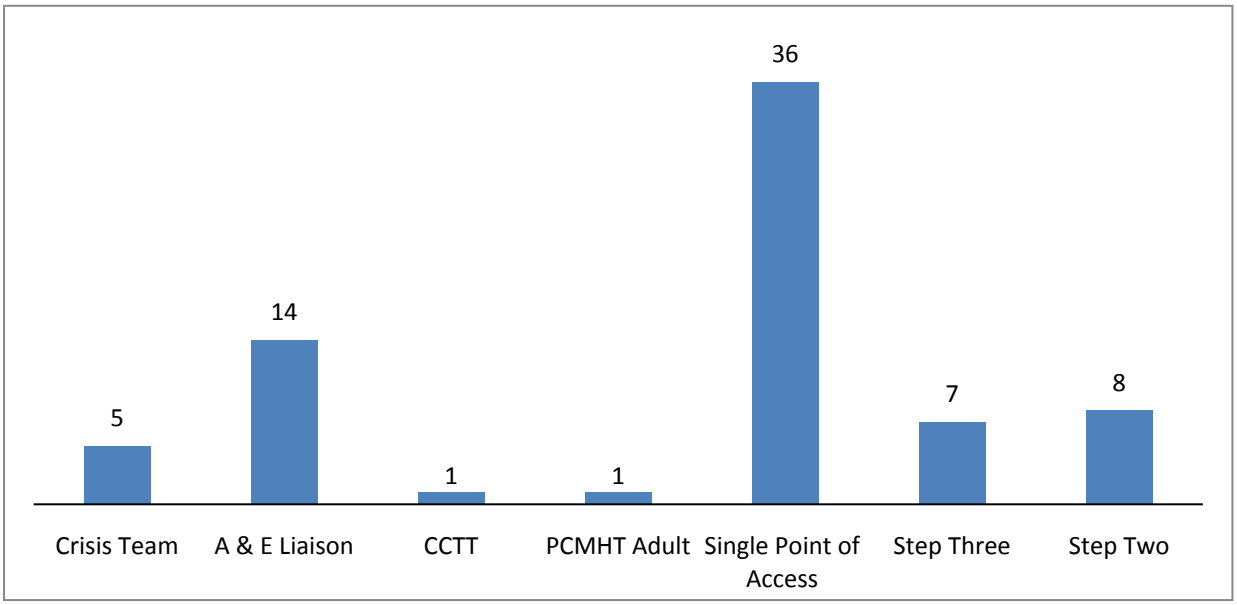
Evaluation

In the absence of the Dataset the information gathered as described produced the following information.

Referrals to adult mental health services and previous CAMHS involvement.

Data from 1 January 2013 to 31 March 2013

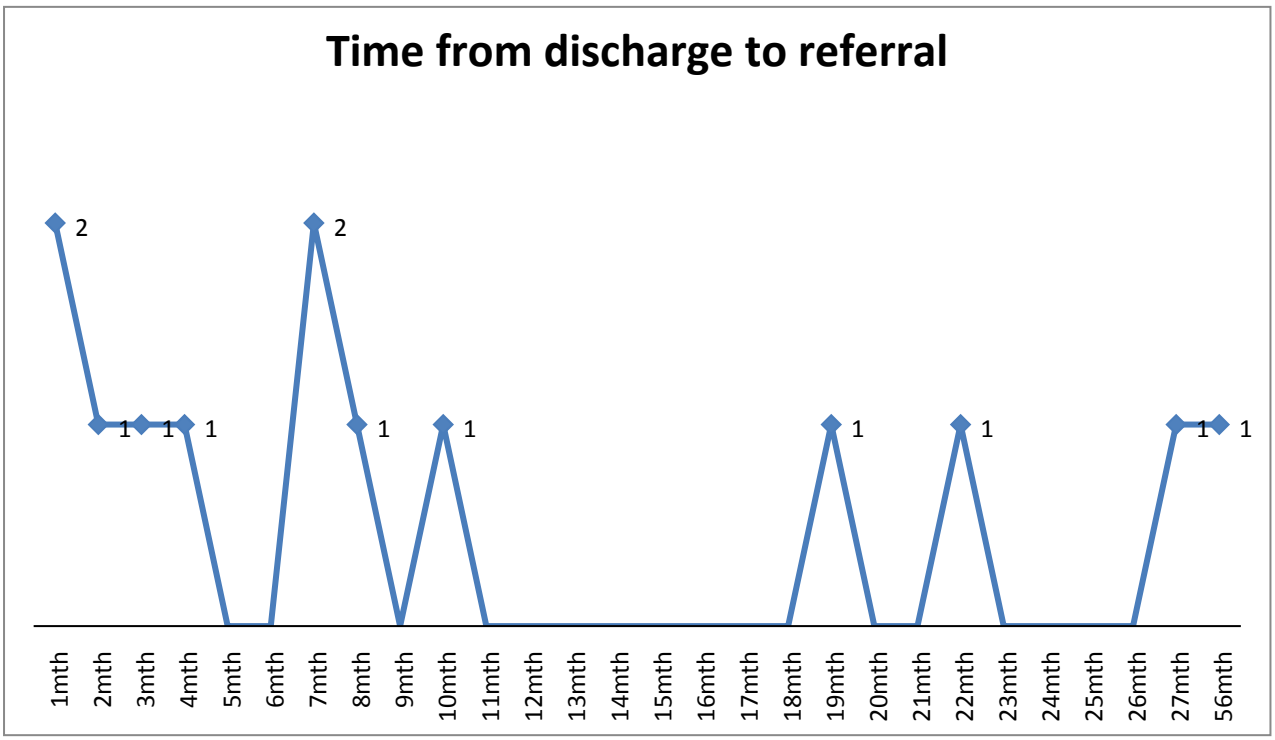
73 referrals for young people aged 16 – 17 at the time of the referral



Some young people had 2 or more referrals. In total **49** individuals had referrals to adult services.

Of these 49, **41%** (20 young people) were known to CAMHS. Of the 49, **8** were open to CAMHS at the time of the referrals. Of those 8, **4** were referrals to A&E Psychiatric Liaison.

Duration between CAMHS discharge and adult referral

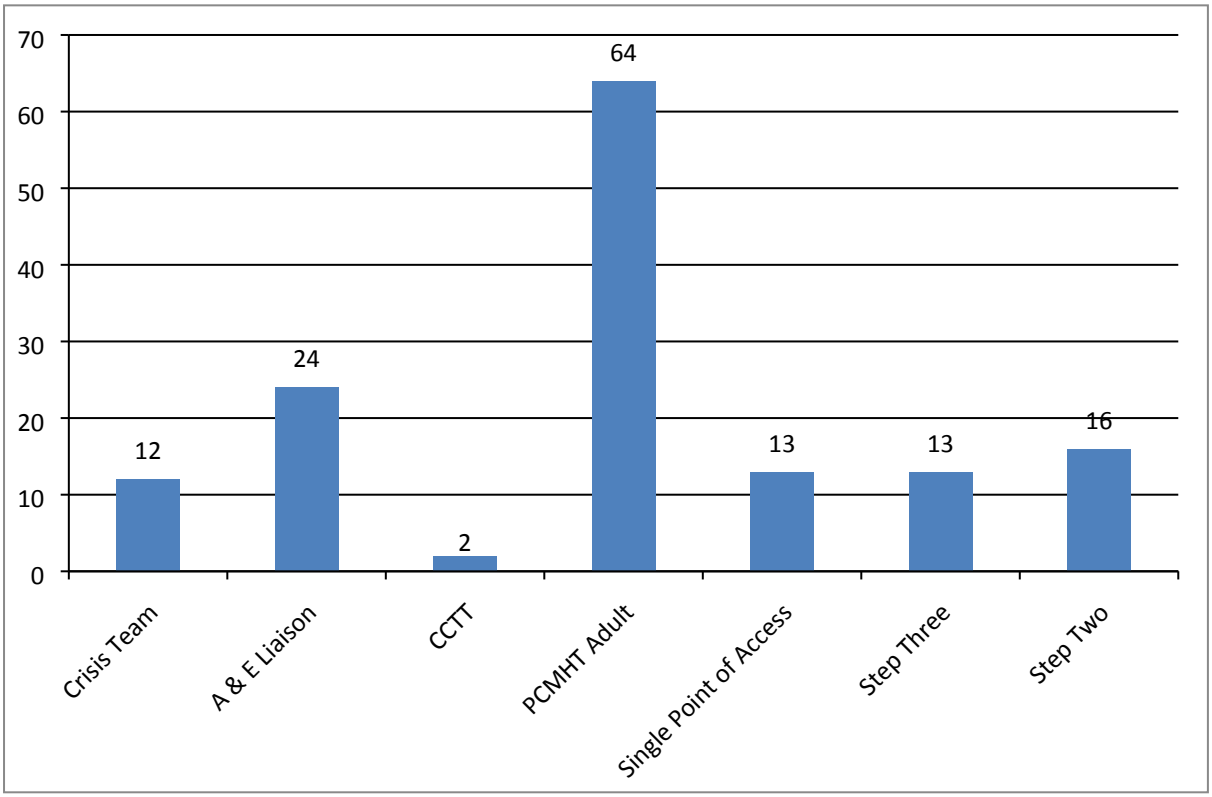


Referral Point/Referrer/CAMHS reason for discharge

Time	Referred to	CAMHS Involvement
1 Month	Crisis Team	Transitioned to EIS
2 Month	SPoA	Discharged DNAs
3 Month	CCTT	Discharged as transitioned
4 Month	Crisis Team	Discharged DNAs
7 Month	SPoA	Discharged DNAs
7 Month	SPoA	Transferred to psychology
8 Month	SPoA	Discharged
10 Month	A&E Liaison	Open to YOT CAMHS Discharged
12 Month	Step 3	Discharge DNAs
1 Year 7 Months	A&E Liaison	Discharge pt request
1 Year 10 Months	SPoA	Discharge DNAs
2 Year 3 Months	SPoA	Discharge DNAs
4 Year 2 Months	SPoA	Discharged

Data from 1 January 2014 to 31 March 2014

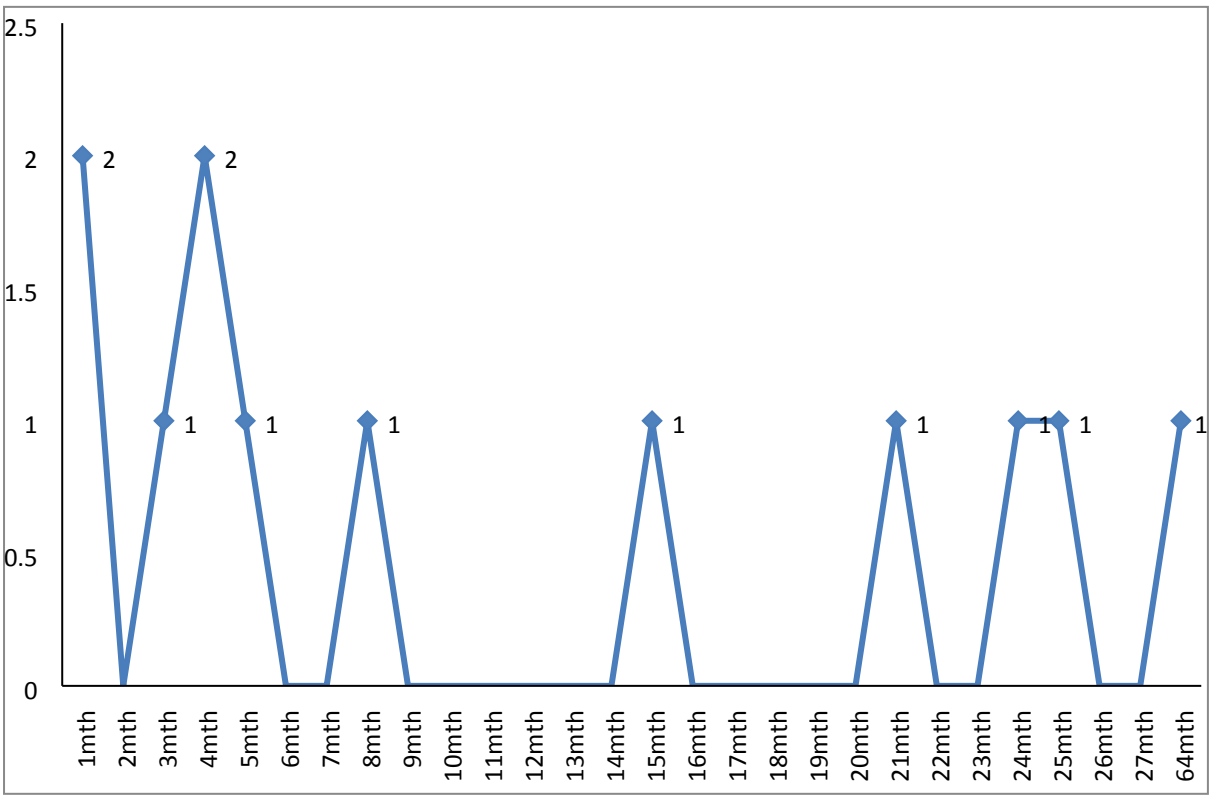
131 referrals for young people aged 16 – 17 at the time of the referral



Some young people had 2 or more referrals. In total **82** individuals had referrals to adult services.

