Public Document Pack

Health & Wellbeing Board
Tuesday, 18th June, 2019
5.30 pm
Conference Room 1 Blackburn Town Hall

AGENDA

1. Welcome and Apologies

2. Minutes of the meeting held on 5th March 2019

To approve as a correct record the minutes of the meeting held on 5th March 2019.

Minutes 5th March 2019 **3 - 9**

3. Declarations of Interest

To receive any declarations of interest

Declarations of Interest **10**

4. Public Questions

5. Age Well Update Presentation (Sayyed Osman)

6. Local Area SEND Update (Jayne Ivory)

To receive a briefing report on the send inspection

SEND Inspection Briefing **11 - 13**

7. Lancashire and South Cumbria Children & Young People's Emotional Wellbeing and Mental Health Transformational Plan 2015-2020/20 (Heather Bryan and Rachel Snow-Miller)

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8. Public Health Annual Report (Gifford Kerr)

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9. Pan Lancashire Health and Wellbeing Board (Laura Wharton)

10. Joint Commissioning and Better Care Fund (Katherine White)

11. Sport England's Local Delivery Pilot (Ken Barnsley)

12. Lung Health Checks Programme for Blackpool & Blackburn with Darwen (Ken Barnsley)

13. General Updates from Board Members

14. Date and Time of the Next Meeting

The next meeting of the Board has been scheduled to take place on 4th September 2019.

Date Published: 11th June 2019
Denise Park, Chief Executive

Health & Wellbeing Board

Start well | Live well | Age well

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON TUESDAY, 5TH MARCH 2019

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Brian Taylor
Clinical Commissioning Group (CCG)	Roger Parr
	Julie Higgins
Lay Members	Joe Slater
Voluntary Sector	Vicky Shepherd
Council	Dominic Harrison
	Jayne Ivory
	Kerry Riley
	Sayyed Osman
	Laura Wharton
Healthwatch	Abdul Mulla
Council Officers	Firoza Hafeji
	Riaz Osman
CCG Officers	Dr Penny Morris
Midland and Lancashire Commissioning Support Unit	Nicola Feeney

1. **Welcome and Apologies**

The Chair welcomed everyone to the meeting. Apologies were received on behalf of Cllr John Slater and Angela Allen.

2. **Minutes of the meeting held on 11th December 2018**

RESOLVED – That the minutes of the last meeting held on 11th December 2018 were agreed as an accurate record and were duly signed by the Chair.

3. **Declarations of Interest**

Cllr Brian Taylor outlined his interest in item 10 on the agenda, "Special Educational Needs and Disabilities Stocktake".

4. Public Questions

The Chair informed the Board that no public questions had been received.

5. PAN Lancashire Health and Wellbeing Board

The Director of Public Health, Dominic Harrison, gave a verbal update on the PAN Lancashire Health and Wellbeing Board. It was noted that there would be a single Health and Wellbeing Board for Lancashire with five local area Health and Wellbeing partnerships reflecting the local area health economies across Lancashire. Concerns were addressed from Members present and Dominic explained that further clarification would be brought to a future Health & Wellbeing Board meeting.

RESOLVED - That the Director of Public Health, Dominic Harrison, to present an update report to a future Health & Wellbeing Board meeting.

6. Eat Well, Move More, Shape up Annual Update

The Director of Public Health, Dominic Harrison, summarised the Eat Well Move More Shape up Strategy Year 2 Report which had been previously circulated with the agenda.

Dominic highlighted that the purpose of the report was:

- To update on the progress made against the Eat Well Move More Shape Up strategic action plan during the second year of delivery.
- To inform the Health & Wellbeing Board about the key priorities and opportunities for year three.
- To highlight key issues impacting on effective delivery of the action plan in year three.

The Health and Wellbeing Board members were recommended to:

- Note the contents of the report.
- Note that physical inactivity and unhealthy weight remains a significant public health issue requiring ongoing senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.
- Note the progress made to date by all partners and the key issues impacting on effective delivery of the action plan.
- Note the priorities and opportunities for Year 3 of the Eat Well Move More Shape Up Strategy.

The Board were updated on some recent progress as:

- The Pennine Lancashire has been chosen by Sport England as one of 12 pilot areas to work on a bold new approach to build healthier, more active communities across England. Blackburn with Darwen has been given the responsibility to manage the £10 million budget.
- The Childhood Obesity Trailblazer had their first meeting in February 2019 to look at ways to tackle unhealthy weight across Pennine Lancashire. One of the areas that drive obesity was identified as fast food and

takeaways.

The Board heard that the Refresh scheme had started offering more services from Community Centres rather than just leisure centres which has been more popular.

The Board were invited to a Healthy Weight Summit event, scheduled on 13th March 2019 at Blackburn Rovers at 9.30am – 4.00pm.

The Board thanked Dominic Harrison for the information.

RESOLVED - That the Health and Wellbeing Board noted the recommendations.

7. Joint Commissioning and Better Care Fund Update

The Director of Adult Services, Neighbourhoods and Community Protection, Sayyed Osman, summarised the Better Care Fund Update report which had been previously circulated with the agenda.

Sayyed highlighted that the purpose of the report was to:

- Provide Health and Wellbeing Board members with an overview of Better Care Fund performance reporting for Q3 2018/19
- Provide HWBB members with the BCF and iBCF Finance position at Q3 2018/19

The Health and Wellbeing Board members were recommended to:

- Note the BCF Q3 2018/19 finance position
- Note the BCF Q3 2018/19 performance metrics
- Note the feedback from the National BCF Team Local Learning Visit
- Note that due to the timing of the national returns and data reporting processes, the metrics described within this report related to data up to November 2018 of Q3.

The Board heard that the CCG minimum pooled budget requirement for 2018/19 was £11,381,000. The DCLG have confirmed the DFG capital allocation for 2018/19 at £1,739,476.

Sayyed highlighted the challenges as:

- **Reduction in non-elective admissions** – There has been an increase (+20.8%) in emergency admissions during 2018/19 due to the intentional change in patient pathways affecting the 'zero day admissions' and activity through the Respiratory Assessment Unit (RAU) and Ambulatory and Emergency Care Unit (AECU).
- **Reablement** – Supporting residents with increasingly complex needs on the rehab programme presents a challenge around maintaining outcomes across a wider cohort of residents with increasingly complex needs.
- **Delayed Transfers of Care (DToC)** – Performance against target for Q3 2018/19 DToC was not on track and had lifted the total reported planned levels above plan. The increase in delayed transfers of care days reported was due to both NHS and social care delays. However, the cumulative position was showing a reduction in delayed days in

comparison to the previous quarter. A series of improvement meetings are continuing to seek to address the current increase in demand and delays. Ensuring there was sufficient capacity to support peaks to get people fit to be discharged from hospital.

In response to questions raised by the Group, Sayyed explained that there was minimum risk of receiving penalties as the NHS England targets had been met. It was noted that BwD had a transparent and open relationship with NHS.

The Chair thanked Sayyed Osman for the information.

RESOLVED - That the Health and Wellbeing Board noted the recommendations.

8. NHS Long Term Plan (CCG)

Roger Parr, Deputy Chief Executive/Chief Finance Officer and Dr Julie Higgins, Joint Chief Officer shared a presentation on NHS Long Term Plan (LTP).

The Board heard that the LTP was published in January 2019 with the overall aim to make the NHS fit for the future. The Board noted the 7 chapters which included:

1. A new service model for the 21st Century
2. More NHS action on prevention and health inequalities
3. Further progress on care quality and outcomes
4. NHS staff will get the backing they need
5. Digitally enabled care will go mainstream across the NHS
6. Taxpayers' investment will be used to maximum effect
7. Next steps

Roger summarised each chapter in detail and the Board noted the Neighbourhood priorities for East, West, North and Darwen.

Dominic summarised by stating that analysing the age range data highlighted that the highest expenditure was in the category of 45 – 65 year olds.

The Chair thanked Roger and Julie for the detailed presentation.

9. Asylum Seekers Refugee Needs Assessment

The Chair welcomed Dominic Harrison, Director of Public Health, and Kerry Riley, Public Health Development Manager to present the Asylum Seekers and Refugees Health Needs Assessment Report.

Dominic summarised the report and recommended that members of the Board:

- Note the recommendations made within the report
- Consider the way in which the recommendations may be used to inform and improve the health and wellbeing of asylum seekers and refugees in Blackburn with Darwen.

The Group heard that people seeking asylum and refugees were among some of the most vulnerable groups in society. Before arriving in the UK, they may have

experienced violence, war, torture and may have been separated from, or even lost family members and friends. Almost universally, people seeking asylum will have experienced dangerous and difficult journeys to escape to safety. They frequently will have been separated from families and friends and may be bereaved. Arriving in an unfamiliar country, where they perhaps find it difficult to communicate and navigate the complex legal processes can be disorientating and disheartening.

Dominic highlighted that there were up to 350 Asylum seekers in the town at any one time and an undetermined number of refugees.

Kerry shared a presentation with the Board summarising the Asylum Seekers Health Needs Assessment highlighting the recommendations and actions so far.

The Group heard that the first Health Needs Assessment was carried out in BwD conducted in early 2018 by Dr Wendy Shepherd.

The vulnerabilities were shared as:

- Isolation
- Language
- Mental Health – PTSD
- ACE's – conflict, poverty, victims of abuse
- Exploitation – employment, private landlords, traffickers
- Substance misuse

The findings from the assessment were noted as:

- Mental Health
- Malnutrition and other dietary associated conditions
- Infectious disease risks
- Incomplete vaccinations/unknown status
- Dental health issues
- Exacerbation chronic health conditions
- Lack of awareness from primary care and dental services on the needs, rights and barriers faced by ASR
- Communication difficulties – lack of translation services
- Female Genital Mutilation
- Victims of abuse rape, modern slavery and trafficking

The Group noted the recommendations as:

Mental Health

- Materials required in community languages.
- Trained mental health professionals facilitating support groups locally to break down barriers/stigma.

Physical Health

- Explore possibilities of specialist services of healthcare professionals.
- Possibilities of one lead GP practice in Blackburn and one in Darwen for ASR.
- Ensure all GP's using the PHE migrant checklist at first GP appointment.
- Dentist to have and use Language line rather than relying on ASR bringing

own interpreters.
- Prepare ASR on future planning for appointments and what to expect.

General Recommendations

- Training required for administration and front line health staff (GP's Dentists and Hospital) on the needs and rights of ASR.
- Translation services must be used by services and not encourage ASR's to use family or friends.
- Written communication to patients should be in native tongue.
- Targeted services for promoting healthy lifestyles should be used more e.g. Re Fresh.
- Development and support needs to enhance community volunteer schemes for ASR's and also peer ASR support programmes.
- Education for adults
- Five ways of wellbeing to be facilitated within this community.

The Board noted that language line used by Health professionals was paid by CCG.

The Chair thanked Dominic and Kerry for the detailed report and presentation.

RESOLVED - That the Health and Wellbeing Board noted the recommendations.

10. <u>SEND Stocktake event feedback</u>

The Chair invited the Director of Children's Services and Education, Jayne Ivory, to present the SEND Stocktake event feedback report.

The Board were provided with an update on the findings of the SEND Stocktake event which took place in November 2018. Thirty-five partner colleagues from the range of health services, the CCG, schools, Children's Services, Adult Services and parent/carer representatives attended the event which was co-hosted by Jayne Ivory, Director of Children's Services and Iain Fletcher, Head of Corporate Business at NHS Blackburn with Darwen CCG.

Recommendations were shared as:

- That the Strategy implementation action plan is updated to include new actions identified through the workshops
- That a review of the membership of each of the key decision making groups (Implementation Group, SEND Board and Joint Commissioning Group is reviewed to ensure the best possible representation and that there are clear communications from these meetings that are circulated).
- To review the terms of reference of each meeting and share new refreshed documents with wider partners.
- That a series of SEND strategy briefing sessions are planned to share the strategy, action plan and the governance structure.

RESOLVED - That the Health and Wellbeing Board noted and endorsed the content of the report and identified key actions.

The Chair reminded the Board that the date and time of the next Health and Wellbeing Board meeting was scheduled for 18th June 2019 at 5.30pm.

Signed…….……..

Chair of the meeting at which the Minutes were signed

Date……

DECLARATIONS OF INTEREST IN

ITEMS ON THIS AGENDA

Members attending a Council, Committee, Board or other meeting with a personal interest in a matter on the Agenda must disclose the existence and nature of the interest and, if it is a Disclosable Pecuniary Interest or an Other Interest under paragraph 16.1 of the Code of Conduct, should leave the meeting during discussion and voting on the item.

Members declaring an interest(s) should complete this form and hand it to the Democratic Services Officer at the commencement of the meeting and declare such an interest at the appropriate point on the agenda.

MEETING: **Health and Wellbeing Board**

DATE: **18th JUNE 2019**

AGENDA ITEM NO.**:**

DESCRIPTION (BRIEF):

NATURE OF INTEREST:

DISCLOSABLE PECUNIARY/OTHER (delete as appropriate)

SIGNED :

PRINT NAME:

(Paragraphs 8 to 17 of the Code of Conduct for Members of the Council refer)

SEND Inspection Briefing
Jayne Ivory, Director of Children's Services

Ofsted and the Care Quality Commission (CQC) are tasked with jointly providing an independent external evaluation of how well a local area effectively carries out and meets its duties in relation to children and young people with SEND.

The local area includes the Local Authority (LA), Blackburn with Darwen's Clinical Commissioning Groups (CCGs), public health, NHS England for specialist services, early year's settings, schools and further education providers.