Of these 82, **34%** (28 young people) were known to CAMHS. Of the 82,**13** were open to CAMHS at the time of the referrals. Of those 13, **3** were referrals to A&E Psychiatric Liaison and **4** were referrals to the Crisis Team. 1 young person was from Fylde and Wyre and 2 young people were from out of county and we were unable to follow up their history.

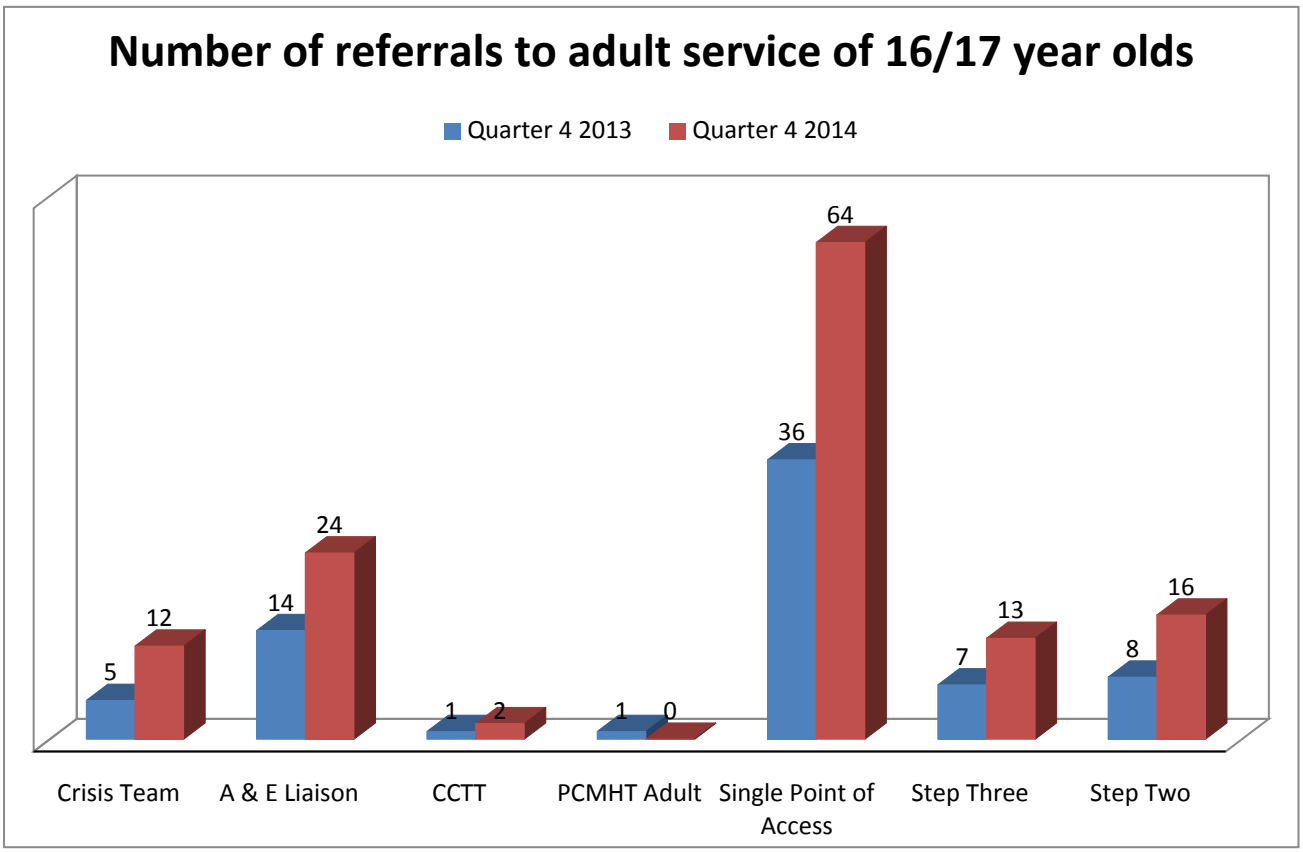
Duration between CAMHS discharge and adult referral



Referral Point/Referrer/CAMHS reason for discharge

Time	Referred to	CAMHS Involvement
<1month	Crisis Team	Discharge pt choice
1 Month	A&E Liaison	Discharged DNAs
1 Month	SPoA	Discharged DNAs
3 Month	SPoA	Transition to ADHD
4 Month	A&E Liaison	Transitioned to EIS
4 Month	A&E Liaison	Discharged DNAs
5 Month	Crisis Team	Discharged pt choice
6 Month	SPoA	Discharged pt choice
7 Month	SPoA	Discharged pt choice
1 Year 3 Months	A&E Liaison	Discharged
1 years 9 months	SPoA	Discharged no contact
2 years 0 months	SPoA	Discharged
4 Years	A&E Liaison	Discharge DNAs

Side by side comparisons



In Q4 2014 adult services experienced an **82%** increase in referrals for 16/17 year olds from the same period in 2013.

The change in CAMHS procedure to not accept new referrals for young people who are 16 years and older meant that **8** young people would have been previously seen by CAMHS. However, **3** of these young people were seen by A&E Liaison appropriately but would previously had been followed up by CAMHS rather than adult services. If CAMHS had not changed their boundaries this would have still resulted in **71%** increase in the two years.

In CAMHS there was an increase in 2013/2014 referrals of **10%** (7% accepted) from the referral rate at 2012/2013.

Unfortunately, we are unable to compare the Quarter 4 2014 CAMHS referral figures.

Recommendation for Roll-Out

Further exploration of the referrals of young people would enable a picture of service demand to be developed and mapped.

Additional areas of interest could include young people's DNAs particularly at first appointment and support of parent/carers of young people who attend adult mental health services.

Recommendations for Roll-Out

Recommendation 1 – All Localities to have a Steering Group which meets monthly consisting of -

- **Service Manager (Chair)**
- **CAMHS Team Manager, CAMHS Consultant Psychiatrist**
- **Step 2/3 Team Manager**
- **Step 4 Team Manager, Lead Psychologist**
- **Step 5 Team Manager**

Recommendation 2 – LCFT to approach an educational provider to facilitate a training package for the roll out 2014/15.

Recommendation 3 – The following staff need to attend the bespoke training on Young Person Development –

- **All A&E Liaison staff**
- **All CRHTT Staff**
- **All SPA Staff**
- **CCTT Young People Champions**
- **CCTT MDT working with Young People**

Recommendation 4 – Each Locality to Develop and Implement a Referral Process for Referrals to Step 2/3 where CAMHS retain Case Management.

Recommendation 5 – All Step 2/3 Staff are given access to record on CAMHS ECR

Recommendation 6 – All CCTTs should nominate 2 Young People Champions to receive all referrals aged 16/17.

Recommendation 7 – CAMHS should identify how each team will provide support from each locality to provide clinical supervision to the CCTT Champions and CRHTT. They will develop local protocols with the teams.

Recommendation 8 – Each locality to produce local guidance for teams when a Young Person in in contact with AMHS using the template developed by the pilot site.

Recommendation 9 – All A&E Liaison Teams to attend their local A&E Liaison Meetings.

Recommendation 10 – 2 Practitioners for each CCTT to receive in-house Meriden (Systemic Intervention) training.

Recommendation 11 – For the AMHS network to decide how best they would like to capture Young People and their Carer's feedback.

Recommendation 12 - Further exploration of the referrals of young people would enable a picture of service demand to be developed and mapped.

Additional areas of interest could include young people's DNAs particularly at first appointment and support of parent/carers of young people who attend adult mental health services.

Cost of Pilot

In trying to understand the cost of implementing the changes we looked to the costs of implementing the pilot.

Please note all the costs for this are using the LD CAMHS Tariff Costs which are inclusive of all on costs including infrastructure and management.

The Steering Group

Meetings	Number	Staff attended
Steering Group	9	Varied Average of 5
Training Subgroup	2	(4 and 2)
Inter-team working subgroup	1	3
Joint responsibility meeting	1	4
Meeting with Commissioners	3	3

The biggest input to the pilot project was from the Project Lead and Transition Co-ordinator CAMHS. To be able to develop and indicative figure of the project we looked at how many email were generated.

For the Transition Co-ordinator there were 245 emails received and 143 emails sent. If we take an average of 5 minutes to read and compose emails (including attachments) emails contributed to 32.3 hours work. This equates to a cost of £2910 (Band 7). The Project lead would have a similar amount of emails. For analysis other members of the group is estimated to have had between 50% (5 members) and 25% (3 members) of these emails with the remaining two members reading but not undertaking taking actions from the emails depending on their role with in the project. This equates to 176 hours spent on the project communicating by emails

NB The number of emails relates only to the Pilot Group and not the work undertaken for this evaluation.

Training

The training was delivered in-house by clinical staff. The training for Day 1 was costed at £4489. This included preparation time (estimated at the same amount as attendance time) but did not include travel time. The venue was within the team base so no additional costs were involved. The evaluation of the training took 1 day at a cost of £533. Future training may negate or at least reduce the amount of preparation time needed. Additionally, some trainers stayed for the whole day so that the quality and flow of the training could be explored with them. Of course additional to this is the staff time for participants to attend the training.

Pathway Development

Creating an explanation of the out of hours pathway for young people. Exploring policy and developing the guide.

Data Analysis

Exploring the data took 1 day for 2013 and 1.5 days for 2014. The survey took approximately X hours to develop but the results were instantaneous

Supervision

1 supervision session

Meridan Training

2 staff to attend the week long Meriden Training in Birmingham.

Cost Framework

Steering Group	**9**	**1 Consultant**	**4 others**	**£8,100**
Training Group 1	**1**		**3 others**	**£510**
Training Group 2	**1**		**2 others**	**£180**
Outcomes Group	**1**	**1 Consultant**	**2 others**	**£510**
Training Day 1	**1**	**1 Consultant**	**4 others**	**£4489**
Pathways 1	**1**		**4 others**	**£600**
Meetings with Commissioners	**3**		**3 others**	**£1620**
Data Analysis	**1**		**1 other**	**£1592**
Supervision	**1**		**1 other**	**£270**
Meriden Training			**2 other**	**£1405**
Emails			**All**	**£15843.15**

Total £35,119.15 (this does not include travel time or expenses)

Appendices

Questionnaire Training CQUIN Age Appropriate services

This questionnaire was completed am ☐ ☐ post ☐ ng

Using a scale of 1 to 10, with **1 meaning low** and **10 meaning high**, please rate yourself on the following questions;

1. When allocated a young person to work with, how confident do you feel in your ability to support them?

1 2 3 4 5 6 7 8 9 10

2. How confident are you when engaging and communicating with young people?

1 2 3 4 5 6 7 8 9 10

3. How likely are you to involve other family members when supporting the people you work with?

1 2 3 4 5 6 7 8 9 10

4. How would you rate your knowledge of the differences in working with young people compared to adults?

1 2 3 4 5 6 7 8 9 10

5. How aware are you of the services available for young people?

1 2 3 4 5 6 7 8 9 10

6. How confident would you feel in making referrals to services for young people?

1 2 3 4 5 6 7 8 9 10

7. How confident do you feel in identifying young people who may need an assessment for ADHD?

1 2 3 4 5 6 7 8 9 10

8. How would you rate your knowledge of where to search for information to help you to support young people?

1 2 3 4 5 6 7 8 9 10

Appendix 1

Questionnaire Training CQUIN Age Appropriate services

This questionnaire was completed an☐ ☐ po☐ning

Please rate the individual sessions as below 10 being really helpful and 1 being not helpful at all

Ian Wood - Confidence and fears of working with Young People

1 2 3 4 5 6 7 8 9 10

Dr Robinson – The physiology of the adolescent brain

1 2 3 4 5 6 7 8 9 10

Lesley Wilson – The REACH Project

1 2 3 4 5 6 7 8 9 10

Sarah Wright -ASD

1 2 3 4 5 6 7 8 9 10

Julia Halpin – Systemic Thinking

1 2 3 4 5 6 7 8 9 10

Ian - Transition.

1 2 3 4 5 6 7 8 9 10

Ian/manager – round up of the day, introduce the resource packs.

1 2 3 4 5 6 7 8 9 10

About the day generally please help us to plan future training by telling us what:

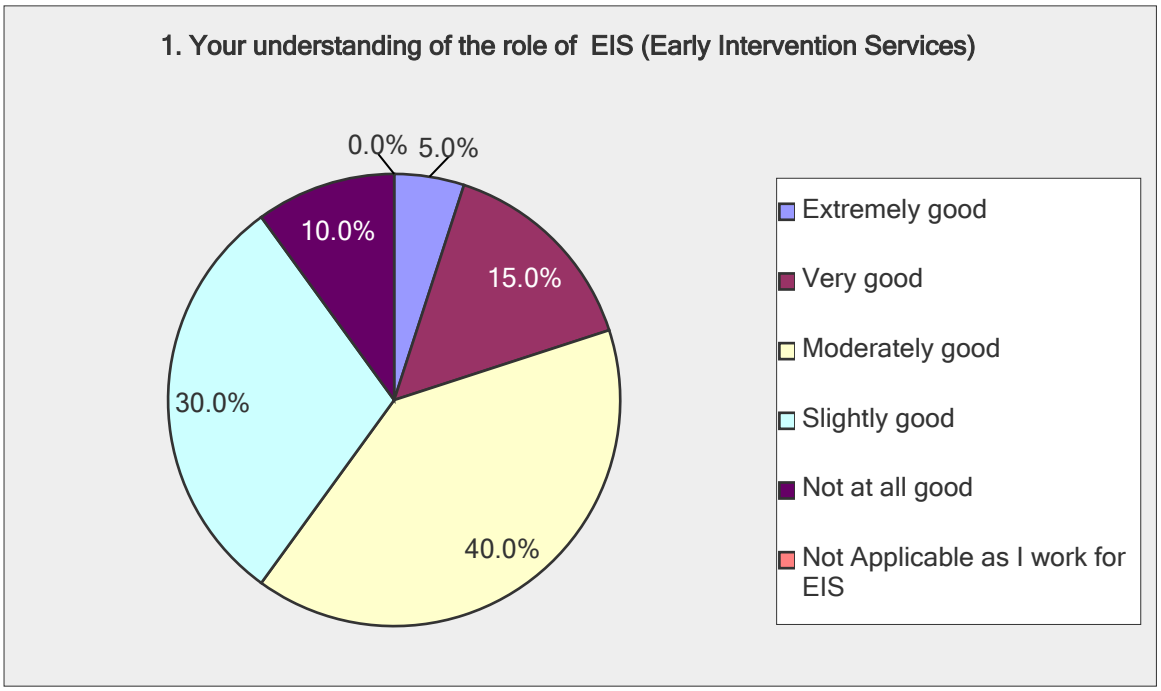
We could have done more of?

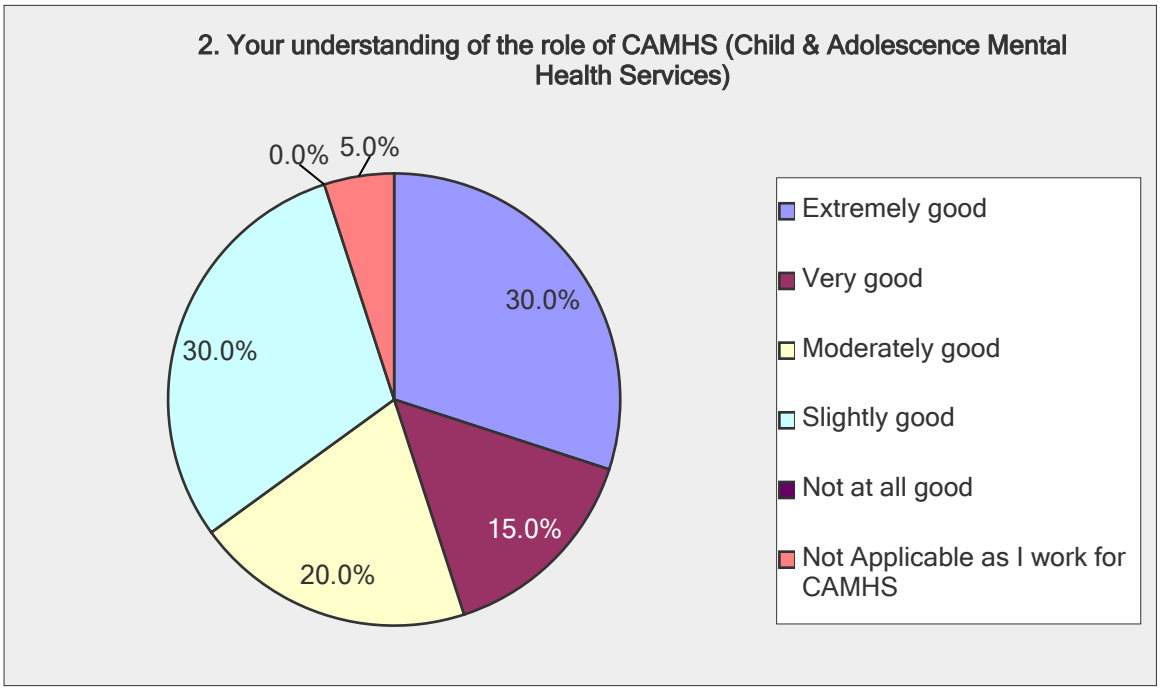
We could have done less of?

We could also have done…..

Appendix 2

CQUIN Team Survey 2013





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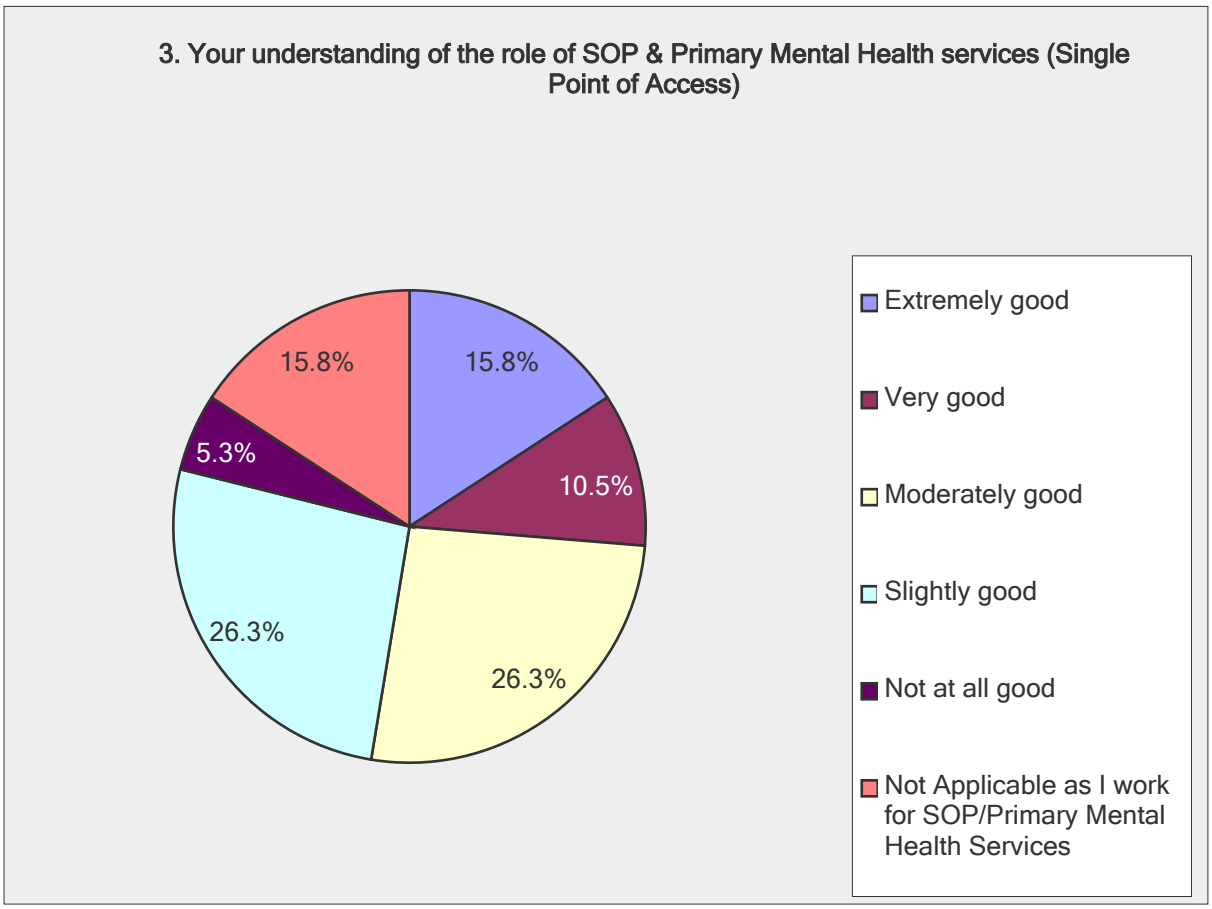
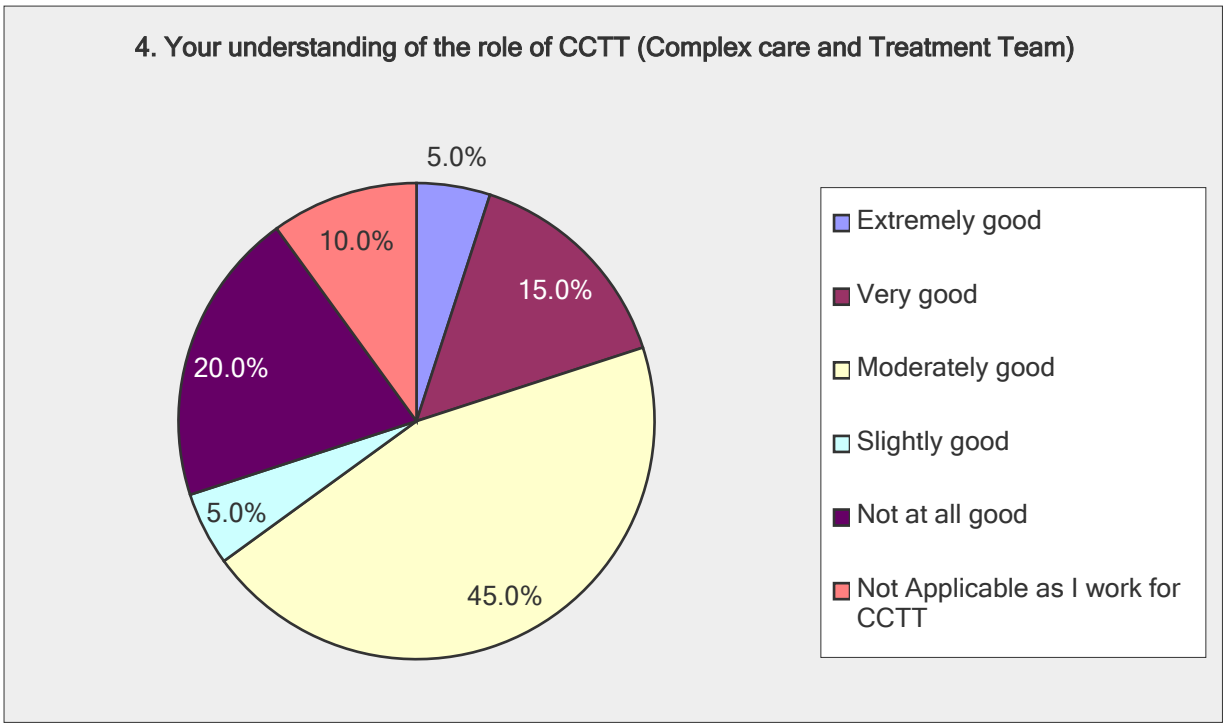
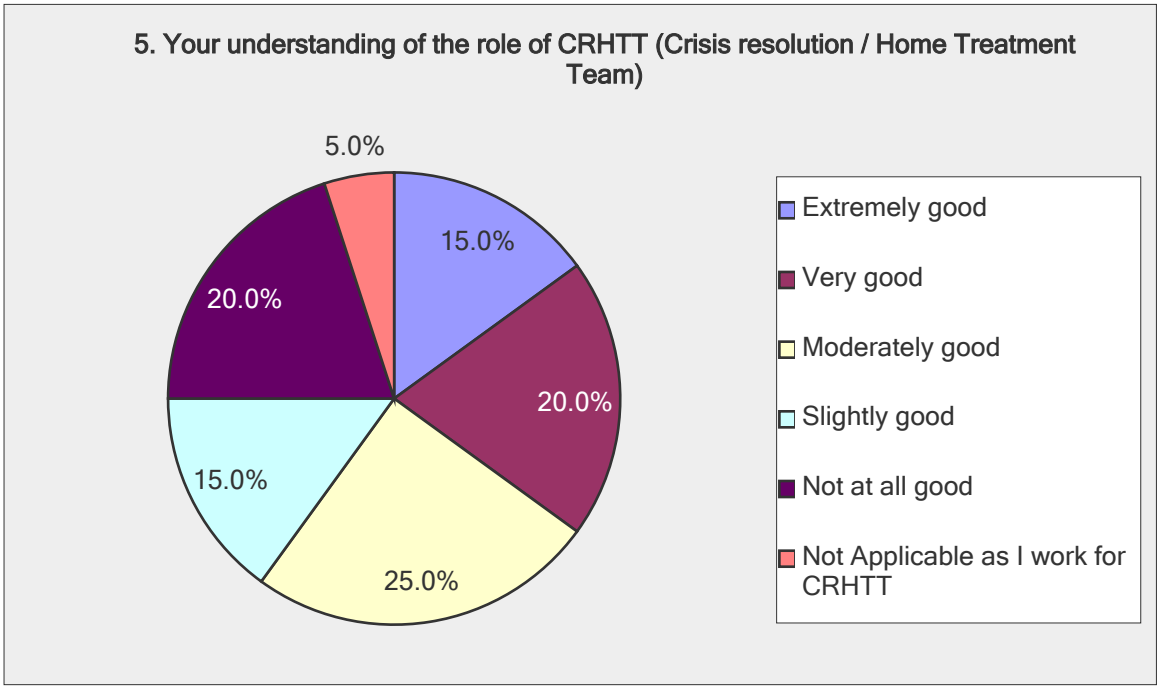
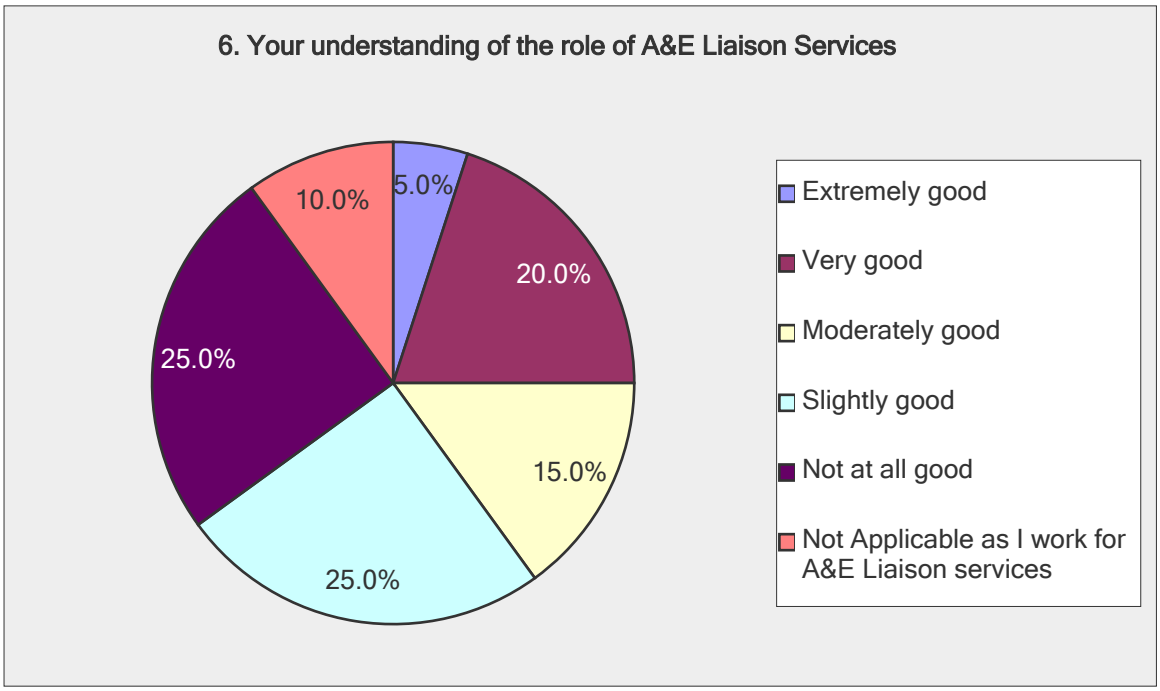