Unlike other Ofsted inspections a SEND inspection is not graded. Inspection reports detail areas of strength and areas for improvement. Where significant weaknesses are identified a Written Statement of Action (WSOA) is required to be produced by the LA and/or the CCG. The WSOA must clearly outline how, and by when, concerns will be addressed and be submitted within 70 working days of receiving the report. Local areas with a WSOA will be re-visited by Ofsted and the CQC usually within 18 months of the WSOA being declared fit for purpose. The purpose of this revisit is solely to determine whether the local area has made sufficient progress in addressing the areas of significant weakness as detailed in the WSOA.

All inspection letters are published on the Ofsted website.

To-date there have been 89 inspection reports published, of these 44% received notifications that written statements of action were required. In the North West of England 57% of those inspected have been required to produce a WSOA.

The inspection

Local areas are notified of inspection on a Monday morning and the inspection starts the following Monday and lasts for five days. Blackburn with Darwen received their notification on the 10 June 2019. Our local area inspection will start on the 17 June and conclude on the 21 June.
A webinar for families, to share their views and experiences, will be available from midday on the day of notification until 16:00 on the 18 June during the inspection week.

The inspection team will include:

- a Her Majesty's Inspector (the inspection lead) with enhanced specialism in SEND
- a CQC specialist children's services inspector
- an Ofsted inspector (often a serving practitioner in another local authority) specially recruited and trained in SEND

The inspection of the local area will cover and report on the following key aspects:

- the effectiveness of the local area in identifying children and young people who have SEND, including children who are looked after, young offenders, care leavers, children known to social care, children missing education, children educated out of Borough, in alternative provision, hospital or educated at home

- the effectiveness of the local area in assessing and meeting the needs of children and young people who have SEND
- the effectiveness of the local area in improving outcomes for children and young people who have SEND
- the effectiveness of the local area in co-producing service developments and strategic decision making with children and young people with SEND and their families

Inspection Meetings and Visits

To review progress against the implementation of the SEND reforms and outcomes for children and young people a series of meetings/visits will take place. The meetings and visits timetable will usually involve:

- Staff from adult and children's social care, health and education
- Children and young people aged 0-25 with SEND and their parents/carers
- Early years providers, including children's centres
- Schools
- Pupil Referral Units and alternative providers
- Colleges
- Respite/short-break providers
- Health providers
- Parent Carer Forum

Key lines of enquiry will be determined by the lead inspector, informed by information gathered from the local area's Annual Peer Review Self Evaluation Report, the parent/carer webinar and other sources of information including:

- Outcomes (as described in the Code of Practice) for children and young people with SEND
- Attendance and exclusion information
- Data relating to the identification of SEN at SEN support and education, health and care (EHC) plan levels
- Evaluations from service users and how these have influenced commissioning and changes to service delivery
- Information about the destinations after leaving school, including about young people not in education, employment or training
- Performance towards meeting expected timescales for statutory assessment
- Inspection reports for the local area, its services and providers
- The published local offer
- The local authority short break statement
- Schools' and nurseries' published SEN information reports
- The joint strategic needs assessment
- The joint health and well-being strategy
- SEND strategic plans devised and used by the local area
- The level of appeals to the First-tier Tribunal (Health and Social Care Chamber) (Special Educational Needs and Disability), including cases resolved prior to tribunal hearing. Also, the level of appeals at the Single Route of Redress

- Complaints to Ofsted and the CQC
- Any relevant serious case reviews and their outcomes

Further Information

For more information on the SEND inspection, your role within it and team preparation for it please speak to your SEND Improvement Group representative.

Representatives are:

- Vikki Dugdale – Strategy, Policy and Performance
- Elizabeth Mannion - Children's Social Care
- Sarah Walsh – Adult Services
- Cathy Reilly - Early Years
- Susan Hayward - SEND Services
- Carol Grimshaw – Access to Learning
- Post 16 – Helen Andrew
- Jane Partington – SENDIASS
- Christina Cramsie – Parents in Partnership
- Jayne Worden - LCFT
- Liz Johnston - Public Health
- Carole Kay – Dedicated Clinical Officer (DCO)
- Lauren Martin - Blackburn with Darwen CCG
- Debbie Mawson – ELHT
- Lidia Cattrell – Secondary Schools
- Ruth Lilliott – Primary Schools

Further information on the SEND inspection and SEND reforms can be found in the useful documents listed below:

- Framework for the Inspection of Local Areas
- Handbook for Inspection of Local Areas
- SEND 0 -25 Years Code of Practice
- Blackburn with Darwen's 0 – 25 SEND Strategy

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

Transformation Plan 2015 – 2020/21

Refresh March 2019

Our Vision

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

Contents

Introduction

The Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Transformation Plan for Lancashire (2015-2020) was published in January 2016. That document set out the first iteration of a five-year plan for Lancashire, to support local implementation of the national ambition and principles as set out in '**Future in Mind'** – promoting, protecting and improving our children and young people's mental health and wellbeing (2015).[1]

The Plan aims to improve the resilience, emotional wellbeing and mental health of children and young people, especially those who are at increased risk due to their vulnerability, making it easier for them and their families to access help and support when they need it and improving the standard of mental health services across Lancashire and now, South Cumbria.

The Case for Change within the first iteration of the Plan is still relevant today, clearly identifying our aims to promote good emotional wellbeing and prevention of mental ill-health through early intervention, care and recovery.

Throughout, the Plan has been informed by consultation with children, young people and families, and based on comprehensive identification of needs and evidence-based practice, as well as a clear understanding of the local context.

In 2016 and 2017, we reviewed and refreshed the plan as part of our ongoing commitment to deliver assurance around the work being undertaken and outcomes achieved. On both occasions we worked closely with local stakeholders including service providers, clinicians and most importantly children, young people and families to review and revise the plan.

In 2018 we were asked to align our review cycle with that of the wider NHS England review programme. In addition, it was proposed that this was an appropriate time to present a Transformation Plan that takes account of the wider Integrated Care System geography bringing Lancashire and South Cumbria together as partners. The work planned in South Cumbria was already closely aligned with the Lancashire Transformation Plan thus a Lancashire and South Cumbria Transformation Plan will be delivered as of April 2019. This recommendation was agreed with NHS England along with the revised review cycle. The refreshed Transformation Plan will now be submitted to NHS England in March 2019 and annually in line with this date.

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

For this reason, a full, in-depth review has been undertaken and facilitated an opportunity to once again extensively engage with children and young people, families and wider stakeholders.

New National Guidance and Policy

NHS Long Term Plan (January 2019)[2] - Children & Young People's Mental Health NHS Long Term Plan Priorities

The NHS Long Term Plan (2019) makes a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people. (p8)

The Plan sets out its ambitions in key areas including (p6-10):

- Better support and joined up care
- Prevention and health inequalities
- Care quality and improved outcomes
- Workforce
- Upgraded technology and digitally enabled care
- Achieving sustainable financial pathways
- Implementation of the Long Term Plan and the role of Integrated Care Systems

The Plan states that:

- Existing commitments in the ***Five Year Forward View*** and national strategies for cancer, mental health, learning disability, general practice and maternity will all continue to be implemented in 2019/20 and 2020/21 as originally planned. (7.2)
- The NHS is making **a new commitment** that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. (3.24)
- Over the next five years, the NHS will therefore **continue to invest** in expanding access to community-based mental health services to meet the needs of more children and young people. (3.25)
- By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to **access** support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that **100%** of children and young people who need specialist care can access it. (3.25)
- Over the next five years, we will also boost investment in children and young people's **eating disorder services.** The NHS is on track to deliver the **new**

[2] https://www.england.nhs.uk/long-term-plan/

waiting time standards for eating disorder services by 2020/21…**extra investment** will allow us to maintain delivery of the **95% standard** beyond 2020/21. (3.26)

- Children and young people experiencing a mental health crisis will be able to access the support they need… With a single point of access through NHS 111, all children and young people experiencing crisis will be able to access **crisis care 24 hours a day, seven days a week.** (3.27)
- Mental health support for children and young people will be **embedded in schools and colleges…** new **Mental Health Support Teams working in schools and colleges…which will be rolled out to between one-fifth and a quarter of the country by the end of 2023.** (3.28)
- Mental Health Support Teams will receive **information and training** to help them support young people more likely to face mental health issues – such as **Lesbian, Gay, Bisexual, Transgender (LGBT+) individuals or children in care**. (3.28)
- New **national waiting time standards** for all children and young people who need specialist mental health services. (3.28)
- **In selected areas**, we will also develop **new services** for children who have complex needs that are not currently being met, including a number of children who have been subject to sexual assault but who are not reaching the attention of Sexual Assault Referral Services. For **6,000 highly vulnerable children with complex trauma**, this will provide consultation, advice, assessment, treatment and transition into integrated services. (3.29)
- A new approach to young adult mental health services for people aged 18-25 will **support the transition to adulthood**… We will extend current service models to create a **comprehensive offer for 0-25 year** olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector. (3.30)
- NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the **capability and capacity of universities** to **improve student welfare services** and improve access to mental health services for the student population, including focusing on **suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.** (3.30)

The objectives within the Transformation Plan reflects the key areas covered by the NHS Long Term Plan, and partners are working towards their delivery. However, to fully meet the requirements of the NHS Long Term Plan, investment will be needed.

At the time of writing this Transformation Plan, CCGs are awaiting publication of guidance relating to 'ringfenced local investment fund for Mental Health' as cited in the NHS Long Term Plan.

Our Commitment

As part of our commitment to continually review and refresh this Plan, we strive to provide assurance to all of our stakeholders and to NHS England, that the Transformation Programme Board and the role of those assigned to deliver the programme have undertaken their responsibility diligently and with the ambition to make a difference to the outcomes for children and young people with emotional wellbeing and mental health issues.

As part of this refresh, the Plan now recognises and is led by nine key Principles that will influence and be accounted for within all aspects of our planning and delivery. 2019 sees the introduction of an additional principle from previous years, with a specific focus on the needs of vulnerable children and young people.

In 2015, the Vulnerable Groups and Inequalities Task & Finish Group delivered their report addressing two key issues concerning children and young people with vulnerabilities:

- that there are groups of children and young people in our society with multiple difficulties and complex needs which significantly impede their access to, engagement with, and outcomes from services;
- that the majority of children and young people who need mental healthcare do have multiple vulnerabilities which contribute to their reasons for needing mental health support

This report offers us an insight into the broad range of vulnerable groups and whilst this is not taken as an exhaustive list, it none the less serves to guide our understanding and recognition of vulnerable children and young people and/or those who have experienced Adverse Childhood Experience(s):

- Adopted children
- Children Looked After, Care Leavers and those on the 'edge of care'
- Children in contact with the Youth Justice system
- Children who are abused (including those who are sexually exploited), neglected or victims of trauma
- Young people who are most excluded including those who are involved in gangs
- Children and young people with Learning Disabilities/Autistic Spectrum Disorder
- Children and young people with protected characteristics, such as disabilities caused by both physical and mental health difficulties, complex medical conditions, race, faith, sexual orientation, or gender reassignment.
- LGBTQ children, particularly those who are just coming to terms with their sexual orientation or gender identity
- Children and young people from minority ethnic groups
- Children who have been bereaved or experienced bereavement
- Children who have experienced or witnessed domestic violence

Furthermore, we recognise the vulnerabilities and needs of children and young people who are carers. Findings tell us that a third more young adult carers report anxiety or depression than other young people and for young carers under the age of 17 years, a survey of 61 young carers in school found that 38% had mental health problems[3]. This group of young people have been included specifically in response to discussions following the consultation period (Appendix 5).

As part of this review, we have been able to celebrate our achievements whilst recognising that we have an ongoing commitment to working with colleagues from across the Lancashire & South Cumbria Integrated Care System. We will continue to raise the profile of children and young people with emotional wellbeing and mental health issues, and ensure their needs are reflected in other programmes of work, such as the Learning Disability & Autism Workstream, the Adult Mental Health programme, the All Age Suicide and Self Harm Strategy and the ICS Workforce Strategy. For this reason, we have closed some of the objectives included in previous iterations of this Plan but have reflected the need to remain cognisant of their importance through the review of our Principles and inclusion of new targets on our Performance Dashboard. Furthermore, reporting arrangements have been agreed to ensure the Transformation Programme Board remains updated on progress and, on our inclusion in and influence of, the work of other programmes such as Peri-natal that now sits within the Adult Mental Health programme.

In summary, as part of this review we have:

- developed a new Lancashire & South Cumbria Transformation Plan following boundary changes during 2018 in Morecambe Bay.

- looked at new national requirements and imperatives that have been published since the 2017/18 plan was refreshed, to ensure that this plan reflects these.

- introduced one new 'Principle' to guide our planning and deliver in regard to the needs of vulnerable children and young people.

- identified and celebrated what we have achieved to date.

- updated our objectives and deliverables.

- incorporated our current Performance Dashboard into the plan and included new elements including Self-Harm & Suicide targets along with targets relevant to the Early Intervention Services for Psychosis. This will show how well we are doing in improving experiences and services for children, young people and families. These will be reported quarterly to the Transformation Programme Board.

[3] https://professionals.carers.org/young-adult-carer-mental-health

- introduced 'Our Priorities for 2019/20' and a new section that focuses on our interdependencies with other programmes of work from across the L&SC ICS.

- secured sign-off for our refreshed plan across the health and social care system.

Principles

Our plan is underpinned by **nine** key Principles drawn from national policy and guidance, that inform all our work. We will:

1. work collaboratively with children, young people, families, carers, partners, providers and wider stakeholders to support them to:
    a. Shape, influence and drive forward the delivery of our objectives.
    b. Engage in the co-production of system solutions.
    c. Identify opportunities to improve efficiency, effectiveness and patient experience.
    d. Understand how their feedback has informed service development and redesign.