3. Your understanding of the role of SOP & Primary Mental Health services (Single Point of Access)
15.8%
15.8%
5.3%
10.5%
26.3%
26.3%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I work for SOP/Primary Mental Health Services

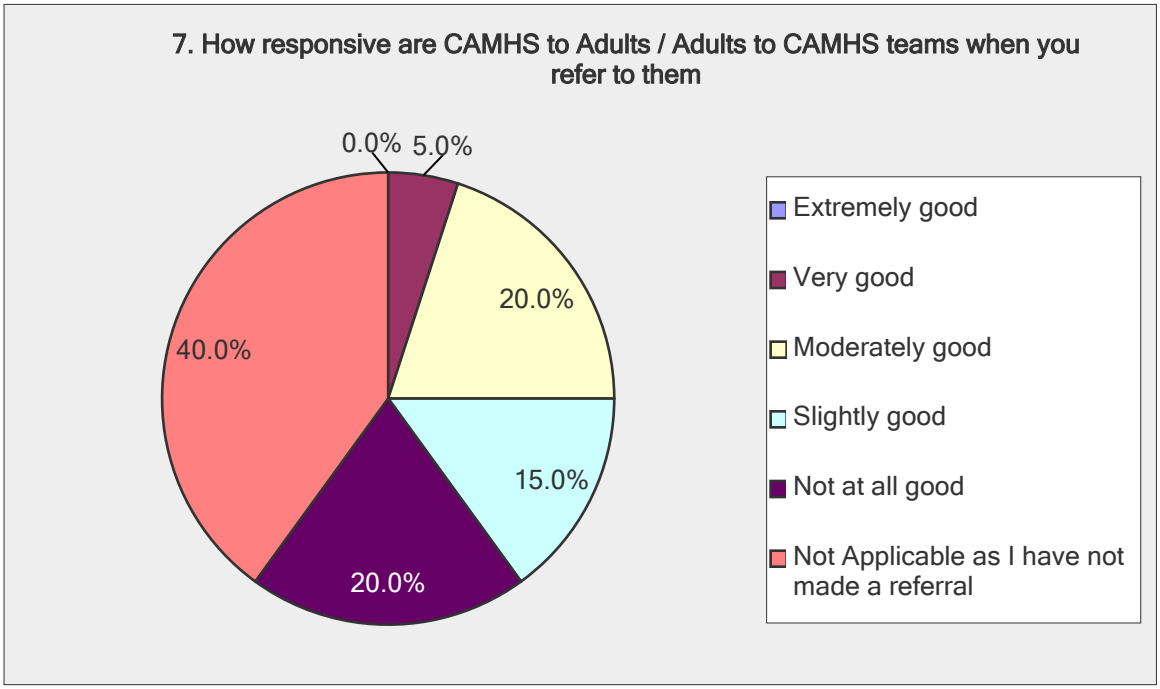

4. Your understanding of the role of CCTT (Complex care and Treatment Team)
5.0%
10.0%
15.0%
20.0%
5.0%
45.0%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I work for CCTT

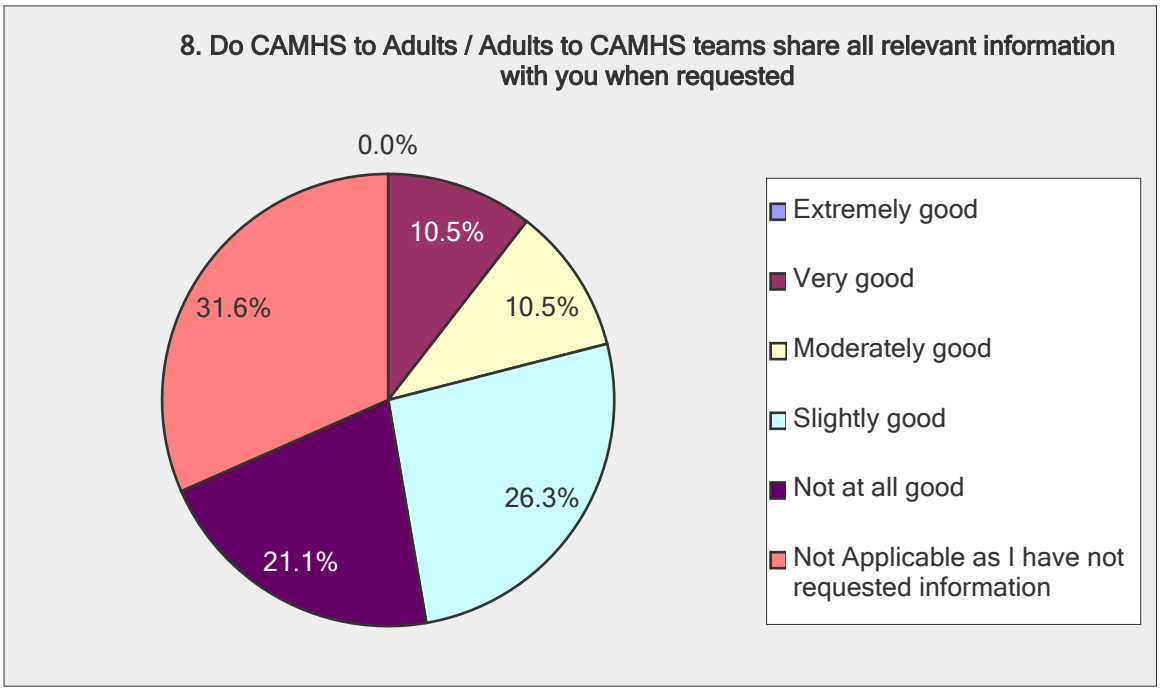
Appendix 3


5. Your understanding of the role of CRHTT (Crisis resolution / Home Treatment Team)
5.0%
15.0%
20.0%
20.0%
15.0%
25.0%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I work for CRHTT

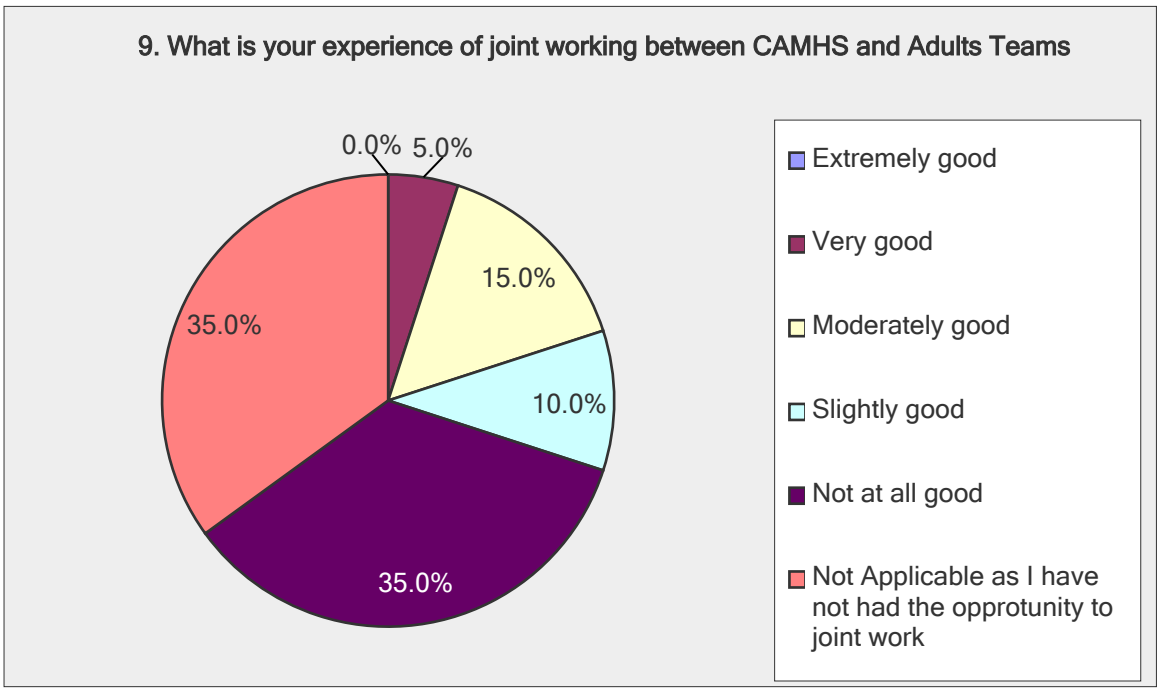

6. Your understanding of the role of A&E Liaison Services
10.0%
5.0%
20.0%
25.0%
15.0%
25.0%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I work for A&E Liaison services