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

3. recognise and respond to the needs of children, young people and families who have protected characteristics. This will include undertaking Equality Impact and Risk Assessments and ensuring that we have due regard to the public sector equality duty (Equality Act, 2010)[4].

4. represent and respond to the needs of children, young people and families, including those deemed to be at greater risk due to their vulnerability, within our planning, commissioning, service delivery and strategy development.

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

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

[4] A Public Sector Equality Duty Guidance document has been developed.

7. strive to achieve ‘parity of esteem’ – valuing mental health equally with physical health, and that this principle will form the foundation of our planning and delivery.

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

9. sustain a culture of ‘continual learning and development’.

Achievements

By working collaboratively, we have achieved considerable improvements and progress in delivering the transformation programme. These are summarised on a year by year basis as below. Alongside this collaborative work, significant work has also been undertaken through local co-ordination and local partnership groups. Whilst local achievements are too many in number to detail within this plan, it is important to acknowledge the extensive work of local partners and the impact for children, young people and their families.

What have we achieved in year 1?

In 2016 we put all our foundational arrangements in place to support the work of the Transformation Programme (this included establishing our governance, initiating our work streams and developing our relationships). We also mobilised 13 key pieces of work that we believe will transform the system of service delivery for children and young people’s emotional well-being and mental health. These are represented below.

What have we achieved in year 2?

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

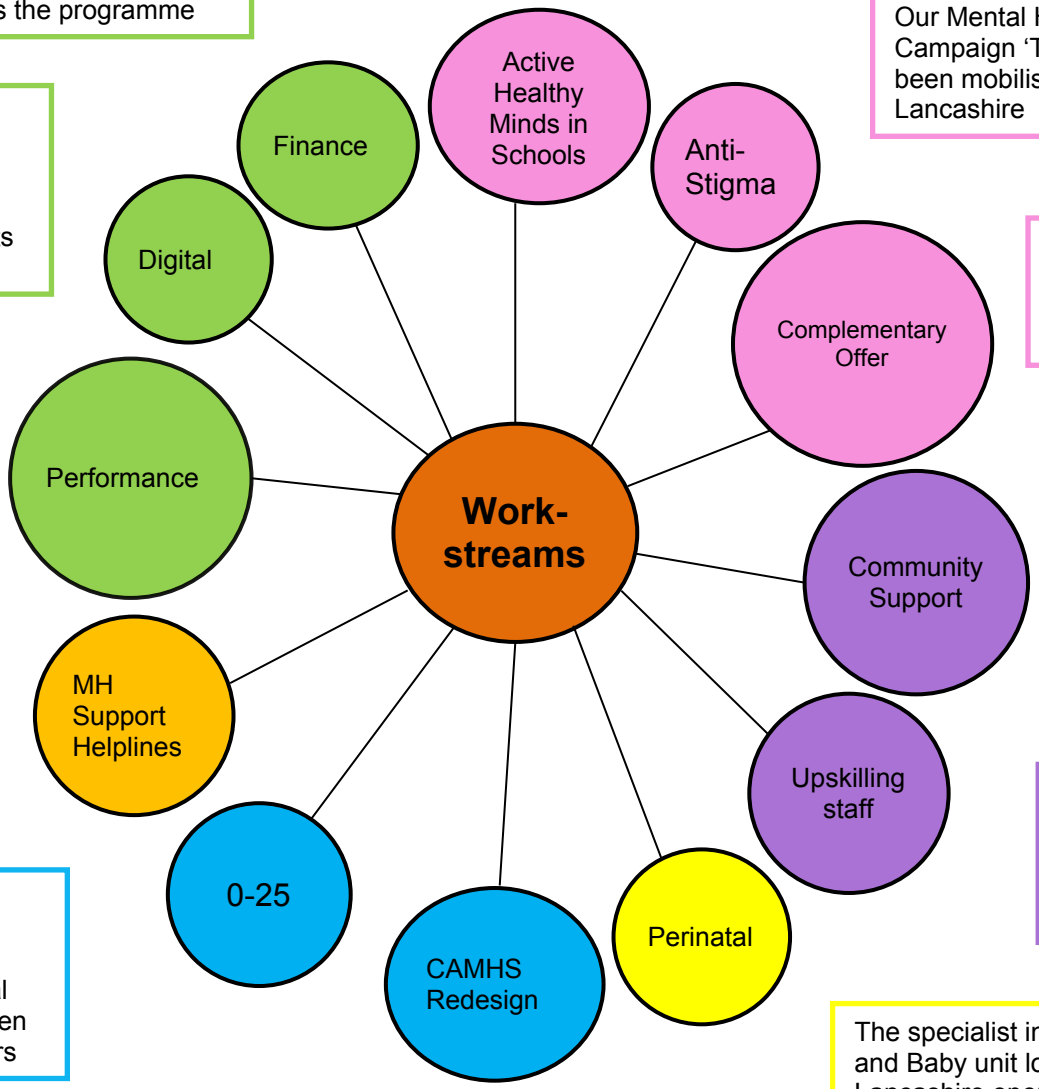
What have we achieved in year 3?

In 2018, we have seen success in delivering five key objectives identified within previous iterations of the Plan and have continued to promote our Anti-Stigma campaign. Our complementary offer of support to vulnerable people who do not access mainstream services has been defined, our Mother and Baby Unit opened ahead of schedule allowing at least an additional 21 women each year to receive evidence-based treatment closer to home when they need it; we have reviewed our dedicated all-age Community Eating Disorder service and made recommendations for future delivery; opportunities have been shared to upskill staff who are working with vulnerable groups

and interim community services have been secured to support children with behaviours that challenge pending our CAMHS redesign.

Our 4 NHS Trusts continued to work collaboratively with voluntary, community and faith sector providers and with CCGs to co-produce a core model for CAMHS services across Lancashire and South Cumbria through a process of engagement and co-production with children, young people, families and wider stakeholders. During 2018, an outline proposal for the clinical model was evaluated by a Core Panel made of up representatives from CCG Commissioners, Clinicians, Local Authorities and Public Health. There was also a Children and Young People's (CYP) Panel, a Family and Carers (F/C) Panel and an Education Panel who contributed to the evaluation process. Following feedback provided on the evaluation, Phase 2 of the work has commenced and will continue during 2019/20.

Review of Achievements to Date



Monitoring of investment across the programme

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

Our Mental Health Anti-stigma Campaign 'Time to Change' has been mobilised across pan-Lancashire

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

Our Complementary Offer of support to vulnerable people who do not access mainstream services has been defined

Enhanced our programme Performance Dashboard which is monitored bi-monthly

Interim community services have been secured to support children with behaviours that challenge pending the CAMHS Redesign

CYP, parents, carers, schools, the VCFS and other professionals are aware of the provision of mental health support helplines

Opportunities have been working with vulnerable groups across pan-Lancashire in line with the training gap analysis

Our local offer of service provision for CYP with emotional wellbeing and mental health needs has been defined for 0-25 years

The specialist inpatient Mother and Baby unit located within Lancashire opened in October 2018

Stakeholders including children, young people and their families have worked together to co-produce a draft model

What are our objectives going forward?

We have reviewed our plan and identified the following **four** key areas of work going forward to 2021. We have then defined a series of objectives that will serve to deliver the programme:

1. Promoting resilience, prevention and early intervention

Objectives:

1. All Primary Mental Health workers will be trained to deliver **'schools mental health first aid'** one day course.

2. Each team of Primary Mental Health workers will deliver four **'mental health first aid courses'** per year, to a maximum of 16 participants per course.

3. We will have mobilised our **'Complementary Offer'** of support for all children and young people that will wrap support around them and their families to avoid escalation, promote recovery and maintain wellbeing. This will be achieved by:

    a. developing a 'whole education approach' in supporting children and young people's social and emotional wellbeing in education settings influenced by the Resilience Framework and Resilience Programme.

    b. working with Local Authorities, Children's Trusts and other key partners to evaluate the minimum early intervention/prevention offer through qualitative and quantitative analysis of the provision.

    c. delivering a change programme that challenges stigma around mental health and evaluate its impact.

    d. empowering the community to co-produce and deliver creative approaches and interventions that raises awareness of mental health issues and supports children and young people to become increasingly engaged in their own community.

    e. developing and delivering a training programme to the wider CYP and family workforce that enables the workforce to contribute to the delivery of the Complementary Offer.

f. ‘Trauma Informed Practice’ informing the development and delivery of all practice, pathways and interventions and has due regard to policy.

2. Improving Access to Effective Support

Objectives:

4. We will have an online portal known locally as **‘Digital THRIVE’** offering information, advice, self-help, care pathways and self-referral for children and young people, parents and carers and professionals.

5. We will have **‘redesigned the CAMHS’** clinical model in Lancashire and South Cumbria in line with THRIVE delivering in year improvements by March 2020 including:

    a. out of hours provision within Acute systems

    b. delivery of the 0-19 service provision

6. We will have developed and agreed a **‘risk support approach’** in line with THRIVE informing the delivery of services and supports across the Complementary Offer and the CAMHS Redesign.

7. We will define and deliver specialist inpatient and community intensive support as part of **‘Getting More Help’** within THRIVE.

8. We will have mobilised the approved **‘redesign of CAMHS’**.

9. We will define and extend our current service models to create a comprehensive offer for **‘0-25year olds’** that reaches across mental health services for children, young people and adults providing an integrated approach across health, social care, education and the voluntary sector, in line with the NHS 10 Year Plan (2019).

10. We will have embedded the agreed **‘0-19 year eating disorder’** model in South Cumbria by March 2020.

11. We will have implemented recommendations from the **‘0-19 Eating Disorder Review’** (2019) into the future delivery of the All-age Eating Disorder model across the Lancashire & South Cumbria ICS footprint.

3. Ensuring appropriate support and intervention for CYP in Crisis

Objectives:

12. We will have developed a **'Case for Change'** regarding facilities in the community for young people experiencing emotional crisis

13. We will have co-produced and implemented a **'crisis training package':**

    a. to support families, carers and residential settings who are caring for young people in crisis

    b. for mental health professionals to improve their confidence in supporting young people in crisis and to avoid admissions or facilitate discharge

4. Improving Service Quality

Objectives:

14. We will have developed and evaluated against an **'outcomes framework'** to demonstrate the impact of the programme:

    a. Develop the specification

    b. Identify key sources of information

    c. Develop an outcomes framework

    d. Undertake an evaluation of the programme against the framework

    e. Report back to the Transformation Programme Board

15. To work with Health Education England (HEE), Skills for Care (SfC), the L&SC ICS and other relevant agencies to inform **'workforce strategies'** to deliver the right mix of skills, competencies and experience across the workforce.

16. **'Key Performance Indicators',** incorporating the Mental Health Standard Data Set (MHSDS), national transition CQUIN and CAMHS outcome

measures, will be monitored and challenged via the Performance Management Group and reported quarterly to the Transformation Programme Board with recommendations for action.

Our Priorities

For 2019/20, our 3 key priorities are to:

1. Develop an online portal known locally as 'Digital THRIVE' offering information, advice, self-help, care pathways and a self-referral process (Objective 4)

2. Redesign CAMHS and the Complementary Offer in line with the THRIVE model (Objective 3 and 5)

3. Define and deliver appropriate specialist inpatient and community intensive supports as part of 'Getting More Help' within THRIVE (Objective 7)

How will we deliver?

THRIVE Model

Building on the Future in Mind[5] principles of promoting, protecting and improving our children and young people's mental health and wellbeing, the programme has adopted the THRIVE model to underpin the development and redesign of services. THRIVE wraps services around children and young people allowing access to the correct level of support at the time that it is needed using a multiagency model.

The model consists of four quadrants:

- Getting Advice
- Getting Help
- Getting More Help
- Getting Risk Support

When it comes to delivering services, all partners are committed to delivery being as close to children, young people and their families as possible with integrated neighbourhood care teams seen as the core delivery mechanism for the majority of community services.

5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Governance

The CYPEWMH Transformation Programme sits within the All Age Mental Health portfolio of the Healthier Lancashire & South Cumbria (HL&SC) Integrated Care System (ICS) and as such reports into the HL&SC Portfolio Management Group and the ICS Executive Leadership Team. As part of this wider programme of work to deliver sustainability and transformation across the ICS, CYPEWMH works collaboratively with a number of other complimentary portfolios including Prevention & Population Health, Digital, and Workforce. A copy of the L&SC ICS Governance structure is included at Appendix 6.

Implementation of the plan is overseen by the Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme Board. As of 2019, the Board includes key partners from across both Lancashire and South Cumbria and is supported by the Clinical Reference Group and the Commissioning & Finance Group. A copy of the CYPEWMH L&SC Governance structure is included at Appendix 1.

The Transformation Programme Board has become an effective body working with a range of services and organisations including 4 Child & Adolescent Mental Health Services (CAMHS), 8 Clinical Commissioning Groups (CCGs), 4 Local Authorities, 7 NHS Trusts, hundreds of schools, a wide ranging third sector including voluntary and faith groups, primary care, community services, various children and young people's support services and groups, and children, young people and their families.

Consensus for recommendations is made by consulting with the appropriate groups through several cycles for each project and at least one cycle involving children, young people, their carers and the public.

The role of the Transformation Programme Board is to:

a. lead in the design, delivery, implementation, review and evaluation of the 5-year Transformation Plan.
b. oversee workstreams, implementation groups, task and finish groups etc. in line with the agreed governance structure.
c. support positive channels of communication and engagement activity.
d. make recommendations for commissioning arrangements including investment priorities and the use of resources.
e. make recommendations for service improvements and new delivery models.
f. make decisions on behalf of organisations in line with delegated decision-making authority.

The Clinical Reference Group is a sub-group of the Board and operates as a support to the work of the Board by:

a. providing a strong professional and clinical voice.
b. giving clinical opinion on matters relating to service development/service improvement.
c. providing a place to test clinical feasibility.
d. operating as a space from which to make shared clinical recommendations.
e. being a place where the work of the Board can be aligned to existing and emerging evidence and best value practice (and vice versa).
f. providing a mechanism for co-production and clinical consultation.
g. being a capacity and capability support to work streams.
h. operating as a transparent and professional forum that ensures a focus on clinical excellence.

The role of the Commissioning & Finance Group:

The purpose of the Commissioning & Finance Group will be to work collaboratively with all relevant key stakeholders to guide the deliverables and overall objectives of the programme. This group is not a decision-making group. Recommendations from the group will be presented to the Children and Young People Emotional Wellbeing and Mental Health Transformation Programme Board and the Directors of Finance Group for appropriate sign off.

Aims of the group are to:

a. reduce the complexity of current commissioning arrangements through joint commissioning and service redesign, developing a system that is built around the needs of children, young people and their families
b. have clear governance arrangements which hold each partner to account for their role in the system
c. Increase transparency through the development of robust metrics on service outcomes
d. ensure that our increased levels of investment will be used transparently, equitably and demonstrate value for money by working together

The role of the **Performance Management Group**:

The purpose of the Performance Management Group will be to work collaboratively with all relevant key stakeholders to support the deliverables and overall objectives of the Improving Service Quality workstream.

We will:

a. have clear governance arrangements which hold each partner to account for their role in the system
b. increase transparency through the development of robust metrics on service outcomes
c. ensure that our increased levels of investment will be used transparently, equitably and demonstrate value for money by working together
d. report the Performance Dashboard on a quarterly basis to the Transformation Programme Board or as required

Programme Management

A Programme Dashboard is in place and currently used to monitor monthly progress against the 16 objectives, and to manage risks and issues within the Transformation Plan with a summary report presented to the Board each month.

For each objective on the dash board a project initiation document incorporating project objectives, benefits and key milestones is developed and signed off through the programme governance.

Enablers

The overarching four workstreams consist of a number of projects with principles and enablers translating the desired outcomes into practice. There are four key enablers supporting the programme:

a. Engagement with children, young people and their families or carers
b. Communication
c. Finance
d. Business Intelligence

Engagement with children, young people and their carers has continued in order to obtain insight and intelligence to inform projects of the improvements and benefits but also the problems and difficulties they have faced whilst using a service.

Since 2016, we have effectively engaged with children, young people and our stakeholders to inform our decision making. After working with children and young people to co-design a visual identity (branding) for the transformation programme, we are now working with children and young people, professionals, carers and family members in order to co-produce a website. We are working with these groups to better understand what they would like from the website, how it will work, what information will

be held on the website, how information will be displayed, and the format of the information i.e. using text and/or videos. 2019 will see greater development of the website, shaped by the views and insights obtained from children and young people, professionals, carers and family members.

During 2019 we will work with children and young people to create films of commonly used venues to allow children, young people, carers and family members to see the location of a forthcoming CAMHS appointment. This filming is a direct result of the feedback and insights from our active engagement with children, young people, carers and family members. We understand that the run up to attending an appointment can be an anxious time when people may not know what to expect, especially if it is a first appointment. By creating video guides people will be able to view the venue of the appointment and therefore allow the person to prepare for the appointment. We also have several forthcoming opportunities for children and young people to create content for the website.

We have hosted numerous surveys via a range of methods - paper, electronic and social media. Using this information, we have been able to better understand patient and carer experience, and so inform decision making.

We have continued to grow the national anti-stigma 'Time to Change' campaign and will run 'Time to Change' training sessions at various locations within Lancashire and South Cumbria. As part of adopting the 'Time to Change' campaign we also promoted and raised awareness of 'Time to Talk' day on Thursday 7th February 2019.

Extensive stakeholder development has continued, and we will continue to work with and strengthen stakeholder partnerships, working with stakeholders to inform decisions and shape change as we move forward. An example being that, stakeholders are invited to be part of various work streams within the programme in order to contribute valuable expertise and insight.

The large-scale change that is being implemented, facilitated through the Transformation Plan, requires large scale **communication** between organisations, staff, the public, children, young people and their carers. There are systems in place to maintain the governance of the programme, which promotes communication between the organisations in the Governance Structure (Appendix 1), this takes the form of presentations to the relevant Boards and a bi-monthly bulletin. Continual work is being carried out to grow and strengthen communication channels and networks.

In addition, we continue to grow our social media presence via our already established Twitter channel. In 2018 we also saw the launch of our Healthy Young Minds - LSC Facebook account which we are developing and promoting as we move forward, providing wider engagement opportunity for all stakeholders.

Finance is governed by the Commissioning & Finance Group who have put systems in place to make recommendations and monitor spend; it is led by a Chief Finance Officer from one of the member CCGs.

Business intelligence - the Programme has commissioned and works closely with colleagues within the Midlands & Lancashire CSU Business Intelligence Team. The team collates and analyses data with specific regard to our Key Performance Indicators, working closely with task groups to deliver accurate and up to date information/data as required. In addition, the team supports the quality assurance and monitoring responsibility of the Programme through the presentation of monthly reports to the Performance Management Group and quarterly reports to the Transformation Programme Board.

Interdependencies

The CYPEWMH Programme is one of a number of key programmes within the Lancashire & South Cumbria Integrated Care System and as such there is value in our being cognisant of their work and vice versa. Consideration of how we can engage in, influence and contribute to their decision making, planning and delivery, on behalf of children, young people and their families is a central to our planning.

The Programme has identified five key interdependencies:

- Adult Mental Health including the Peri-natal programme
- Learning Disability & Autism workstream
- Workforce Development
- Commissioning Development
- Prevention and Population Health and the work of the All Age Self Harm and Suicide Prevention programme

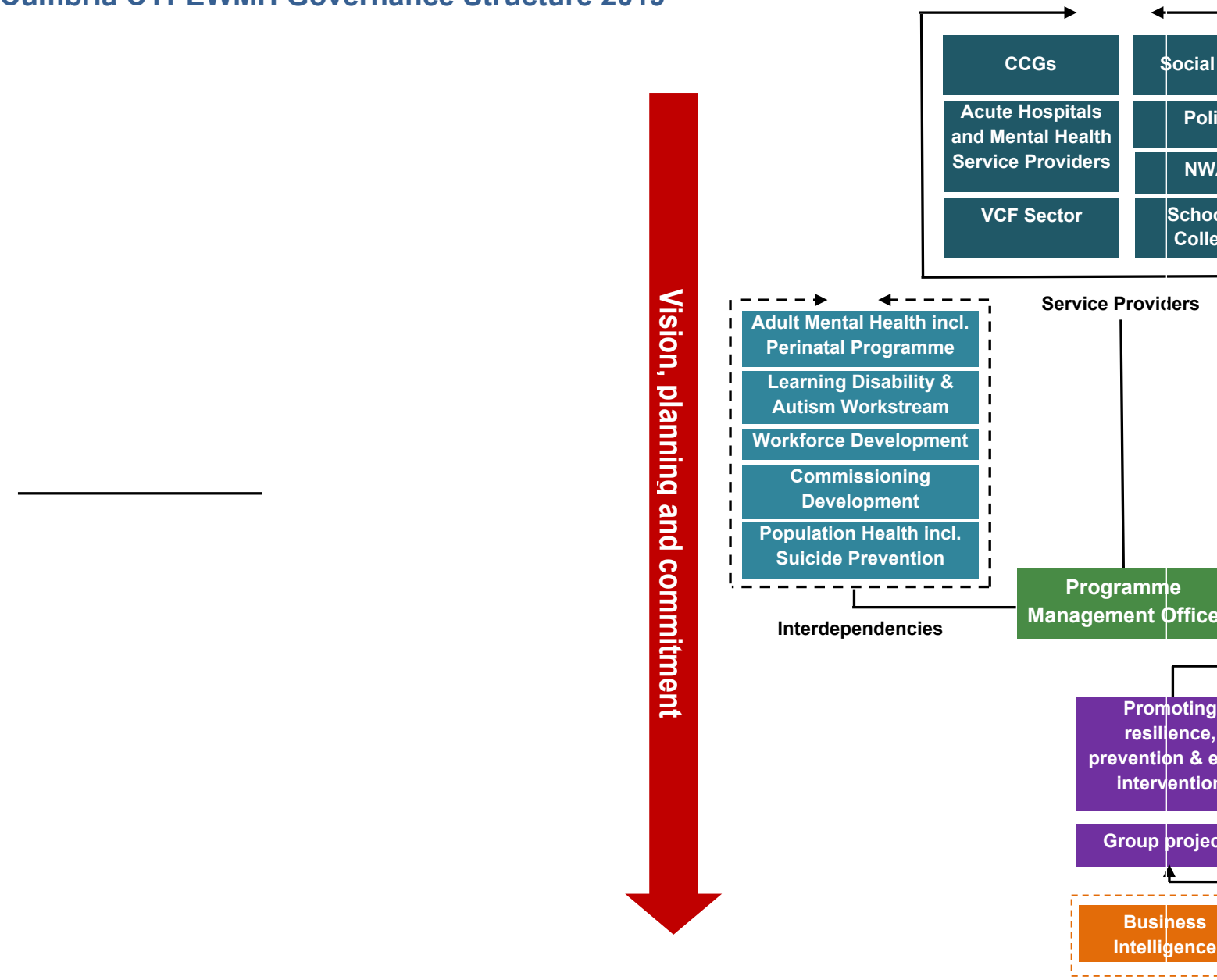
Partners

We work collaboratively with a wide range of partners and stakeholders, many of whom have been identified within our Governance Structure below (Appendix 1).

It is important to us to ensure that the communities of Lancashire & South Cumbria are equitably represented through our partners. To support this, we will continue to explore and utilise creative ways to support engagement and participation through the use of digital technology to minimise the distance people have to travel, especially given our new geographical footprint.

We regularly check the membership and accessibility of our groups and seek ways to remain engaged with all of our key partners and stakeholders especially representatives from our four Local Authorities and Public Health services; the Voluntary, Community & Faith sector; schools, colleges and further education providers; and our Health and Social Care providers. This section has been included following feedback from our consultation (Appendix 5).

Appendix 1 - Lancashire & South Cumbria CYPEWMH Governance Structure 2019



Appendix 2 - Summary of new national must do's and imperatives 2018/19

ID	Narrative	Reference
	'Transforming children and young people's mental health provision' https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper	DH, HEE (2018) Government response to the consultation on 'Transforming children and young people's mental health provision: a green paper' and next steps
	NHS Long Term Plan https://www.england.nhs.uk/long-term-plan/	NHS Long Term Plan 2019
	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770675/The_Handbook_to_the_NHS_Constitution_-_2019.pdf	DH. (2019), The handbook to the NHS Constitution
	https://www.ucl.ac.uk/pals/sites/pals/files/self-harm_and_suicide_prevention_competence_framework_-_children_and_young_8th_oct_18.pdf	Health Education England (2018) Self-harm and suicide prevention competence framework, for children and young people
	https://www.childrenssociety.org.uk/sites/default/files/the_good_childhood_report_full_2018.pdf	The children's society, (2018) The Good Childhood Report 2018

ID	Narrative	Reference
	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pd	DHSC HEE (2018) Government response to the consultation on *Transforming Children and Young People's Mental Health Provision:* a green paper and next steps
	Future in Mind https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf	DH (2015) Future in Mind, promoting, protecting and improving our children and young people's mental health and wellbeing
	Robust local workforce plans to grow and transform the Mental Health workforce, aligned with finance and service plans p.28 https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan	Stepping Forward to 2020/21: Mental Health Workforce Plan for England
	New support for schools with every secondary school in the country to be offered mental health first aid training and new trials to look at how to strengthen the links between schools and local NHS mental health staff https://mhfaengland.org/mhfa-centre/news/2017-01-09-government-announces-plans-for-youth-mental-health/	Government announcement (Jan 17)
	Robust local workforce plans to grow and transform the Mental Health workforce, aligned with finance and service plans https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan	Stepping Forward to 2020/21: Mental Health Workforce Plan for England

ID	Narrative	Reference
	Improved care for children and young people. An extra 35,000 children and young people being treated through NHS-commissioned community services next year compared to 2014/15, growing to an extra 49,000 children and young people getting the care they need in two years' time. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf	Next Steps on the NHS Five Year Forward View
	Approval of courses for approved mental health professionals http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted	Children & Social Work Act (2017)

Appendix 3 - Finance

There is a national expectation that investment in children's mental health is expected to continue to rise over the course of the five-year Transformation Programme, up to 2020 as outlined in Table 1 below. The investment is added into CCG baselines. Future investment is being linked to the achievement of targets aimed at increasing access to support for those with a diagnosable mental health need. It should be noted that revised figures published by the Department of Health in 2018 have resulted in a slight change to the figures in the table below from those presented in the 2018/19 Transformation Plan.

Table 1 – Total Transformation Funding by CCG

CCG Name	2016/17	2017/18	2018/19	2019/20	2020/21
Blackburn with Darwen CCG	£367,510	£432,277	£524,658	£586,151	£647,531
Blackpool CCG	£423,027	£497,579	£603,915	£674,698	£745,350
Chorley and South Ribble CCG	£392,084	£461,182	£559,739	£625,344	£690,827
East Lancashire CCG	£889,325	£1,046,053	£1,269,603	£1,418,359	£1,566,595
Fylde and Wyre CCG	£360,870	£424,467	£515,179	£575,561	£635,831
Greater Preston CCG	£445,867	£524,444	£636,522	£711,126	£785,593
Morecambe Bay CCG (Lancashire North)	£353,363	£415,637	£504,462	£563,588	£622,605
Morecambe Bay CCG (South Cumbria)				£737,080	£814,265
West Lancashire CCG	£247,296	£290,877	£353,040	£394,418	£435,720
Total Lancashire	**£3,479,341**	**£4,092,516**	**£4,967,120**	**£6,286,324**	**£6,944,317**

Increased Investment from 2014/15 – 2018/19

The following table shows the investment by CCG for 2018/19 compared to the baseline position in 2014/15.