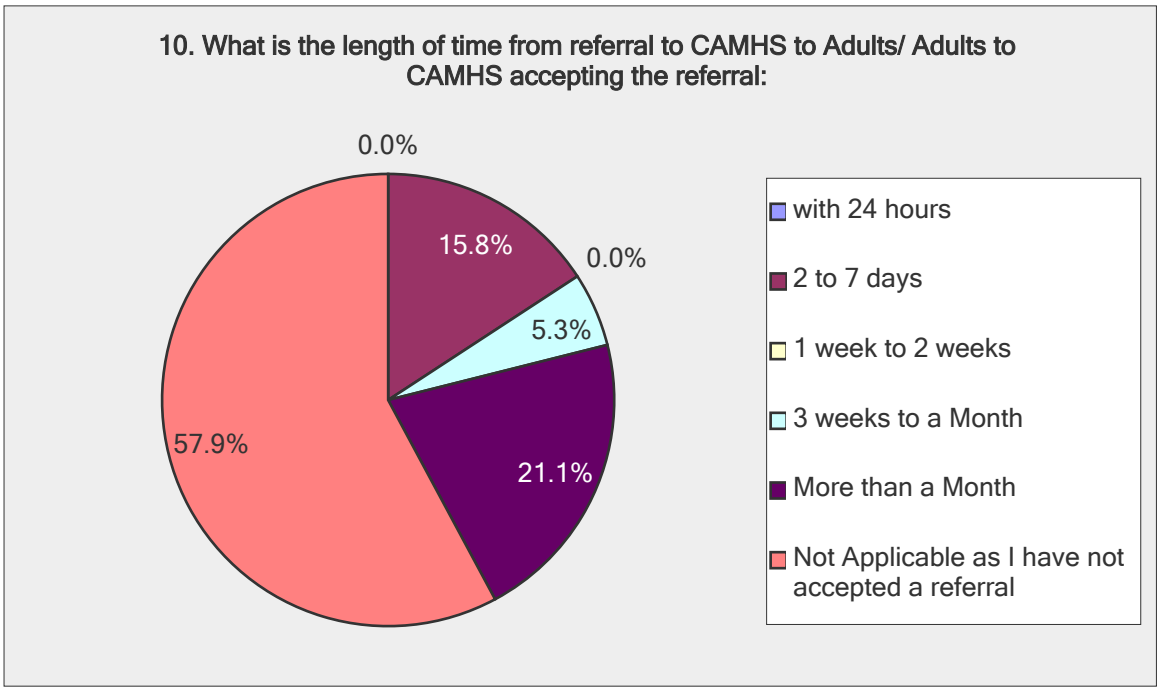
Appendix 3


7. How responsive are CAMHS to Adults / Adults to CAMHS teams when you refer to them
0.0%
5.0%
20.0%
40.0%
15.0%
20.0%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I have not made a referral


8. Do CAMHS to Adults / Adults to CAMHS teams share all relevant information with you when requested
0.0%
10.5%
10.5%
31.6%
26.3%
21.1%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I have not requested information

Appendix 3


9. What is your experience of joint working between CAMHS and Adults Teams
0.0%
5.0%
15.0%
35.0%
10.0%
35.0%
Extremely good
Very good
Moderately good
Slightly good
Not at all good
Not Applicable as I have not had the opprotunity to joint work


10. What is the length of time from referral to CAMHS to Adults/ Adults to CAMHS accepting the referral:
0.0%
15.8%
0.0%
5.3%
57.9%
21.1%
with 24 hours
2 to 7 days
1 week to 2 weeks
3 weeks to a Month
More than a Month
Not Applicable as I have not accepted a referral

Appendix 4

Lancashire Care NHS
NHS Foundation Trust

Guidance for Teams for when a 16-17 year old is in contact with Adult Mental Health Services

Table of Contents

Introduction

This procedure aims to address consistency and high standards of care for young people accessing mental health services in Preston. Preston is the first locality in the LCFT footprint to pilot the CQUIN Child and Adolescent Mental Health Services (CAMHS) targets with a view to roll out across the rest of the LCFT footprint within 2014.

Young people previously accessed CAMHS, although, Preston Central now provides care and treatment for this age group within adult mental health services.

This procedure aims to provide staff working within these services guidance as to how this group of service users should be managed when accessing adult mental health services, whilst jointly working with CAMHS when applicable. Joint working will occur when a young person is being transitioned from CAMHS to adult services as care is required to continue (this is explained more in Appendix 3).

Specifically, when caring for young people presenting with mental health difficulties, this procedure is aims to support how staff gain awareness of the growing adolescent brain and the impact of the experience for staff working with this service user group.

Improving the understanding of adolescents should assist with signposting to appropriate services/interventions to reduce the number of young people presenting in crisis out of hours who require admission to an inpatient beds.

This procedure also aims to improve the experiences of care and recovery through greater family and systemic interventions and through the wider applications of the Common Assessment Framework process when necessary.

1.0 Scope

This procedure is aimed at the following mental health services within the Preston Central locality:

- CAMHS
- Primary Care Mental health team (PCMHT)
- Single Point of Access (SPoA)
- Complex care and treatment Teams (CCTT)
- Crisis Resolution and Home Treatment Teams (CRHTT)
- Early Intervention Service (EIS)
- Inpatient psychiatric facilities
- Eating Disorder Service

2.0 Definitions

The following definitions are applicable to this procedure:
Young person – defined as a 16-17 year old person
Child and Adolescent Mental Health Service (CAMHS)

Primary Care Mental Health Team (PCMHT)
Single Point of Access (SPoA)
Complex Care and Treatment Teams (CCTT)
Crisis Resolution and Home Treatment Teams (CRHTT)
Early Intervention Service (EIS)
Inpatient psychiatric facilities
Eating Disorder Service

3.0 Duties

Each staff member within the defined teams, are expected to follow the procedure when a young person comes into contact with a mental health services. There are specific young person key workers identified in each of the adult teams who have obtained further training in this field relevant to the contacts they will have with young people. They will work closely with the young person as the named key worker/care co-ordinator, or supervise and advise staff who are working with the young person.

It is the Team Manager responsibility to ensure that there are staff within the team with specific skills to work young people. They must also ensure these guidelines are embedded within practice.

4.0 The Procedure

In order to understand the procedure, the source of the referral and the point of access of this referral are identified in the procedural flow chart below. This then provides the dictates standards required in order to care and treatment young person contacting adult mental health services.

There are further specific standards that must be followed when a young person is admitted to an adult inpatient facility, which are also detailed below.

Young People (16-17 year old) Contacting Preston Mental Health Services

SOURCE OF REFERRAL

- GP
- CAMHS
- School
- College
- Self
- Parent /Guardian
- General hospital depts.
- Social care
- School Nurses
- CAMHS (at 16th birthday) See **APPENDIX 2** – Transition Protocol
- Edge of Care (Barnardo's)

POINT OF CONTACT INTO MENTAL HEALTH SERVICE

- Mental Health A&E Liaison
- Single Point of Access
- Primary Mental Health Care (PCMHT)
- Crisis Resolution & Home Treatment (CRHTT)
- Complex Care and Treatment team (CCTT)
- Early Intervention Service (EIS)
- Criminal Justice Liaison (CJL)
- Inpatient facility

AGE SPECIFIC ACTIONS IF ADMITTED INTO SERVICE -

These actions are in addition to regular care and treatment pathways.

- Care Coordinator /keyworker should be preferably a CAMHS/young person link worker in the team
- Obtain records from referral source e.g. School, CAMHS
- Call Ellen House CAMHS for consultation and support - **01772 777344**
- Social Inclusion work to applicable to need and age
- Interventions offered to be adapted appropriately to age and maturity, for example, in relation to family involvement, links with school etc.
- If medication required Locality pharmacist can assist with advice due to being under 18
- Complete CAF if concerns identified
- Inform the young person of what advocacy service can do to assist them
- Is there a need for young person's organisations to be involved at any stage e.g. connexions etc.
- Complete carers assessment with the family/guardian if applicable
- Liaise with other partners as necessary: Homeless Team, Drug and Alcohol services
- Where possible, young people are to be fast tracked within the service they are accessing.

DISCHARGE PATHWAYS OUT OF COMMUNITY SERVICES

- Refer back to GP with concise discharge from service letter
- Inform College/School pastoral care of discharge and possible follow care.
- Ensure the young person and their parents/guardian, if applicable, are in agreement with Crisis Contingency Plan
- If admission into an inpatient bed is required, a young persons bed is to be sought, if not adolescent beds available, an adult inpatient bed may be used – if so, use the 2 documents in **APPENDIX 1** – 'Alerting the safeguarding team' and 'Admission checklist'

When young people are admitted to adult inpatient wards
The following checklist has been designed to meet the requirements within the LCFT 'Safeguarding young people admitted to adult wards' (CP002) and the guidelines stipulated within the Pushed into the Shadows action plan. This checklist is to be completed alongside the normal admission pathway for the ward.


Procedure For
Safeguarding Young I

The Care Quality Commission (CQC) must also be notified of the admission onto a psychiatric inpatient unit, the procedure attached below must be followed. The form at the end of the procedure must be completed and forwarded to the Units Mental Health Administrator who will then forward to the CQC.


The admission of
children and adolesce

5.0 Training

Training to identified staff within the teams will be given to ensure there are link workers within each team with an increased knowledge and awareness of the care and treatment young persons and how to assess their needs.

There will be nominated staff within each of the teams, they will be seen as the young person link workers, they will continue to develop their skills and be seen as a point of contact within the team they work within.

Appendix 1

NOTIFICATION TO LCFT SAFEGUARDING TEAM OF ADMISSION OF YOUNG PERSON (16 or 17 years) TO ADULT MENTAL HEALTH WARD

DATE OF ADMISSION/CONTACT	
DETAILS OF WARD	
NAME OF TEAM AND STAFF MEMENER	
NAME OF YOUNG PERSON	
DATE OF BIRTH	
HOME ADDRESS	
GP	

SCHOOL/COLLEGE	
BRIEF SUMMARY OF ADMISSION – DETAILS OF LIAISON WITH OTHER AGENCIES I.E. SCHOOL NURSE, CHILDREN'S SERVICES ETC	

On completion of form please forward by email to LCFTs Safeguarding Team

Check List for Admission of Young Person to Adult Inpatient Unit

	Yes	No	Outcome
LIAISON INFORMATION SHARING			
Has contact been made with CAMHS Tier 4 Outreach Team?			
Has the LCFT Notification form been completed and forwarded to LCFT Safeguarding Team?			
Has the SUI procedure been followed?			
Has the ecpa safeguarding assessment been completed (if appropriate)?			
Are there any known child protection or safeguarding issues? **If so please follow CP001 procedure**			
Is the young person a Looked After Child?			
Has the young person got access to LCFT Interpreting service?			
Has the young person been offered advocacy services?			
Has the young person been offered the CAF process?			

Has consent for information to be shared with parents/carer/other agencies been discussed?			
ENVIRONMENT			
Is a single room/bathroom available?			
Has the room been subject to environmental risk assessment?			
Are staffing levels appropriate to meet the needs of the young person?			
Is the room able to be readily observed?			
Is the room equipped with a means of summoning urgent assistance?			
Is the ward free of service users/others including visitors, who may present any risk to the young person by their behaviour?			
Could the young person pose a risk to other service users/staff or visitors? **If so please ensure safety profile is completed**			

WHEN THIS LIST IS COMPLETE IT MUST BE SCANNED ONTO ECPA

Appendix 2

The Transition protocol below provides guidance to practitioners as to how young people should be transferred into on-going mental health services after CAMHS, to ensure continued support to the young person and their family/carers.

Transition from CAMHS

Guidance for Central Lancashire CAMHS

Contents

1. Background

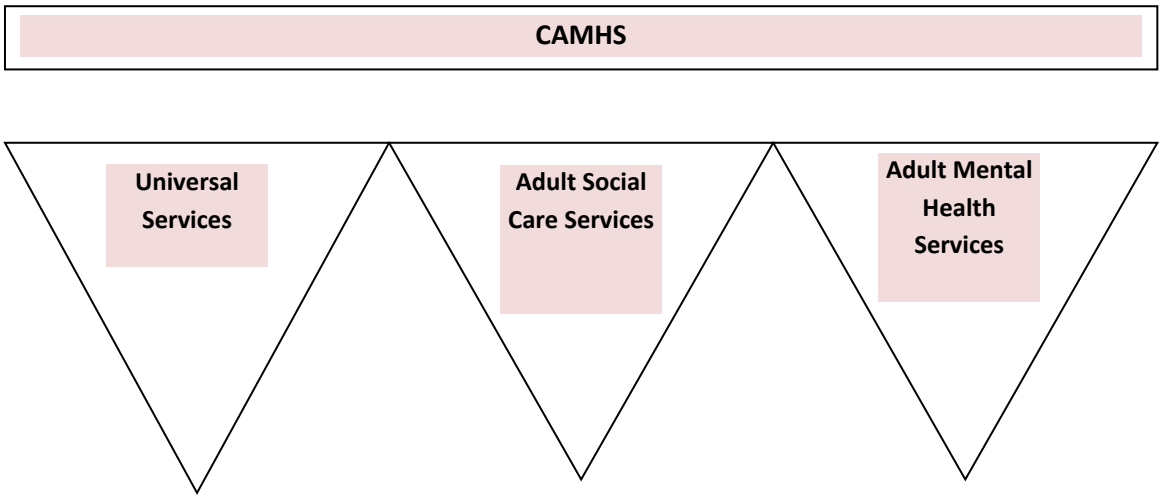
Some young people who receive services from CAMHS may need continued support beyond the age range of young people that CAMHS currently offer services to. Transition is recognised as a difficult time for young people, their family members and even professionals. During transition young people have to move from services that they are familiar with to services they do not know.