	0-18 pop (10%)	2014/15 Baseline	£ per prevalent child	2018/19	£ per prevalent child
Blackburn With Darwen CCG	4463	£1,286,230	£288.20	£1,833,175	£410.75
Blackpool CCG	3413	£ 2,188,255	£641.15	£2,526,072	£740.13
Chorley & South Ribble CCG	3851	£1,287,350	£334.29	£1,823,739	£473.58
East Lancashire CCG	10755	£3,652,596	£339.62	£4,833,839	£449.45
Fylde & Wyre CCG	2807	£987,070	£351.65	£1,593,344	£567.63
Greater Preston CCG	4635	£1,206,841	£260.38	£1,695,522	£365.81
Morecambe Bay CCG (Lancashire North)	3095	£662,366	£214.01	£1,129,621	£364.98
West Lancashire CCG	2284	£862,548	£377.65	£1,220,980	£534.58
Lancashire Total	**35,303**	**£12,133,256**	**£343.69**	**£16,656,292**	**£471.81**

In 2018/19 the 85% aligned transformation funding was spent across several transformation priorities. Details are shown in table 2 below. A significant proportion, 27% (£1.1m of £4.3m of transformation funding) was allocated to plug the gap left by the withdrawal of funding by Lancashire County Council (LCC) from the CAMHS services. This is now a recurrent position, so the decision has been taken to continue to support these services to preserve current levels of access and to safeguard the access targets. The outcome of the alternative investment by LCC into emotional health and well-being support is being monitored by the Transformation Board.

Table 2 - Allocated Spend of 2018/19 Aligned Transformation Funding (85%)

Theme	Objective	Grand Total
Ensuring appropriate support and intervention for C&YP in Crisis	Continue to fund the 7 day CAMHS response and support its implementation across Lancashire	£630,261
	CAMHS Crisis / Home Treatment	£53,554
	Psychiatry input to 7 days CAMHS response	£60,000
General	Transformation Coordination & Events	£119,293

Improving Access to Effective Support	Purchase additional capacity from LCFT (0-19 CAMHS replacement of LCC Disinvestment)	£1,129,695
Improving Care for the most Vulnerable	As part of the ASD/ADHD pathway work we will develop our pre and post diagnosis support offer	£314,067
	Behavioural Support Programme	£229,920
Improving Service Quality	While we are working on this, we will continue to fund IAPT trainees	£347,481
Increasing Access to Perinatal and Infant Mental Health Support	Continue to fund perinatal pathway pilot schemes where evidence suggests	£66,197
Promoting Resilience, prevention and Early Intervention	Complimentary offer of support to wrap around clinical services	£262,210
	Kooth	£34,000
	Primary Mental Health Workers/Psychological Wellbeing Practitioners	£653,957
	Youth Mental Health	£3,790
Other	Other Blackpool	£79,004
	Care Partnership Support	£150,000
Grand Total		**£4,133,429**

The remaining 15% would stay in the CCGs to fund local coordination and innovation.

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

In line with the Five Year Forward View for Mental Health the eight CCGs have, in addition to the above investment, commissioned a pan Lancashire Community Eating Disorder service.

The contributions to this are detailed in the table below:

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

Appendix 4 - Performance

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

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

CYP Access Targets

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

1. Targets based on the **original baseline** which was submitted for the **NHS England plan** in 2017 and is based on a definition which was lacking some clarity nationally. This was used to provide the programme with an early indication of performance until the national definition was further clarified. 2018/19 plan has been based on the finalised NHSE definition for this indicator
2. **Local Position** which is calculated using data that is collected locally, based on the national definition and monitored locally to understand the current position.
3. **National Mental Health Data Set (MHSDS) position** which is based on the data that is submitted to the MHSDS and is expected to be used for monitoring the indicator nationally by NHSE. Currently only a limited amount of local data is flowing to the MHSDS.

NHS England have advised to continue to monitor against all 3 of the above views. Therefore, this is monitored on a monthly and quarterly basis via several internal and external meetings.

Access Targets as per the NHSE submitted plans

CCG	Total no. of CYP aged 0-18 with a diagnosable mental health condition	16/17 Baseline (Ref accepted)		16/17 Baseline (1st Treatment)		2017/18	Total NEW no. of CYP aged 0-18 with a diagnosable mental health condition	2018/19	2019/20	2020/21
						30%		32%	34%	35%
NHS Blackburn with Darwen CCG	3,871	762	20%	463	12%	1,161	3,871	1,239	1,316	1,355
NHS Blackpool CCG	2,952	1,298	44%	767	26%	886	2,952	945	1,004	1,033
NHS Chorley And South Ribble CCG	3,227	700	22%	349	11%	968	3,227	1,033	1,097	1,129
NHS East Lancashire CCG	8,115	1,747	22%	1,058	13%	2,435	8,115	2,597	2,759	2,840
NHS Fylde & Wyre CCG	2,293	548	24%	260	11%	688	2,702	865	919	946
NHS Greater Preston CCG	3,975	736	19%	378	10%	1,193	3,975	1,272	1,352	1,391
NHS Morcambe Bay CCG	6,398	NA	NA	NA	NA	1,919	6,084	1,947	2,069	2,129
- Lancashire North	3,059	468	15%	304	10%	918	2,616	837	889	916
- South Cumbria	3,339	NA	NA	NA	NA	1,001	3,468	1,110	1,179	1,214
NHS West Lancashire	2,040	397	19%	237	12%	612	2,040	653	694	714
Lancashire & SC CCGs Total	32,871					9,861	32,966	10,549	11,208	11,538

Access Targets as per the Local calculated position

		Part 1a: The number of children and young people with a new referral from 1st January 2016, receiving at least two contacts (Including Indirect contacts) within six week period where their first contact occurs before their 18th birthday		Part 2a: The number of children and young people, regardless of when their referral started, receiving at least two contacts (Including Indirect contacts) and where their first contact occurs before their 18th birthday				Part 2a: The number of children and young people, regardless of when their referral started, receiving at least two contacts (Including Indirect contacts) and where their first contact occurs before their 18th birthday			
CCG	CYP aged 0-18 with a diagnosable mental health condition	16/17 Baseline Actuals (CYP New referrals receiving at least 2 contacts within 6 weeks period)		16/17 Baseline Actuals (All CYP) versus 28% Target		17/18 Actuals (All CYP) versus 30% Target		Total NEW no. of CYP aged 0-18 with a diagnosable mental health condition	2018/19 @ 32% Target	2019/20 @ 34% Target	2020/21 @ 35% Target
NHS Blackburn with Darwen CCG	3,871	291	8%	767	20%	1,292	33%	3,871	1,239	1,316	1,355
NHS Blackpool CCG	2,952	624	21%	1,154	39%	1,651	56%	2,952	945	1,004	1,033
NHS Chorley And South Ribble CCG	3,227	461	14%	987	31%	1,371	42%	3,227	1,033	1,097	1,129
NHS East Lancashire CCG	8,115	799	10%	1,769	22%	3,312	41%	8,115	2,597	2,759	2,840
NHS Fylde & Wyre CCG	2,293	418	18%	818	36%	1,313	57%	2,702	865	919	946
NHS Greater Preston CCG	3,975	417	10%	905	23%	1,403	35%	3,975	1,272	1,352	1,391
NHS Morcambe Bay CCG	6,398	323	5%	548	NA	1,806	28%	6,084	1,947	2,069	2,129
- Lancashire North	3,059	323	11%	548	18%	1,806	59%	2,616	837	889	916
- South Cumbria	3,339	NA	NA	NA	NA	NA	NA	3,468	1,110	1,179	1,214
NHS West Lancashire	2,040	295	14%	574	28%	851	42%	2,040	653	694	714
Lancashire & SC CCGs Total	32,871	3,628	11%	7,522	23%	12,148	39%	32,966	10,549	11,208	11,538

All Lancashire and South Cumbria CCGs have achieved the access target (see table above for details) during 2017/18 apart from Morecambe Bay CCG. Four CCGs have either met or exceeded the 2018/19 trajectory at quarter 3 YTD (see table below for details). The 2019/20 and 2020/21 trajectories may be amended further dependant on actual performance for 2018/19 and new guidance during the re-submission of the CCG plan.

Please note that the local position for 2017/18 is based on main providers[6] and voluntary sector providers data.

[6] Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust

Access Targets position based on MHSDS

18/19 Actuals (All CYP @ Qtr 3) versus 32% Target

CCG	Part 2a	Prevalence Annual (2B)	Target Achieved
NHS Blackburn with Darwen CCG	905	3,871	**23%**
NHS Blackpool CCG	1,260	2,952	**43%**
NHS Chorley And South Ribble CCG	675	3,227	**21%**
NHS East Lancashire CCG	1,715	8,115	**21%**
NHS Fylde & Wyre CCG	690	2,702	**26%**
NHS Greater Preston CCG	625	3,975	**16%**
NHS Morcambe Bay CCG	1,195	6,084	**20%**
NHS West Lancashire	475	2,040	**23%**
Total	**7,540**	**32,966**	**23%**

Please note that Fylde & Wyre CCG's prevalence changed in 2017/18 from 2,293 to 2,702 and Morecambe Bay CCG's prevalence changed in 2018/19 from 6,398 to 6,084.

Further work is underway to include voluntary sector providers activity which should therefore improve this position during Q4 period.

CCG Trajectories for Eating Disorder Service

CCG trajectories for eating disorder services show performance increasing from 20% to 95% over a five-year period. It is expected that the Children and Young People Eating Disorder services achieves, by 2020, a minimum of 95% of referrals waiting less than the targets above and depicted below:

No. Urgent Patients seen within 1 week	2016	2017	2018	2019	2020	2021
	20%	40%	60%	80%	95%	95%

No. Routine Patients seen within 4 weeks	2016	2017	2018	2019	2020	2021
	20%	40%	60%	80%	95%	95%

CCG Actuals for Eating Disorder Service

There are two waiting time standards Eating Disorder services are required to respond to, these are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within:

- One week for urgent cases
- Four weeks for every other case

Routine (% seen within 4 weeks)

CCG	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 YTD 2018/19
NHS BLACKBURN WITH DARWEN CCG	100%	100%	67%	88%
NHS BLACKPOOL CCG	83%	100%	100%	94%
NHS CHORLEY AND SOUTH RIBBLE CCG	80%	86%	80%	82%
NHS EAST LANCASHIRE CCG	100%	62%	43%	58%
NHS FYLDE & WYRE CCG	100%	100%	75%	91%
NHS GREATER PRESTON CCG	50%	58%	100%	75%
NHS MORECAMBE BAY CCG	0%	82%	100%	92%
NHS WEST LANCASHIRE CCG	88%	75%	100%	89%
Total	84%	76%	79%	81%

Routine (No's seen within 4 weeks)

CCG	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 YTD 2018/19
NHS BLACKBURN WITH DARWEN CCG	4	1	2	7
NHS BLACKPOOL CCG	5	4	8	17
NHS CHORLEY AND SOUTH RIBBLE CCG	4	6	8	18
NHS EAST LANCASHIRE CCG	4	8	6	18
NHS FYLDE & WYRE CCG	1	6	3	10
NHS GREATER PRESTON CCG	1	7	3	11
NHS MORECAMBE BAY CCG	0	9	10	19
NHS WEST LANCASHIRE CCG	7	3	6	16
Total	26	44	46	116

Urgent (% seen within 1 week)

CCG	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 YTD 2018/19
NHS BLACKBURN WITH DARWEN CCG	-	100%	0%	50%
NHS BLACKPOOL CCG	100%	100%	-	33%
NHS CHORLEY AND SOUTH RIBBLE CCG	100%	-	50%	75%
NHS EAST LANCASHIRE CCG	50%	50%	0%	40%
NHS FYLDE & WYRE CCG	-	-	100%	100%
NHS GREATER PRESTON CCG	100%	-	40%	43%
NHS MORECAMBE BAY CCG	100%	100%	-	67%
NHS WEST LANCASHIRE CCG	-	25%	-	25%
Total	93%	60%	40%	48%

Urgent (No's seen within 1 week)

CCG	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 YTD 2018/19
NHS BLACKBURN WITH DARWEN CCG	0	1	0	1
NHS BLACKPOOL CCG	2	1	0	3
NHS CHORLEY AND SOUTH RIBBLE CCG	2	0	1	3
NHS EAST LANCASHIRE CCG	1	1	0	2
NHS FYLDE & WYRE CCG	0	0	1	1
NHS GREATER PRESTON CCG	5	0	2	7
NHS MORECAMBE BAY CCG	4	2	0	6
NHS WEST LANCASHIRE CCG	0	1	0	1
Total	14	6	4	24

The tables above show CCG performance against the 2018 target of 60% for both urgent patients seen, and routine patients seen. Performance against the routine target as at Quarter 3 2018/19 is at a satisfactory level as the target is currently being met Quarter to Date. CCGs are currently working with the provider, with plans in place to improve performance for urgent referrals to be seen against the target of 60%.

Further work is underway in conjunction with NHS England to confirm an accurate methodology to monitor performance as low numbers tend to skew performance for this indicator. Locally the All-Age Eating Disorder Service Review would also support this indicator.