The best transitions are those were:

1. the young person feels supported;
2. the young person is aware of the changes and how the services they access are different;
3. the young person is involved in the decisions;
4. the young person is informed of the progress of transition;
5. the young person experiences a handover of care.

2. Context

At present there are three options for young people at the time of transition. Some young people will no longer need the support of CAMHS and can be discharged. They will continue to be able to receive support from services, including primary health care services, available to all young people. In Lancashire the statutory service for young people is the **Young People Service**.



There is currently a lot of guidance about transition. However, there are local agreements in place as recommended in guidance.

These include:
Procedure For The Referral And Transition Of Young People With Mental Health Problems Into Lancashire Adult Mental Health Services. (Lancashire Care Foundation Trust)

And
Transition Policy (Lancashire County Council)
These documents form the basis of transition in Central Lancashire. The needs of the young person will help to identify which process would be must useful to enable young people to move through transition. The documents relate to the different sections of the population that they offer a service to.

Procedure For The Referral And Transition Of Young People With Mental Health Problems Into Lancashire Adult Mental Health Services relates to adult services for young people from the age of 16 who experience mental health problems.

The *Transition Policy* describes the transition into adult social care services for young people who may need support from the adult service. Adult social care services support young people and adults from the age of 18 years old.

3. Involving Young People and their family members

Young people need to be fully involved in their transition. Most young people who are supported by CAMHS will be supported by parents/ carers or other family members. Young people should be kept up to date of progress during the transition. They must be allowed to contribute to transition planning and agree with all decisions that are made about the transition. Young people should be encouraged to involve their parents in transition and role of parental support should be highlighted.

4. Actions for Transition

1) The Transition Co-ordinator will compile reports of young people who are aged 15 and older. These will be shared with the Team Co-ordinators and Service Manager. The reports will be used to help plan transition and for discussion in Case Supervision.

2) The starting point for the transition process is to talk to the young person and their family members about transition. The purpose of this is to:

   a) Introduce to the young person that the services they receive are going to change;
   b) Start to discuss whether continued support would be helpful;
   c) Explore what services, including those in the community, could offer support for the young person's identified needs;
   d) Gain consent to commence the transition process.

3) The Case Manager will discuss the young person with the Team Co-ordinator and inform the Transition Co-ordinator.

4) The Case Manager will decide which adult service is most appropriate to send the referral to using the documents as a guide and following a discussion with the Transition Co-ordinator if this is required.

5) The Case Manager will discuss with the young person the importance of their family members or carers remaining involved in their care as they had experienced in CAMHS. The Case Manager should seek the young person's consent that adult services copy appointment letter to their parent/carers.

6) The Case Manager will compile the paperwork that is necessary for a referral for transition.
   Referrals to adult mental health will include:
   a) A CAF;
   b) Copies of recent and relevant letters to the young person, GP, family and other professionals (including, if appropriate, letters to Commissioners)
   c) Copies of clinical assessments and reports;
   d) Covering letter including whether the young person has given their consent that appointment letters can be sent to Parent/Carer (point 5).

Referrals will be made to the appropriate team.

Chorley and South Ribble		
Name of Team	**Referral pathway vai email**	**Tel. No**
Chorley CCTT	Via email: chorleycmht@lancashirecare.nhs.uk	01772 676068
Chorley & South Ribble PCMHT	Via letter: Leyland House Lancashire Business park Centurion Way Leyland PR26 6TR	01772 643168
Chorley GP area	Chorley and West Lancs CRHTT Via phone	01772 773525
South Ribble GP area	Preston and South Ribble CRHTT	01772 773433
Preston		
Preston CCTT	Via email WestStrand- CMHTMailbox@lancashirecare.nhs.uk	01772 401255
Preston PCMHT	Via letter: Primary Care Mental Health Team West Strand House Block C Strand Road Ashton on Ribble Preston PR1 8UY	01772 773437

Preston GP area	Preston and South Ribble CRHTT	01772 773433
West Lancashire		
West Lancs CCTT	Referral by letter: Bickerstaff House Ormskirk and District General Hospital Wigan Road Ormskirk L39 2JW	01695 598257
West Lancs PCMHT	Bickerstaff House Ormskirk and District General Hospital Wigan Road Ormskirk L39 2JW	01695 598340
West Lancs GP area	Chorley and West Lancs CRHTT	1772 25

5.Eating Disorders Services

Chorley, South Ribble and West Lancashire only: Young people who have a diagnosed eating disorder should be discussed with the Eating Disorder Service in the first instance. Young people who need Care Co-ordination will need a referral to CCTT.
Tel No: 01772 647072

Preston: Referrals will go to CCTT.

Referrals to adult Mental Health Services should be made 6 months before the transition is expected to be completed. Copies of the covering letter or email should be sent to the GP, Transition Co-ordinator and young person. With the young person's permission copies should also be sent to family members and other professionals who need to know about the referral.

Referrals to adult social care

a) Young people who are who are aged 16 years or older, are in transition and may need the support from adult social care should be notified to the Transition Operations Group.
b) The Transition Operations Group may request further information or updates which may require attendance at the meetings.
c) Referrals for adult social care are made through Customer Care at The Hub on **0845 053 0009.**
d) Further information should be made available as requested by the service the referral was made to.

Referrals to adult social care services should be made at least 6 months before the young person's 18th Birthday unless it has been agreed otherwise by the Transition Operations Group.

Adult Mental Health Services

Referrals made to the adult mental health services will be logged and a decision made as follows:

a. The young person will have an assessment from the team receiving the referral.
b. The young person's details may be passed to another team for consideration or action.
c. That the young person does not appear to have needs that would indicate that they should receive services. The referral is declined.

Adult services will contact the CAMHS referrer and if necessary request further information. The decision about the referral will be communicated to the CAMHS refer.

The outcome of the decision will clarify who will contact you next.

6. Accepted Referrals

Should the referral be accepted there should be an agreed period of co-working that allows that young person to continue to be supported by CAMHS while beginning the introduction to adult services.

Any appointments sent out by adult mental health services should be copied to the young persons' parent/carer (with the young person's consent **see 4.5**) and CAMHS Referrer.

A joint appointment for the young person with CAMHS and adult services attending should be arranged. During this time the assessment by adult services, including Carers Assessment should be completed. A gradual handover of responsibilities should take place allow the young person to experience a smooth transition.

7. Declined Referrals

Should the referral be declined the Case Manager should discuss this with the Team Co-ordinator.

8. Discharge

Where there is a clinical reason for discharge or when a young person does not consent to the transition the discharge planning process will be followed. Additionally,

it should be discussed with young people the services that may be able to offer support in the future. These should be written clearly in the discharge letter.

9. Safeguarding

Nothing in the transition process should deter, if necessary, action to be taken about Safeguarding concerns. Where these concerns exist Safeguarding policies must be followed at all times. All services involved have a responsibility towards the welfare of the young person. All services involved with a young person have a duty to raise safeguarding concerns when they are identified.

From the Transition Protocol.

Appendix 5 – Inclusion and Exclusion Criteria (Extract From CCTT Operational Policy Dated March 2011)

Inclusion criteria: Service users offered on-going treatment, care and monitoring by the care co-ordination function can broadly be split into the following groups:-

1. Service users with mental health problems of mild to moderate severity where sustained attempts have been made, but have failed, to manage the service user within primary care (ie service users on steps 1, 2 and 3 of the stepped care model).
2. Severe and persistent mental disorders associated with significant disability and/or mental health disorders leading to marked vulnerability and/or social displacement, in addition some service users may be difficult to engage.
3. Severe disorders of personality i.e., which give rise to a history of severe social disability, risk of self-harm, self-neglect or a serious risk of danger to others where these can be shown to benefit by continued contact and support.
4. Service users in the above categories who have disorders requiring skilled or intensive treatments provided within secondary care eg Dialetic Behavioural Therapy (DBT), 'Mindfulness' and '2B'.
5. Service users requiring interventions under the Mental Health Act (1983).

Exclusion criteria: There may be instances when it is clear to the individual receiving the referral that the CCTT is not the appropriate team to be providing interventions based on the available information. In these instances, the CCTT would discuss the referral and agree with the referrer the appropriate service or agency.

In general terms those excluded from being appropriate for on-going CCTT care co-ordination are those who do not meet the CCTT inclusion criteria.

Also excluded will be clients whose primary difficulties relate to:-

- Substance misuse
- Severe learning disability
- Developmental disorder (e.g. autistic spectrum disorders, adult ADHD)
- Neurological dysfunction
- Normal bereavement reaction
- Sleep disorder
- Sexual dysfunction
- Chronic fatigue syndrome/ Myalgic Encephalopathy (ME)
- Social, housing, financial and relationship difficulties
- Anger problems
- Early onset dementia (following assessment and diagnosis this client group may require

- specialist intervention from older adults services).

Service users having primary difficulties in these areas who meet the inclusion criteria for CCTT input based on them experiencing a mental health disorder (whether or not this seemed to be as a direct result of the primary difficulty) would not be excluded.

However, CCTT input and, if required, care co-ordination would depend upon the presence of this mental disorder. Long-term input for the primary problem would not be provided by the CCTT.

E.g. A service user with Asperger's Syndrome who developed depression leading to severe impairment of their usual functioning, may be appropriate for input from the CCaTT. However, they would not necessarily be eligible for long-term follow-up for the primary problem of Asperger's Syndrome (even if this, in itself, led to significant difficulties) when the features of the super-imposed mental disorder of depression had resolved.

How was this meeting?

Date: ◯◯/◯◯/ 20◯◯ Time: ◯◯ h ◯◯ m Session N°

		0	1	2	3	4
1	Did you feel listened to?	Not at all	Only a little	Somewhat	Quite a bit	Totally
2	Did you talk about what you wanted to talk about?	Not at all	Only a little	Somewhat	Quite a bit	Totally
3	Did you understand the things said in the meeting?	Not at all	Only a little	Somewhat	Quite a bit	Totally
4	Did you feel the meeting gave you ideas for what to do?	Not at all	Only a little	Somewhat	Quite a bit	Totally

---

Who gave this feedback (tick below):

Child/young person ◯
Mother ◯
Father ◯
Professional ◯
Other (please specify):

SUM: ◯

NHS ID: ---

Service allocated case ID ---

Appendix 5

How was this meeting?

Date: ☐☐/☐☐/20☐☐ Time: ☐☐h☐☐m

		0	1	2	3	4
1	Did you feel listened to?	Not at all	Only a little	Somewhat	Quite a bit	Totally
2	Did you talk about what you wanted to talk about?	Not at all	Only a little	Somewhat	Quite a bit	Totally
3	Did you understand the things said in the meeting?	Not at all	Only a little	Somewhat	Quite a bit	Totally
4	Did you feel the meeting gave you ideas for what to do?	Not at all	Only a little	Somewhat	Quite a bit	Totally

---

Who gave this feedback (tick below):

Child/young person ○
Mother ○
Father ○
Professional ○
Other (please specify):

SUM: ○

NHS ID: ---

Service allocated case ID ---

Appendix 6

Example of Interagency work and school liaison

BK

14 year old girl, only biological child of Mum and Dad, who separated when BK was 8 years old. Dad has older daughters from previous relationships. Mum from China, Dad older from the UK. BK has issues about her identity and struggles with thoughts of being different. BK doesn't speak Chinese, Mum needs an interpreter. BK previously known to CAMHS.

BK was referred by GP due to being described as a vulnerable young woman, taking part in risky behaviour, and experiencing suicidal ideas. The school had already initiated the Team around the Family (TAF) process involving Young Addaction, YPS, school and Mum. By the time CAMHS were involved so were social care and that meeting had been escalated to a Child in Need (CIN) due to domestic violence from BK towards her Mum and because BK was going missing and being found by Police in Liverpool in her 18 year old boyfriends house.

BK refused to attend the initial assessment appointment on 01/12/14 but attended a follow up appointment. At that time BK was living with Mum. Our service recommended family work that can be done with BK and her mum to improve their relationship.

After BK attended she was asked BK to keep a diary of anything that was keeping her awake at night and any worries she may experience before the next session. After Christmas BK presented in school as very upset.

I did a joint visit with social care and the result was a private fostering arrangement with one of BK's friends.

BK now reporting an increase in mood but reporting hearing voices. Family therapy or Video Interaction Guidance (VIG) still indicated between BK and Mum. Social care doing work on family relationships and parenting support.

JA

Aged six years. Example of joined up working with Social Care and Education. J has a life limiting illness as was born without a short bowel. This means lots of extra care at home and he doesn't eat. His mum is young, was adopted herself and has two older children and one younger. For as long as she has been a parent there have been come concerns around low level neglect. The two fathers of the 4 children offer no support or contact.

Original referral was around offering some work to improve the attachment in order to improve the behaviour as he was out of control when in hospital and this was impacting on his health and the decision as to whether he could have a transplant. Initially a piece of work with the Mum using VIG made a big difference to her ability to tune in to his needs and respond more sensitively to his distress (not easy when you have to do carry out painful procedures for your own child).Quite quickly the child was called for transplant where the mum and J had to live in Birmingham hospital for several months.

Social care were already involved for his health needs but CP got involved for the three siblings as they went to live with their maternal Grandfather. At this point, the action plan on the CP plan was that all three children should be referred to CAMHS for "support around the separation and loss".

Even though my piece of work had really concluded with J and his Mum and I was tempted to close I decided that this wasn't helpful to the professionals involved with the four children and wasn't going to help CAMHS if all three were referred for various different presentations. I was under some pressure to facilitate the referral but felt really strongly that this was not the way to go. So, I explained why I didn't think a referral for CAMHS for each child was helpful to them, their granddad or services.

Once I had won this battle I offered to do group consultation to the Social Worker, Family Support Worker, Edge of Care worker and School staff about the needs of the three children. We met for two group sessions where we mapped their needs, concerns about them and Granddad and used this time to action plan what everyone was going to do without the children being referred to CAMHS. This was effective in that the children needed stability and routines and nurturing and contact with their mum and brother but they did not need CAMHS.

I thought it was a good piece of joined up working to do the right thing for the kids and not use up resources that weren't necessary. Following these two consultations I went back to Core Group and told them I was discharging J. There are ongoing issues around safeguarding in that the mum doesn't have capacity to meet the needs of all four children at once and the boy is still in hospital but I said these were safeguarding decisions rather than clinical psychology or CAMHS ones.

Example of Service development through outreach to schools (ELCAS)

A number of local high schools over the last couple of years have identified pockets of particular need for young people with mental health disorders. Over a similar timeframe, within the service we were identifying higher than average referral rates from local schools/GP practices all linked to a couple of specific areas within East Lancashire.

Following discussion with one of the local high schools, we agreed to provide further input into the schools, to work alongside the teaching staff and offer a resource for teachers who had concerns about pupils to "drop in" and talk through their concerns. The worker was also able to sit in classes and do some basic classroom observations of young people (with parental consent) to identify those where further mental health intervention may be required.

As well as being able to identify young people who require Tier3 mental health services, it has also meant that young people have been able to be identified more quickly and managed in primary care with support rather than requiring referral on to specialist services.

As part of this we are also involved in school open days and school road-shows for the schools we are involved in both for pupils and for other professionals and parents.

We offer an open consultation system to schools who can ring within the working day and speak to a team member of Team-Co-ordinator to discuss any issues they have regarding children who are both referred and non-referred. This is helping with quicker referrals and more speedy response to children and families.

CAMHS and YOT

1. A young man was convicted of robbery and although he was not charged with a sexual offence there was a sexual element to the crime. The case was referred to the YOT CAMHS practitioner. YOT asked CAMHS asked for advice from the FACTS team and they assessed and offered to do some joint work with me to address the sexual element. We completed the work and are reasonably confident that he will not commit a similar offence again. I coordinated with the police and the social worker from YOT and prevented him from being given an ASBO which would have been very detrimental to his health and his future.

2. A young man was charged with an offence of unlawful taking of a motor vehicle and causing a great deal of damage. This young man has a significant learning disability, ADHD and genetic abnormalities. Coordinating with the social worker from YOT and the police we managed to divert him from the Criminal Justice system and CAMHS YOT worker has made a referral to the Learning Disability Team for specific work around his inappropriate sexual behaviour.

Patient journey where there has been child sexual exploitation.

Child sexual exploitation is becoming more common place in the referrals received in ELCAS. Whilst there is undoubtedly more activity generally, recent media coverage has equally heightened people's awareness and we have seen an increase in the referral rate. The interventions for this young lady revolved around re-establishing relationships with family members. There was no clear evidence of a mental illness however she had become physically aggressive towards her family, had become defiant and sullen isolating herself and had become totally centred around the inappropriate relationship with a 19 year old male to the extent that she leapt out of her bedroom window to try to see him and sustained a fracture to two vertebrae of the spine.

She became known to our service both by the social worker and the Engage team. These services remained involved and engaged as part of a multi-agency plan. This working together allowed specialist services to step in and deliver specialist intervention whilst keeping the stability of a multi-agency team as a step up and down service.

The interventions in ELCAS were to re-centre her within the family and allow safe space for her to be able to express thoughts and feelings and about helping her and others to ensure that she felt valued in relationships. We did offer the family the option of family therapy, but given that there was some positive relationships within the family, they did not wish to take advantage of this and the work undertaken with the young re-engaged her back into those relationships.

The interventions were not easy, the young person was reluctant to engage in therapy originally, but did so after a relatively short period of time. The case was open for about seven months and ended with a positive outcome.

A Patient Journey through East Lancs Youth Offending Service Integrated Mental Health Team

East Lancashire Child and Adolescent Service works closely with the Lancashire Youth Offending team in the localities of Burnley, Pendle & Hyndburn and provides an in-reach service for young people who have Youth Referral Orders or who fall within the remit of the YOT via the Criminal Justice System. This is service is known as the ELCAS Integrated Mental Health Team

This young man first came to the attention of ELCAS following a referral from his GP with disruptive behaviours.

Some initial thoughts regarding Attention Deficit Hyperactivity Disorder (ADHD) were considered, and assessment started - unfortunately some appointments were not kept by the family but these were followed up by the ELCAS team. Following an assessment appointment in mum felt able to manage the situation and consequently the young man was discharged to the care of his GP.

He became known the Integrated Mental Health Team (IMHT) in some 9 months later following a request for information from Youth Offending Team (YOT) Social Worker. The above information was shared. No request for input was received so no further action taken at this time.

IMHT was asked to assess the young man some 2 months later as he was very agitated at a YOT appointment. IMHT member agreed to join the session briefly to introduce possible mental health support, with a view to trying to generate further appointments for assessment. Initially support from “mental health services” met with hostility but after a discussion, a few weekly appointments were offered to initially look at anger management and perhaps touch on other issues. This was agreed to by the young man and his mum.

Discussion during the session took place about possible ADHD and following a subsequent assessment by consultant psychiatrist support the family agreed to formal assessment process being initiated. Cognitive Behavioural Therapy (CBT) informed anger management, and CBT continued on a weekly basis.

Discussion initiated with YOT about a possible referral to Forensic Adolescent Consultation and Treatment Service, this is currently underway initiated by defence solicitors.

IMHT made aware that the young man would be in court the following month for sentencing.

Seen the following day for an initial meeting with consultant Psychiatrist and agreement to formal investigate ADHD was agreed. CBT sessions to continue weekly/fortnightly depending on YOT order

QB test arranged, Connors forms completed with family and QB test completed all within 5 working days.

Further appointment with consultant psychiatrist 4 days later- diagnosis of ADHD given, and trial of medication commenced. CBT sessions continue on fortnightly /weekly basis in line with YOT order

ELCAS information delivered to YOT for inclusion in considerations regarding sentencing. CBT sessions continue.

The outcome was that the young man received a youth rehabilitation order with intensive supervision and surveillance.

CAMHS and Children Looked After

Case Study – Katie*(name changed)

Summary of referral to ELCAS

- 8 Year old girl
- Emotional dysregulation – Anger, worry
- Early impaired attachment relationships
- Trauma and neglect
- From carers' perspective – "extreme challenging behaviour", "manipulative, lack of remorse, defiant, lying, lashing out, very controlling behaviour".

Timer Line in brief

Katie born 2004. Mother – prolific drug user, alcoholic, involved in prostitution.

Birth father ex-military (PTSD), committed suicide when Katie was 4 months old – he was unaware that mother was expecting his 2nd child.

Mother was involved in frequent, brief relationships with men after partner's death; some violent, often drug users.

Mother had one partner who was around more. She had 4 more children with him. He was physically violent to her and to Katie. Katie witnessed repeated DV, excessively inappropriate language directed to her and other young children.

Katie and her sister were placed by Children's Services with paternal Grandfather for 12 months due to neglect and physical abuse.

then removed again due to concerns about Grandfather and allegations of historical sexual abuse of children. Girls were placed with foster carer.

Placement broke down due to challenging behaviour, alternative placement found.

Placement broke down again due to challenging behaviour, girls placed with Paternal Grandmother and her husband.

At Referral

- Katie and her sister were living with paternal Grandmother and her husband.
- Perception that they "had no choice" and had taken on special guardianship order.
- Contact with birth mother was seldom, sporadic and unpredictable.
- Girls had supervised contact with paternal Grandfather who was undergoing a serious police investigation involving multiple allegations of sexual abuse.

ELCAS Intervention

- 4 week Art Psychotherapy assessment to ascertain suitability for a psychodynamic therapy and to gain more understanding of Katie's difficulties
- Close liaison with Social Worker and CAPPS worker, increasingly so as placement with Grandparents became more precarious.
- Acknowledgement during regular reviews with Grandparents that Katie was finding Art Psychotherapy helpful in providing a boundaried space to explore difficulties and express thoughts/feelings in a visual way.
- Continued to provide weekly, individual Art Psychotherapy over the next 10 months.
- Continuation of weekly Art Psychotherapy during transition stage due to Katie and sister's move to placement in long term foster care provision.
- Regular reviews with new foster parents and social worker to discuss their experience of Katie and to provide some feedback of the therapeutic work.
- Liaison with social worker about the legal status of the placement.
- Working towards a planned ending of therapy and work with ELCAS. Liaison both written and by telephone with SCAYT following discharge regarding their on-going involvement with Katie.

Example of CAMHS and working with Young people who have been fostered

G was fostered but her birth grandmother wanted her to live with them. Her situation was uncertain as the foster family had had her for 2 years and loved her and were considering a long term commitment but assessments were not clear as to whether her Grandmother was a good enough carer. When I got involved the foster carer wanted help to ease behavioural problems (lying, destructive behaviours, tempers) and was worried she had PTSD as a court report had said she had this when she was 5. I held back from offering EMDR or behavioural strategies until I met with the new Social Worker. She and I developed a shared formulation around the predicament this child was in and identified two things to work on: 1.attunement and attachment between carer and child rather than behavioural approach or post trauma therapy and 2. She was determined to quickly resolve the indecision about this child's future.

I attended two Social Care planning meetings where we discussed this formulation. This was clearly helpful for the carer and the other professionals working with the child and carer. They fully engaged in Video Interaction Guidance (VIG) and it was amazingly effective in that "all the barriers came down and we just gelled" (foster carer's words). When the decision was made that the child would move to live with Grandma and keep contact with her foster family, we used the VIG to consolidate the bonds she had with her foster siblings, was able to explain all this work and the formulation to Grandma and give Grandma information about what to look out for going forward in terms of understanding and monitoring. It felt like a joined up piece of work with carer, Social Worker, other professionals involved and Grandma.

Case study "L" aged 4 at referral

L was 4 at the time of the referral being made to SCAYT+. L and older sister were adopted 2 years prior. In their early lives they experienced neglect and domestic violence. Adoptive Mum had received support from SCAYT+ once before which focused on advice and support around therapeutic parenting approaches. SCAYT+ then received another referral from the post adoption team specifically requesting Theraplay for L and Mum. This was accepted as felt appropriate work to follow on from the previous sessions Mum had already had.

As a starting point a MIM (Theraplay assessment tool) was undertaken with Mum and L, this identified areas to work on within the Theraplay sessions. Following this SCAYT+ had a meeting with parents and the post adoption social worker to identify from the MIM and further discussion the goals that would be worked towards during the Theraplay.

Theraplay sessions were undertaken with L and Mum on a weekly basis for approximately 12 months. Once it was felt by all that the goals were met and there was clear evidence of this in the sessions and through L's behaviour at home the work came to an end. During the involvement SCAYT+ also held regular network meetings, including parents, post adoption social worker, L's teacher, TA and head teacher. This encouraged a 'team around the family' approach and ensured everyone was working in the same way and had a shared understanding of L's emotional health. As well as the network meetings reviews of the Theraplay sessions were carried out with the post adoption social worker and parents to ensure that the intervention was meeting the agreed goals and as a way of supporting Mum.

At points, it was necessary due to complexities around the case to have joint supervision with the post adoption social worker and a SCAYT+ psychologist. Throughout the work SCAYT+ and post adoption were able to reflect together resulting in a positive working relationship.

This case has demonstrated the following good working practices:

- Joined up working, using a 'team around the family' approach which enabled parents and school to feel supported which impacted positively on L.
- Good working relationship with post adoption.
- Good use of supervision, clinical, managerial and peer.

- The use of an attachment based intervention that engages children and helps parents to become more attuned to their child.
- The work was led by the needs of the family.
- The set goals were achieved.

The below email is from L's Mum after the work had ended.

Mummy thinks I am a lot like an orchid, incredibly beautiful to look at but difficult to care for at times.

To achieve the best possible flower an orchid needs a variety of things, the right environment, lots of love and attention, oh and the occasional prayer. Sometimes when you have tried everything and your orchid is still not flowering you need to ask an expert for some advice.

You need to pick your expert with care, lots of people offered advice but with such a delicate flower you need a very special person that really cares about helping and starts at the roots.