Appendix 5 - Consultation and feedback

Over 500 stakeholders received an email with the link inviting them to read the re-freshed Plan and respond to the consultation survey. The survey and the Transformation Plan also featured within the Healthier Lancashire & South Cumbria Integrated Care System newsletter which has a mailing membership of 1,057. Social media was utilised to promote the Transformation Plan and the consultation survey. The link to the re-freshed Plan and consultation survey reached 542 people via Facebook with 35 engagements[7] and 3,893 people via Twitter with 45 engagements[8]. Within the newsletters and emails, people were also invited to share the Transformation Plan and take up the opportunity to comment on it.

Stakeholders were asked to indicate the extent to which they agreed with the Plan and the priorities set out and then to provide an explanation of their response. Respondents were also asked some questions about themselves to help us understand their comments and ensure representation. There were 39 completed responses. Of the respondents, 2 disagreed with the objectives and the majority (58.07%) agreed fully with them, 35.48% of respondents felt that they partly agreed with the objectives. All groups of respondents (i.e. service users, parents/carers, health professionals, members of the public and others) had some respondents who partly agreed with the refreshed objectives. The largest group of respondents were from local authority (29.03%), followed closely by health professionals (22.58%) with parents and carers accounting for (19.36%). 12.9% of respondents were from other groups such as voluntary and faith sector, social work or children's advocate. A further 3.23% of respondents were young people and service users. Most of the respondents were female (70.97%). Whilst there is no reason to think that males, whether service users or not, feel any differently about the objectives, as we only have a small level of male respondents, we cannot say this conclusively. There is some representation from the Indian communities (6.45%) but there is under representation from certain other groups however 4 respondents skipped the question therefore we don't have a full picture of all sections of the demographics of the respondents.

We strive to engage with our wide range of diverse stakeholders across our vast geography, this year we have received contributions from several seldom heard communities which haven't been represented in previous years. In order to increase engagement with our vulnerable groups we will continue to build on stronger communication channels as we move forward, to ensure we continue to involve and engage with as many members of society as possible.

[7] Facebook engagement rate; an engagement includes when people preform actions on to your post/page for example someone may like, share, click on a link or comment

[8] Twitter engagement rate; an engagement includes any way someone interacts with a tweet, including but not limited to, retweets, clicks and likes.

Nearly a quarter of respondents made a comment(s), replying to 'please tell us why'. The comments were largely positive but quite varied; although several common themes/points could be identified. The most common points made are as follows:

- The objectives are strong for school aged children but need strengthening for the early years
- The objectives are in line with the local need
- Online portals are services youths are likely to access and be open and honest
- Need more work for those suffering on a low level - to stop them escalating before interventions
- I do agree with the objectives but would say time needs to be spent making sure that provisions are resourced properly, and all health care professionals are aware of where to signpost young people.

We thank all of those who took the time to reply to the survey and your comments have been responded to within the next section – You Said, We Did.

You Said **Do you agree with our objectives for the next 3 years?**	We Did
I do agree with the objectives but would say time needs to be spent making sure that provisions are resourced properly and all health care professionals are aware of where to signpost young people	Thank you for your agreement with the objectives. Please find our response to your comments: **Resourcing** – we continue to support the work of the ICS Workforce Strategy and the individual workstreams also have the needs of the workforce high on their agenda. The Plan has been developed with the support of colleagues within the 8 CCGs and is reviewed monthly within the Commissioning & Finance group. Your comments will also be shared with this group. **Awareness** – with any changes and service developments, we recognise the importance of ensuring those working closely with children and young people understand the support pathways and how

	best to signpost people. The CYPEWMH Website aims to provide one element of the support options that will be available to both individuals and professionals taking account of geography, availability and accessibility The CAMHS Redesign will also map out an implementation plan that will be asked to consider awareness raising of any changes.
I feel we need to consider the needs now and the vulnerabilities of children. Educating them more than we are.	Within the Plan we have been able to celebrate the achievements that have been made over the last 3 years. But we continue to acknowledge that the needs of children and young people remain central to our day to day work and our planning for the future - **Objectives 1 - 3** The Plan recognises the needs of **vulnerable children and young people** and have now included reference to our Young Carers – pages 6 & 7 The Plan has and continue to explore new ways of raising awareness of Mental Health issues within our **schools and colleges** – the Plan continues to support the role of Primary MH Workers and the introduction of MH Champions in schools in line with the Green Paper. **School and Colleges** also remain strong partners within the Governance of the programme.

Need more work for those suffering on a low level - to stop them escalating before interventions	The Plan offers a specific focus on the development of the **'Complementary Offer'** (Objective 3) and also the design and implementation of **Digital Thrive** (Objective 4) delivering online information via our Website as part of a range of low-level interventions.
The objectives are strong for school aged children but need strengthening for the early years	The Plan recognises the importance of considering the needs of children and young people from 0 – 25 years. Your concern for those **under school age** is acknowledged, the needs of all CYP aged 0-19 are in scope for the CAMHS Redesign and includes the following requirement 'take referrals from birth up to 18th birthday and continue to support up to 19th birthday, as needed' (Objectives 5 & 9) In addition, the **'Complementary Offer**' takes into account the needs of young children/early years support (Objective 3)
Concern that whilst putting right the system YP 'almost in crisis' remain unsupported for such long periods of time they disengage and even if/when support becomes available they are beyond feeling able to access it	The Plan embraces the principles of the **THRIVE Model** incorporating the Complementary Offer, Digital THRIVE and the CAMHS Redesign. The **'Complementary Offer'** in particular aims to wrap support around them and their families to avoid escalation, promote recovery and maintain wellbeing (Objective 3) Your comments will however also be shared with the workstream leads.

The objectives are in line with the local need, we need to join all our pathways and develop joined up working but also have a sustainable model that can last the test of time	Thank you for your comments. The principles of the THRIVE Model aim to ensure that services and support work **seamlessly and collaboratively**. In addition, workshops have been delivered with service providers and clinical leads to ensure that where **pathways** exist that they are aligned and understand if gaps exist in our future plans. The Programme Board along with the Lancashire & South Cumbria Integrated Care System, seek to achieve **sustainability** within the service transformations they oversee. The objectives within this Plan aim to deliver this. Your comments will be shared with the Programme Board
It has been very difficult to read the professionalized jargon in this plan and therefore young people are unable to comment in depth about whether they agree or not with the objectives. would it be possible to extend the deadline and circulate the key information translated into plain English	We thank you for this comment however, we are unable to extend the **deadline** as we are accountable to the timescales of NHS England. However, we will in future strive to use **plain English** within our Plan. We also aim to deliver a **'User Friendly'** version of this Plan following sign off at our Board. Next year, we will produce a **user-friendly** version relevant to children and young people prior to the consultation period and it will be this document that children and young people will be asked to comment on. Your comments will be shared with our Communication and Engagement team.

The positive intent of this document is clear but as someone who has a lot of experience in this area I remain very concerned that the child mental health strategy is far too short on clarity about the systemic reasons we are seeing so many very stressed children. Given the amounts being invested in the reorganisation itself there is an urgent need for a stronger bigger picture evidence based analysis that is no where apparent in this document.	The Board and the Programme leads share your concerns. National Strategy and research drives and influences the shape of our Plan. But in turn we seek the opportunity to contribute to wider research which serves to inform and give **clarity on the reasons** for increased incidence of mental health issues amongst children and young people. Our Plan serves to address both the practical, and system wide changes that are needed to respond to key issues and 'must do's' identified through national policy. **Evidence based decision making and analysis** is undertaken at both CCG and ICS level and drives the local planning agenda. Findings and prevalence data inform development work being undertaken. Your comments will be shared with the Programme and relevant groups
The revised document is too complacent. On the ground, as a Third Sector provider, we have seen no improvement in many of the provisions. There is lip-service (only) paid to the contribution of the 3rd Sector. More imagination should be used in helping to fund these useful (and cheaper!) organisations. Meetings are time-consuming, and often involve senior staff going long distances, taking them away from their day-day roles.	The opportunity to refresh the Plan also provides the opportunity to celebrate our achievements. In revising our objectives and priorities, we endeavour to drive change that will offer sustainability locally whilst meeting national expectations. It is regrettable that you feel this plan **is too complacent** however your comments will be shared with the Transformation Board for consideration.

	We recognise the contributions of the **Voluntary, Community and Faith sector** as one of our key partners and have included further wording to support this within the Plan. In addition, we are currently undertaking a full review of our governance arrangements which will include membership, roles and expectations. We continue to explore and apply creative solutions to enable all out partners to participate in meetings despite geographical location, so **minimising travel and time away from the day job**. The Board and the Transformation programme appreciate and recognise the contributions of the **Voluntary, Community & Faith Sector** organisations and we acknowledge your views.
Looking back over what has been happening the plans have been fluid, however I do sometimes feel with this plan that South Cumbria are left out of it and we do not always have access like those in Lancashire even though it should be South Cumbria too.	The process that we went through to develop the draft Plan has accounted for the representations of South Cumbria via their 2018/19 Transformation Plan, objectives and priorities. We do recognise that there are gaps in services however these will be address as the plan continues to develop. The Plan will continue to be informed through South Cumbria's representation within our Governance arrangements, and workstreams
Objective 15 in respect of 'continuous improvement and learning' – is this more of a principle than an objective that can be evaluated and measured?	After consideration of this comment, we agree and have **re-sighted this objective within the Principles section.**

	The Plan now supports nine Principles.

You Said **Do you agree with our priorities for 2019/20?**	We Did
Using a digitalised service both provides an accessible channel for young people whilst providing a sustainable solution financially It's not clear at first glance but this must be fully backed up with face to face support where required	We agree. The website, developed as part of the **Digital THRIVE** programme will offer a signposting service via a directory of services, this is a complementary service alongside all of the **'face to face'** services. This is not a replacement to those services. **Face to face** services are seen as intrinsic to the support approach and all other services, be they digital or otherwise are complementary.
It would be great if there is something consistent in both North Lancs and South Cumbria. I would be more than happy to continue to be involved in this process	Thank you for your comment. We also acknowledge that any service redesign will endorse the **delivery of services equitably** across the geography of **Lancashire & South Cumbria.** We invite people to email healthyyoung.minds@nhs.net to register their interest in receiving **communication** about the programme and/or the opportunity to be **involved**.
Online portals are services youths are likely to access and be open and honest	Thank you for your comment
I imagine CAMHS will still be inaccessible for those who are not meeting thresholds	The principles of the **THRIVE model** enables people to **access services** and supports at the appropriate point and time for them. This includes Getting Advice, Getting Help, Getting More Help, Getting

	Risk Support. This model aims to **wrap services** around children and young people allowing **access** to correct level of support at the time that it is needed using a multi-agency model. The **CAMHS service** primarily functions within the 3 and 4th quadrants of the THRIVE model (Getting More Help/Getting Risk Support) and will be **accessible** to those who need this level of intervention when needed.
I am unclear where work with perinatal mental health and early years sits under the above priorities. Intervention early in the age of the child is vital and I believe should be given prominence each year	**Perinatal Mental Health is now cited within the Adult Mental Health portfolio**. The CYPEWMH programme is interdependent with the Adult Mental Health programme so that can influence and inform developments on behalf of children, young people and their families. The Board will maintain their **oversight** of this work via quarterly reporting processes. This has been referred to within the **Interdependencies section** of the Plan
Not sure the portal is really something a large proportion of YP who need support will access. Redesigning seems to have been on the agenda for too long - need service now	The **website and portal** are being developed in conjunction with children, young people and their families. **Feedback** has been received via engagement and co-production activities. Feedback has been that this will be a **valuable resource.** Children and young people have told us that they have enjoyed being part of the process, however we acknowledge that the **Digital THRIVE** development will need continued input for it to remain relevant and

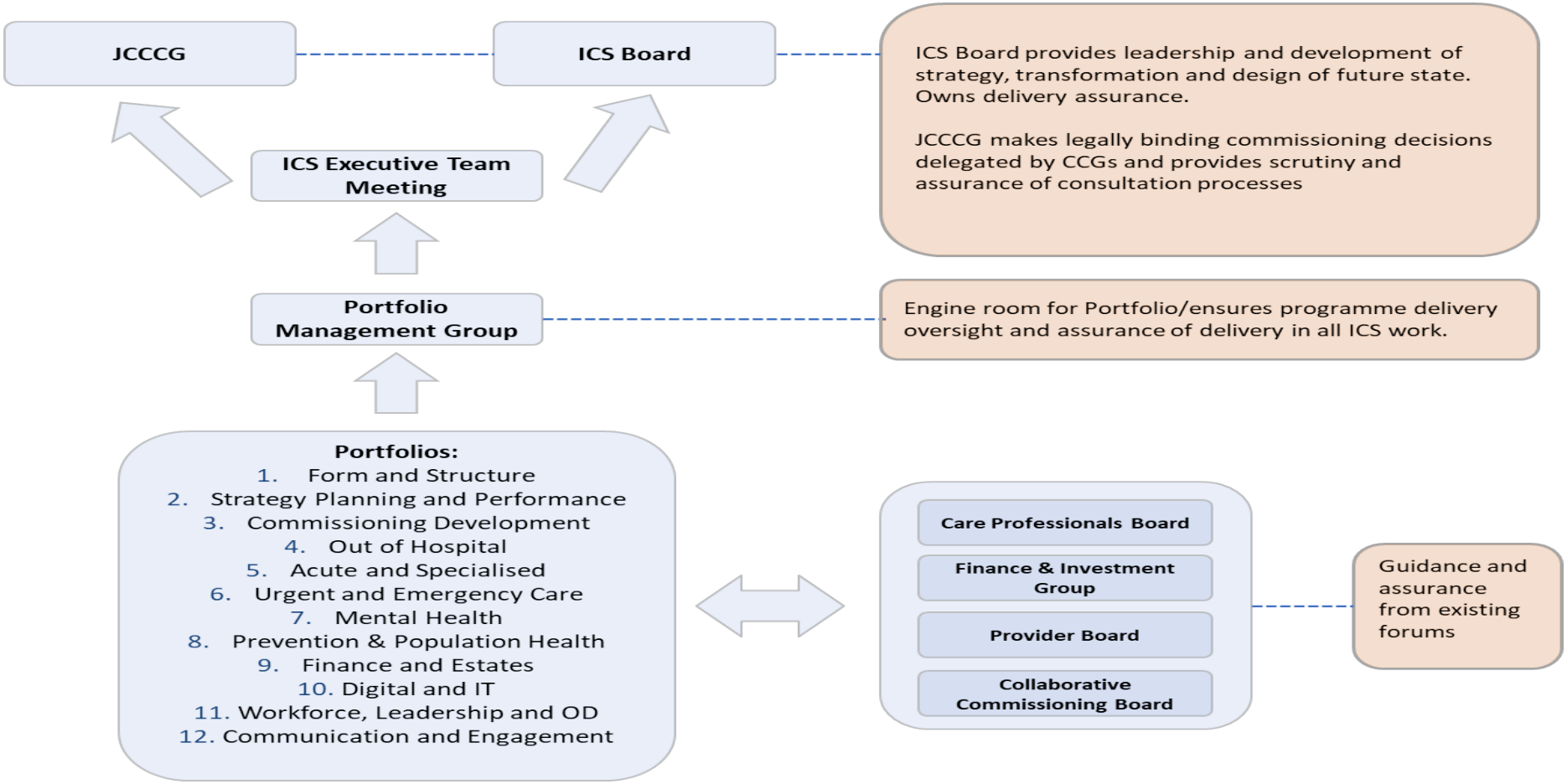
	accessible for the large proportion of CYP who have voiced that they want to use this. In **redesigning services,** we appreciate that this can take **time**. In the example of the CAMHS Redesign, we are using a co-production approach. This approach will support a more **meaningful outcome**, one that is sustainable and will be **fit for purpose**. The timeline for this piece of work is closely monitored through the Board and its governance arrangements. Your comments, however, will be shared with the Board and the Care Partnership who are delivering the Redesign for CAMHS.
There is still an issue with the professionalised jargon of the priorities, however young people have asked the question about how these 3 priorities will actually make a difference to young people. for example, it is not clear how re designing CAMHS in line with the thrive model will improve how young people experience their support. " my friend has appts at CAMHS and is really upset about having to tell his story every time he goes to a new person. It makes him cry every time because he gets upset about it" will this change if priority 2 is successful and how?	We acknowledge your comments about the use of **'professionalised jargon'** and we aim to deliver a **user-friendly version** of the Plan following the sign off of this document. Your comments will be shared with the Programme Team and the Communication and Engagement leads. The 3 priorities have been developed in response to nationally identified priorities and also those specific to our local communities. Whilst the outcomes have not been detailed within this Plan, the programme is working to clearly defined project plans leading to **outcomes and change** that will be **seen/experienced** by children, young people and families using services. These are some of the **key areas of change** that will be evident as we go forward – website and online information

	service, redesign of CAMHS, redressing the geographical variations in provision, increasing access, clarity of pathways for service access. The programme is currently developing an **outcomes framework** that will evaluate the impact of the programme. We acknowledge your points and will work with the programme leads to build in **communication** at key points in time to improve understanding of the programme **deliverables and outputs**. We will also share your comments with the Board, and the Care Partnership to be considered within CAMHS Redesign clinical modelling.
Given the amount of time and energy that has gone into Thrive and the redesign, I think the work should be completed. However I am not clear that the most vulnerable and those with longer term needs are well served by this document or approach itself which does not inform front line practitioners of anything very useful. In comparison with the old tiered triangle it communicates perhaps that children should not be referred 'out' to specialist services but I believe it still promotes a very medicalised psychiatric approach which tells the general public that if they see challenging or struggling children that the reason is something wrong in the child which must first be diagnosed and treated by experts - who can then rarely be found. This can be very disempowering and sometimes actively damaging to children and their families and communities because it too often takes the eye off key issues that need attention such as the health of relationships, and curriculum fit and the active skills that need support. Again Thrive is too short on adequate analysis of the	Thank you for your comments and they will be shared with the Board and the Care Partnership who are leading the CAMHS Redesign. As stated previously we acknowledge that in order to deliver a **redesign programme** via a co-production approach, it **does take time**. This approach will serve to deliver a CAMHS service across Lancashire and South Cumbria that is **fit for purpose and, one that will be sustainable**. There is a well-defined **governance structure** that oversees progress, holding the Care Partnership to account in its delivery of **meaningful outcomes** for children, young people and their families.

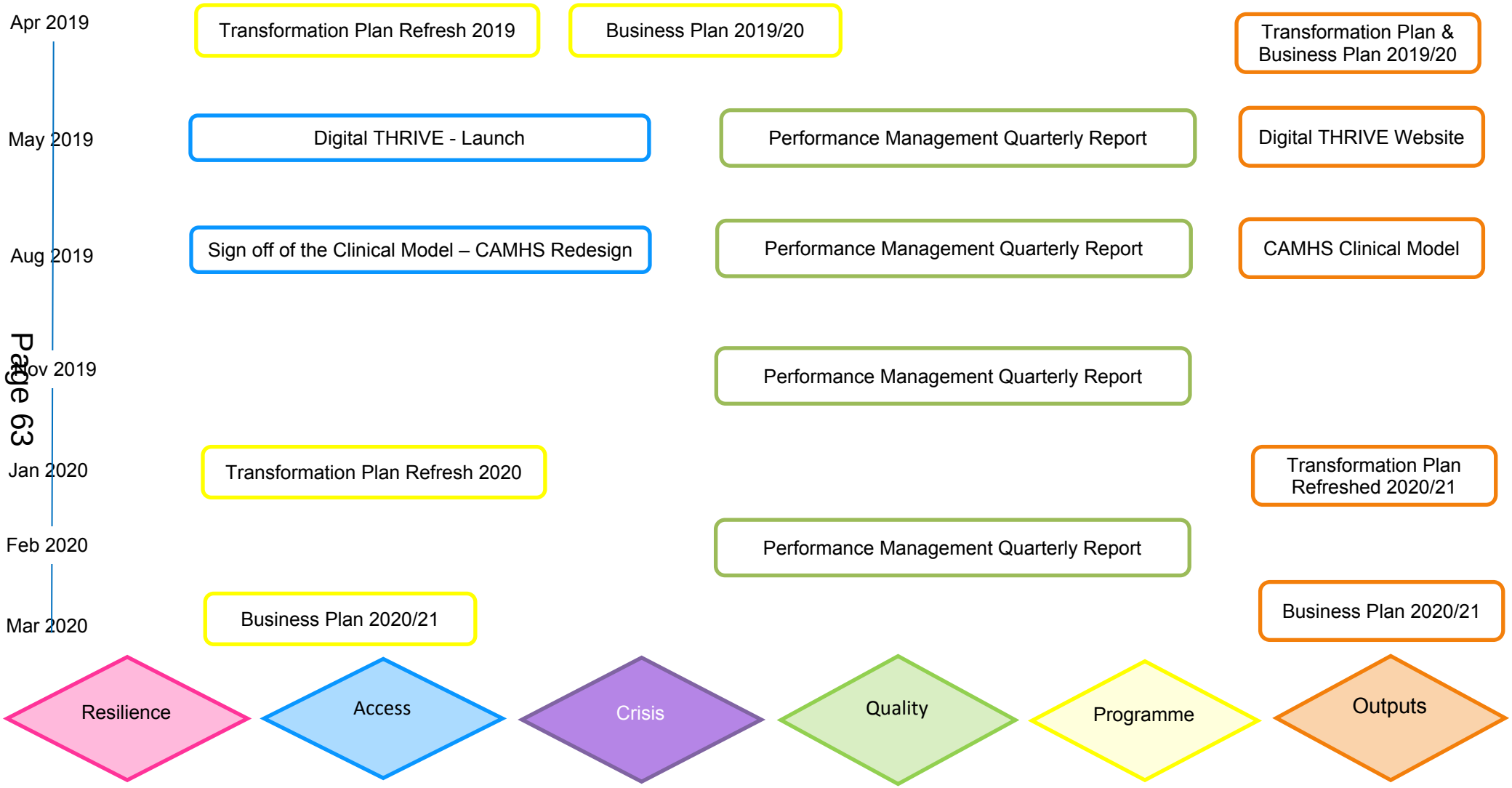
reasons we are seeing so many stressed children and there are consequences arising which though clearly unintended are very real. When a system is designed to answer questions about 'what a child has got'	**The THRIVE Model** will deliver services that wrap around children and young people through **low level supports to more complex interventions**. **The THRIVE model** accounts for the **needs of the individual** in a holistic approach rather than the current system that takes people through a tiered approached to need. We have however in response to your comments, **now included** more information within the Plan as to the rational of working within the **THRIVE principles.** Furthermore, we remain cognisant of the national agenda and research that is being undertaken both locally and nationally to better understand the **reasons behind** occurrences of mental health in children and young people in order to **influence design and delivery** of current and future services. In addition, your comments have been passed to our Communications and Engagement Team to expand our **communication** links with **frontline practitioners.**
Need to include the 'Eating Disorder' priority too. Need to engage with, and partly fund, local 3rd sector contributors. Fewer meetings; more action. Better designed questionnaire: there are more questions about me than about the plan.	The CYPEWMH Programme now have lead responsibility for the **All Age Eating Disorder Service** and is an objective within the plan – see Objectives 10 & 11. We recognise the contributions and value of the **Voluntary, Community and Faith Sector** across Lancashire & South Cumbria and wish to continue working with you as **partners**. We have therefore included **further narrative** within the Plan that refers specifically to the Voluntary, Community & Faith Sector as one of our

	key stakeholders. As the geography of Lancashire and South Cumbria is extensive, we continue to explore **more creative ways to engage** with our partners, especially through the use of **technology and digital communications**. This will serve to minimise travel and time spent away from the day job whilst maintaining **positive engagement**. We acknowledge your comments in regard to the **Questionnaire**. We are however legally obliged to collate demographic details of the respondents. We have chosen to **limit the questions** in regard to the Plan, in order to encourage completion of the survey and to ensure this is not an onerous task. Going forward, we will however ask for suggestions as to how we can **improve the questionnaire** in future. Your comments have been shared with the Board and the Communication and Engagement Team for consideration.

Appendix 6 - Lancashire & South Cumbria Integrated Care System Governance Structure 2019



Appendix 7 – Milestones, Decision Points and Outputs 2019/20



BLACKBURN WITH DARWEN
ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH
2018/19

Contents

FOREWORD

by Professor Dominic Harrison, Director of Public Health

Child poverty is a national issue. It is also one of the most potent drivers of lifelong ill health and health inequalities.

Since 2010, welfare benefits available to families with children have been systematically reduced, disproportionately affecting those who are most disadvantaged.[1,2,3] (Figure 1). This has particular resonance in Blackburn with Darwen, where it is estimated that nearly half of children are living in poverty.

For many, this means a childhood of insecurity, educational underachievement, and isolation from their peers. Research shows that not only does poverty have an impact on their health and life chances, but it is likely to affect the next generation too, unless we can address the root causes. A United Nations envoy has recently described the levels of child poverty in Britain as:

> '… not just a disgrace, but a social calamity and an economic disaster, all rolled into one'
>
> *Prof Philip Alston, UN Special Rapporteur on extreme poverty and human rights*[4]

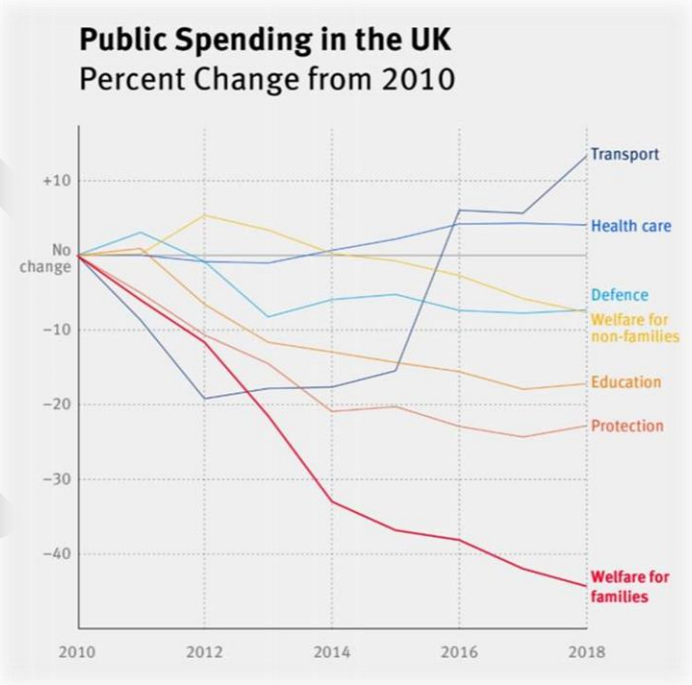


Figure 1 - Fall in public spending on welfare for families
(Figure produced by Human Rights Watch[3])

Locally, a lot of excellent work is being done to mitigate the effects of child poverty. There are holiday lunchbox schemes, advice and guidance on financial and welfare matters for parents, mentoring programmes for young people – almost every agency is, in some way, working to reduce the effects of poverty on local families.

However, in Blackburn with Darwen our biggest opportunity lies in developing a model of economic growth that addresses child poverty.