From baby lotion on glasses, handprints and chaos to orchids – we have achieved a lot together. Thanks for being my special friend, I will miss our times together but I have a great team on my side who have all learnt from you and will help me to carry on blossoming.

Case Example: 'J' aged 8

This case was referred to Scayt+ in September 2014 by J's Social Worker. **'J'** along with his older sister became looked after in March 2014 following child protection concerns whereby mum was failing to meet the children's needs due to her substance abuse, there had also been significant domestic violence between parents. Scayt+ were requested to offer advice and support to carers in managing 'J's behaviours at home, help with thinking around contact with mum and sister and how best to manage this as 'J"s behaviours escalate before and after contact, he was noted to become more anxious, aggressive with general regression in behaviour. Carers at this stage were unsure if they would be able to provide 'J' with a long term placement as they were concerned about the effects of 'J"s behaviours on their younger adopted son.

As with all new cases we began with a consultation with both carers and Social Worker present. During this consultation we were able to explore with carers 'J's early experiences and how this will have affected brain development and therefore this explains his delayed development. Also how his blueprint/internal model is one of low self esteem and he expects things to go wrong. Advice and guidance was provided to carers in terms of therapeutic parenting and using the approach of PACE: (playfulness, acceptance, curiosity and empathy) as well as Theraplay ideas.

Feedback comments from Social Worker:
'The consultation was very useful in terms of understanding where the SU is at and how best to support. Particularly useful strategies which foster carers can implement. Advice/perspectives re: contact also helpful.'

Feedback comments from carers:
'Really useful sessions with new ideas to work on. Thank you.'
'Excellent information and advice. Thank you ladies.'

A follow up session took place at the contact centre and included the family support worker who supervises the contact. During this session, theraplay activities were demonstrated and the carers were given the opportunity to experience being the recipient and the leader of the activities. Feedback from this session was very positive as carers could see the benefits of the activities having on all of their relationships. The support worker was encouraged in facilitating a much more positive quality contact experience for 'J' as she could see how theraplay could help to structure contact as well as provide containment rather than the present chaotic nature of the contact. Moreover the theraplay approach was seen especially as a valuable tool in providing consistency at home and during contact thereby enabling 'J' to experience positive interactions with his carers and family.

Feedback comments from the theraplay session:
'Valuable advice on how to structure contact including activities and lay out of the room. Theraplay activities are non competitive and very helpful as mum is very competitive and she wants to win all games played during contact.'

Due to the success of the above session, a further theraplay demonstration took place with a group of support workers and as 'J's current support worker was changing it further ensured consistency in working practice.

Feedback from support workers:
'Really interesting and informative, will be really useful in our work as FSW to use in 1:1 sessions with children and to pass on the information to parents carers for them to use. Thanks very much.'

'This will improve the value of contacts for both child and parents. Also it will be of great value during direct work sessions. It will help with trust and interaction.'
'Really good ideas which can be used after Life Story work sessions. Would benefit the child. I feel I would use it after contact, during contact. Really impressive, will use it in my role.'

Scayt+ have also contributed to planning meetings and this has facilitated multi agency working. The outcomes in this case have been achieved as 'J' is much more settled in his placement, he looks forward to contact, carers confidence in their abilities have increased and they have put themselves forward as J's long term carers.

Case study re young person L. Aged almost 16 at the time of referral.

Presenting issues: L has been looked after for 4 years and in that time has lived in a number of local authority residential units. Given the high level of risk with regard to a history of being sexually exploited within her own area she now resides outside the county. She has also been missing from establishments on over 80 occasions within a short time period. Other difficulties exist for L within her relationships with peers, family particularly her mother and residential staff.

Assessment: Initially I met with the professional support network around L and we thought about the difficulties of trying to support her when the placement she was currently in was temporary and her longer term geographical whereabouts were unknown. L was unwilling to access any form of counselling in the area where she was residing due to the temporary nature of her accommodation. She had been assessed by Child and Adolescent services in Cumbria as needing a service from their team but was refusing to attend.

I agreed to meet with her and offer her four sessions to look at how a service which was acceptable to her and which she would be willing to access either from outside the County or from her new placement could be sought.

I met with L for the four sessions. She engaged extremely well even reminding staff when she changed placements the time and date of appointments. We were able to think about her experiences of adults and relationships and why within an attachment framework she might struggle to allow adults to parent her and her very fixed black and white thinking.

We were able to think about risk and why adults might worry so much about the risk she posed to herself and possibly others. She was scared about her own thoughts and feelings and had no way of trusting anyone to think these through. As a result of this she accepted that I would make referral to CAMHS in her locality and I would attend with her

At her meeting she was to be considered for follow on services even though she was almost 16. Agreed I would see her until these were in place. I saw her on two more occasions. She was able to agree that she was now confident in her new staff to attend the appointment with the psychiatrist with her and therefore our sessions had achieved their purpose.

Outcomes: This girl was reluctant to commit anything to paper and throughout our sessions had struggled with any notion of goals. However despite this I think she was very clear about what we hoped to achieve together. She had had very difficult life experiences and began her first session by saying she had never been parented. At the end of the last session she filled out an evaluation and I felt this was in itself positive and she wrote what was for her a lot saying she felt the sessions had been really useful and had helped her.

Case study 'C' age 5

Background: 'C' came into LA care in April 2014 due to CP concerns in respect of physical injuries towards 'C' and her male sibling, parental domestic violence and alcohol dependency. 'C' currently is in short term foster care with her two male siblings placed with X and their two children in May 2014.

Reasons for the RFI to SCAYT+: Referral received in August 2014: 'C' is displaying sexualised behaviours in foster placement. She is rubbing her genital area on soft toys and incidents of this are increasing in frequency. She does not stop immediately when asked. Outcome: For foster carers to confidently manage sexualised behaviour and guide 'C's understanding of her own identity.

SCAYT+ Involvement and overview: Began in August 2014 when we provided an initial consultation. A further five consultations have been provided to foster carers with a sixth session booked for May. In addition I have provided a joint visit with CSW and liaised with private Theraplay therapist in respect of commissioning a service.

Initial consultation provided advice around the sexualised behaviour. We discussed SCAYT+'s approach is to view the behaviour in the context of developing a safe base and secure attachments. Once we develop and strengthen secure attachments, this behaviour should decrease. I also advised about helping 'C' to experience appropriate touch and develop body awareness and gave examples from Theraplay involving measuring exercises.

Additionally 'C' has difficulties in regulating her emotions, sibling interactions and is routinely aggressive in her behaviour and language.

I have provided advice on therapeutic parenting and PACE. I advised on and demonstrated Theraplay techniques. Foster carers have incorporated the advice and techniques to assist 'C' strengthen her attachments and also help with strengthening sibling's relationships.

Foster Carer describes 'C' as much more adoptable. She is making good progress her sibling relationships and her ability to play independently. There continues to be improvements in 'C's vocabulary which is now more appropriate and sweeter. 'C''s pattern of sexualised behaviour (masturbation) is approximately once every two weeks. 'C' is now starting to differentiate between private and public space and is starting to be more private by using her bedroom.

Foster carer's feedback: *I have found the advice and guidance extremely helpful and it has enabled me to have a better understanding of why* 'C' *has difficult behaviour. This has also been very helpful for my sons in particular the 17 yr old who originally struggled to understand why Cheyenne was aggressive and expressed he felt she was just being naughty.*

CCSW Feedback. *I found the session very informative. I have a better understanding of the child's behaviour*

Future involvement is to advise the bridging to adoption process.

Example: Three siblings

These three children are siblings and placed together with foster carers Mr and Mrs C. They had suffered severe neglect and this is their long term placement. They all had behavioural and developmental issues. All three children were in individual therapy as had been recommended by court experts- and had been for 18 months. The request was to review the issues regarding emotional well-being of the children and address carer and school concerns about behaviour.

Upon our detailed review it was clear to SCAYT+ that the individual therapy was being conducted in isolation. Not only was this failing to address key concerns with carers and the wider professional network, it also seemed unnecessary (and costly). It was

agreed to wind down this work, and that was supervised by the SCAYT+ worker. Support and advice were offered to carers and head teacher- something that they much appreciated, although initially there was much anxiety about finishing the individual therapy (fuelled inappropriately by the private therapist). A strengths-based approach helped the adults move from a position of high anxiety and fear to one of emotional containment. At closure the children were reported to be doing very well in school (including a successful transition to secondary) and placement following SCAYT+ intervention. Infrequent, but regular consultations were provided to guide the carers in their use of attachment ideas and practices. Although this work was primarily consultation to carers, the children were seen together on one occasion at the carers request.

This work lasted about one year.

The following email was received:

"*Thanks very much for coming to see us all. I have to say that I saw why you do the job you do- you have a special way with kids! They were eating out of the palm of your hand, they loved your company and the way you talked to them was fantastic, and I was so proud at the way they interacted back with you, as you say, they have indeed come a long way and if we do have any major hiccups we know Scayt+ team are there if we need them."*

CASE STUDY 'L' Age 7

'L' has one older brother and one older sister who are both in different placements. There had been concerns about the care of all three children since 2005 and they became looked after in June 2013. They had experienced extremely poor home conditions, neglect, emotional abuse and possibly physical abuse. They were exposed to mothers' suicide attempts and frightening adult behaviour between their parents.

An initial consultation was arranged with the foster carer following a referral in November 2014 from the school nurse and supported by the social worker. The main concerns were about 'L' telling lies and fabricating stories which they knew were not true. She had been in placement for a year and it was planned that she remain with their family long term. However 'L' was very dismissive with the male carer and liked getting their two sons in to trouble and would exaggerate the incidents. The placement was under pressure because of possible allegations. Her play was very much around teddies being unwell and visits to doctors and clinics. 'L' talked constantly and wanted the foster carers attention all of the time. She could not bear silence and would talk through T.V programmes too! In school she was always on red or amber because of her behaviour.

'L' had been in a previous foster placement but had shown no upset when moved. Her present placement was very nurturing and it helped to look at the progress she had made in the year that she had been with this family. Over the next five months I saw the foster carer on six occasions and attended the CLA review in school in December. We talked about her experiences at home in more detail and made connections with her present behaviour. We discussed being clearer with boundaries

and giving short explanations when there were difficulties. The foster carer also tried out various Theraplay ideas and read her stories at bedtime.

I had my final meeting with the foster carer in April 2015 and 'L' is doing well. Since January she has stayed on green in school and is achieving and making progress academically .She is settled and is more affectionate and listens to both foster carers and is better with the boys. The incidents of lying are rare.

The foster carer commented at our final session that she is very glad she came to our service. The most helpful thing from her point of view was being given the knowledge to be able to understand 'L' better. She thought the written information was extremely useful between sessions. She says that 'L' is 100% better both at home and school and thinks the service is excellent and would contact us in the future for advice/support.

Scrutiny Committee
Meeting to be held on 19 June 2015

Electoral Division affected:
None

Work Plan and Task Group Update
(Appendix 'A' refers)

Contact for further information:
Dave Gorman, (01772) 534261, dave.gorman@lancashire.gov.uk

Executive Summary

The plan set out at Appendix 'A' summarises the work to be undertaken by the Committee in the coming months, including an update on Task Group work. The information will be updated and presented to each meeting of the Committee for information.

Recommendation

The Committee is asked to note the report.

Background and Advice

Information on the current status of work being undertaken by the Committee and Task Groups is presented to each meeting for information.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management implications.

Lancashire County Council

List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A		

Reason for inclusion in Part II, if appropriate

N/A

Appendix 'A'

Scrutiny Committee Work Plan 2014/15

19 June 2015		**Child and Adolescent Mental Health Service (CAMHS)**	Dave Carr	Update Report on the review of CAMHS by the Health and Wellbeing Board
17 July 2015		**Safeguarding Children**	Lancashire Safeguarding Children Board/Louise Taylor/ Lancashire Constabulary	Update from the meeting held in December 2014
		Apprenticeships	Eddie Sutton/Anne-Marie Morgan	
18 September 2015		**LEP Update**	Martin Kelly	Quarterly Update
		Learning Disabilities	Tony Pounder/Ian Crabtree	

16 October 2015		**Road Safety**	Clare Platt/Debbie Thompson	Service area identified by the BSWG
13 November 2015		**Superfast Broadband Roll Out**	Sean McGrath	Full update on progress as agreed as requested by Executive Scrutiny Committee on 31 March 2015
		Libraries and Cultural Services	Phil Barrett/Julie Bell	Service area identified by the BSWG

Future Topics: not yet scheduled

- Bus Services and Subsidies - to consider outcomes of discussions with districts and next steps
- Transforming Social Care - to consider the work undertaken by independent consultants

Task Groups

The following task and finish groups are ongoing or have recently been established:

- Planning Matters: Interface between upper and lower tiers authorities in making the right decisions on planning applications (especially flood management and educational provision)
- Fire Prevention Measures in Schools
- Transport Asset Management Plan (TAMP)