This Public Health Annual Report seeks to outline the scale of the problem of child poverty in Blackburn with Darwen, as well as identifying actions that we can take locally to address the issue. We want to celebrate the work that is already being done, but also challenge ourselves to address the root causes of child poverty, and ameliorate its effects where it is possible to do so.

I hope that this Public Health Annual Report supports the continuation and development of the excellent work already being undertaken in the borough by the local authority and partners, and galvanises us all to take further action to try to eradicate local child poverty for good.

What is poverty?

Definitions

Children are considered to be in poverty if the household they live in is in poverty, but there is no single, agreed way of defining what that means.

Relative poverty

Being in 'relative poverty' means that a person or family has been 'left behind' financially, so that they cannot afford the normal activities and opportunities enjoyed by their peers.[5]

The government's measure of relative poverty starts by looking at median household income. The 'median' is the level which divides the population into two equal halves (Figure 2):

Figure 2 - meaning of Median Household Income *(Figure produced by DWP[8])*

Box 1 - 'Before' versus 'After' Housing Costs

Household income can be measured '**Before Housing Costs**' or '**After Housing Costs**'. The '**After Housing Costs**' is often preferred when looking at poverty, because households at the lower end of the income scale generally spend a larger share of their income on housing.[2,6,7]

In 2017/18, the official UK median household income was £437 per week (after housing costs).[9] This relates to a notional type of household (a couple with no children).

In reality, households come in all shapes and sizes, so incomes have to be 'equivalised' to take account of this. For instance, a single person needs less income than a couple (but more than half as much). So the first adult in a household counts as 0.58 of a couple, and the next (if there is one) counts as 0.42. Each child carries 0.2 times as much weight as a couple (Figure 3):

Figure 3 - How household income is 'equivalised'
(Figure produced by DWP[9], but amended to use 'After Housing Cost' weighting factors)[10]

After all these adjustments, any household which has an income of **less than 60% of the UK median** is said to be in 'relative poverty'. Thus in 2017/18, a couple with a weekly income of less than £262 per week after housing costs (i.e. 60% of £437) was in 'relative poverty'. A single person living on less than 0.58*£262 = £152, or a 2-adult 2-child family living on less than 1.4*£262 = £367, would also count as being in 'relative poverty'.

Absolute poverty / material deprivation

The 'textbook' definition of **absolute poverty** is that it means not being able to afford the necessities of life, such as food, heating, clothing and shelter.[5,11]

However, this is **not** the way the term 'absolute poverty' is used in official publications in the UK. Instead, the government uses it to describe those households whose income now, after adjusting for inflation, is below the '60% of the median' threshold from some fixed year *in the past* (namely 2010/11).[5,6,11] The government definition of 'absolute poverty' thus provides an answer to the question: 'What proportion of the population would be considered 'poor' today by the standards of 2010/11?'

The government does carry out surveys to assess the level of inability to access key goods and services, but the term they use for this is '**material deprivation**'.[6]

New poverty metric (Social Metrics Commission)

In 2018, a new independent body called the **Social Metrics Commission** (SMC) published what it called 'A new measure of poverty for the UK'.[12] The SMC has representation from bodies such as the Joseph Rowntree Foundation, Royal Statistical Society, and leading universities.

Rather than focusing entirely on income, the SMC measure acknowledges that some people can use savings and other liquid assets to help meet their needs. On the other hand, it factors in a broader range of housing costs than does the official 'after housing costs' measure, as well as making specific allowance for the 'inescapable' costs associated with childcare and disability. The overall number of people deemed to be in poverty under the new metric is roughly the same as for the official 'after housing costs' measure, but the balance shifts away from pensioners, and towards families with children and/or a disabled person.[12]

The new measure has been widely praised, including by the UN's special rapporteur on poverty, Professor Philip Alston.[13] It has now been announced that the Department for Work & Pensions will develop it further as experimental statistics, the first step towards possible adoption as an official national measure.[14,15]

Figure 4 – Common misconceptions about poverty *(from JRF Toolkit[16])*

Talking about poverty

There are widely-held misconceptions about poverty, which make it harder to galvanise public opinion and political will to do something about it (Figure 4).

The Joseph Rowntree Foundation has recently published what it calls a 'Framing Toolkit', setting out how it (and we) need to try telling the story of poverty in a new way.[16]

The toolkit recommends portraying poverty in a way that appeals to shared common values, and cuts across political divisions (Figure 5):

> It is not right that a fifth of our population live in poverty and that more and more people are relying on foodbanks. We need to redesign the way our economy works to free people from the grip of poverty.

Figure 5 – Example of how to get the message across *(from JRF Toolkit[16])*

What is happening to child poverty?

Trends and projections

In 2017, the Institute for Fiscal Studies predicted that welfare reforms and other factors would lead to a sharp rise in relative child poverty in the UK, reaching 36% by 2021/22.[2] The Equality and Human Rights Commission in 2018[17], and most recently the Resolution Foundation in 2019[7], have predicted even steeper rises. Figures released since then show that child poverty in 2017/18 remained at around 30%. However, this is based on a survey, and is therefore subject to a margin of error. In any case, it is clear that child poverty has been on an upward trend, and is far above the rate for other age-groups (Figure 6):

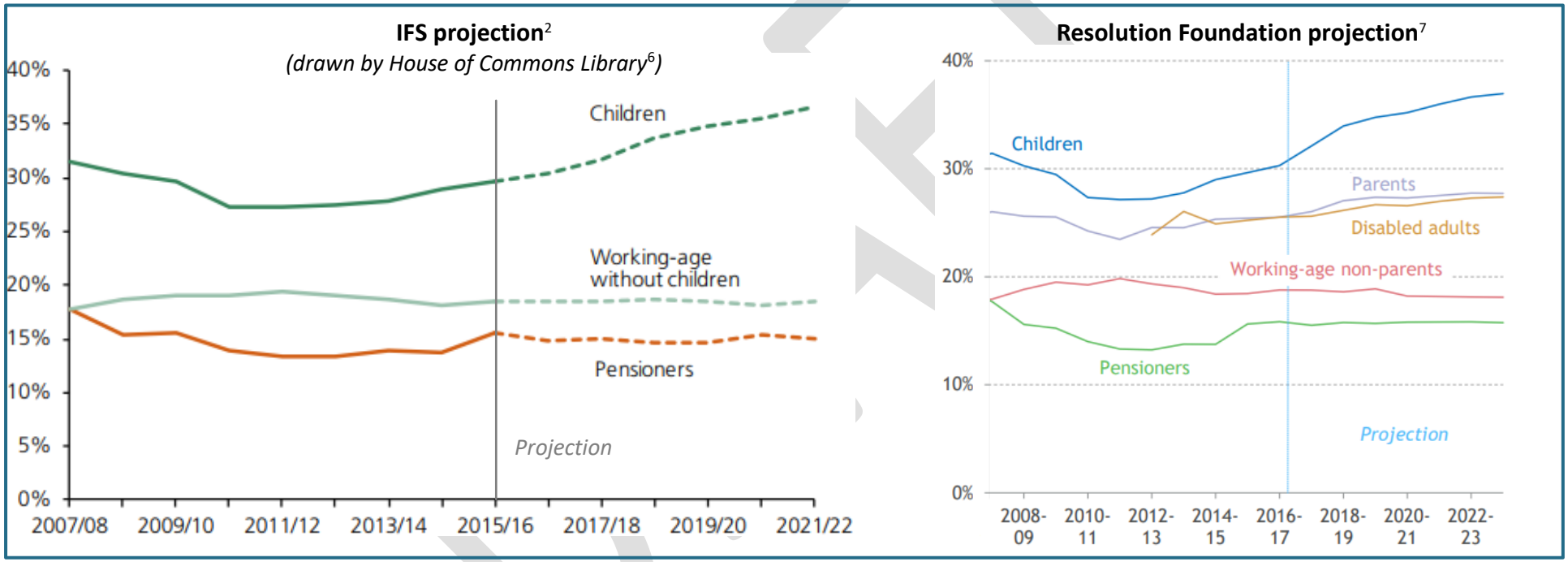


Figure 6 - % of people in relative low income, UK (after housing costs)

At the press conference concluding his investigation into poverty in the UK, United Nations special rapporteur Philip Alston summed it up by saying:

> 'The child poverty rates are staggering, and are predicted…to go up significantly'[18]

Inequalities

The Equalities and Human Rights Commission produces predictions of child poverty not only for *all* children, but for particular *groups* of children.[17] They anticipate that by 2021/22, 41.3% of all children in Great Britain will be living in relative poverty (after housing costs). However, this rises to 62.1% among children living in one-parent families, 65.9% among children of Pakistani ethnicity, and 51.7% among all those in families of three or more children (Figure 7):

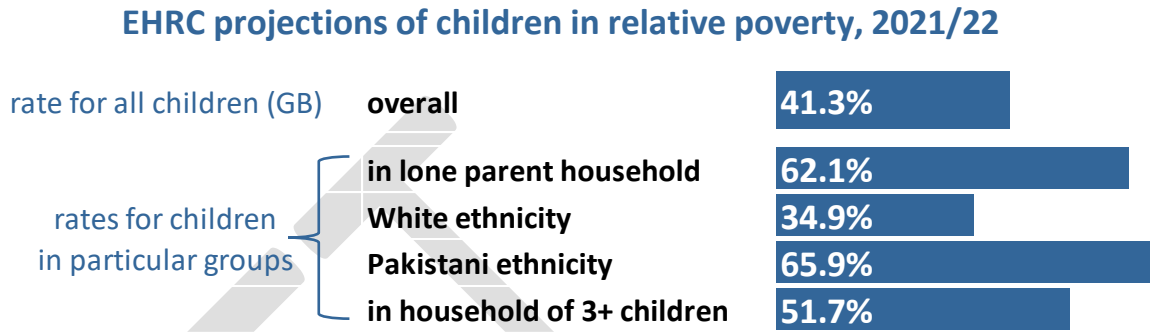


Figure 7 – EHRC projections of children in relative poverty (after housing costs), GB 2021/22[17]

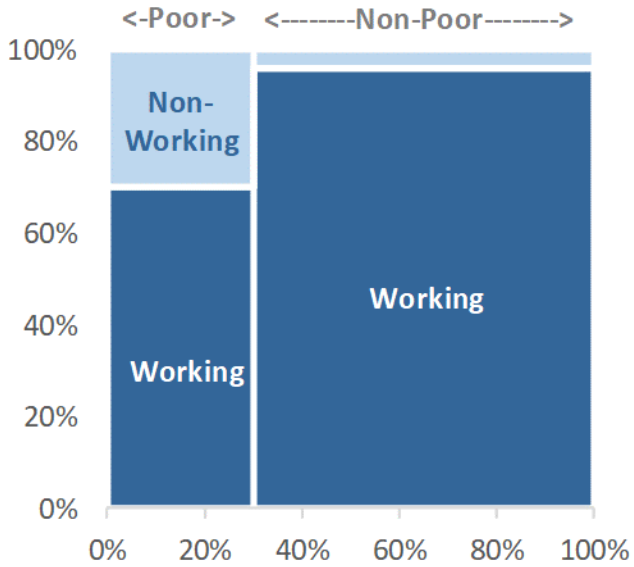


Figure 8 – 'Poor' v. 'Non-Poor' children (relative poverty, after housing costs, 2017/18) by working status of the family

In-work child poverty

When the 2017/18 estimates came out[9], showing that 30% of children are in relative poverty, many commentators picked up on the fact that most of those children come from families where at least one adult *is* working:

"Nearly 3m children in poverty despite parents working"[19]

"Child poverty in working families on the rise"[20]

"Work not enough to stop children being trapped in poverty"[21]

Figure 8 shows UK children split into 30% 'Poor' and 70% 'Non-Poor' (based on relative poverty after housing costs).[9] Within each group, the darker shading shows the proportion who belong to families where at least one adult is working.[22] Even in the 'Poor' group, 70% of children come from working families (as do nearly all of the 'Non-Poor' children).

It is clear from this that helping parents into employment, while it may be important, will not be sufficient on its own to solve the problem of child poverty.

'Austerity' policies

In his investigation into poverty in the UK, United Nations special rapporteur Philip Alston added his voice to the many who consider that government policies are leading to increasing economic vulnerability within households.[4] The poorest members of society, particularly children, are disproportionately affected by austerity.[17,23,24] Links between austerity and food poverty are plain to see, and foodbank usage is growing rapidly.[25,26]

Over the past decade, the general shift in social security spending has been away from families and children.[27] The repeal of the Child Poverty Act (2010) – which set in law a commitment to meet four challenging child poverty targets by 2020/21 - removed the accountability of the Government to tackle this problem at a national level.[28] Its policies since then have either increased the numbers of children in poverty, or exacerbated the situation for those already in that position:

- Introduction of **Universal Credit** with built in delays from claim to receipt of support; complex calculation system which leaves families out of pocket if their wages fluctuate on a monthly basis; online-only access to claiming
- **Benefits cap** – limits on the amount of welfare support available to family, regardless of individual situations
- **Benefits freeze** (no increase with RPI or inflation from 2016-2020). Putting this into context, JRF calculates that the current, final year of the benefits freeze alone will cost families in poverty an average of £560, which for them is equivalent to three months of food shopping.[29]
- Removal of '**spare room subsidy**' – i.e. families being financially penalised for having a spare bedroom if they are in receipt of benefits
- **2-child limit** in tax credits, Housing Benefit and Universal Credit (i.e. no allowance made for third or subsequent child)*
- **Minimum wage** being insufficient to survive on, sparking pressure for a National Living Wage

In June 2018, the National Audit Office found that the roll-out of Universal Credit was leading to hardship for many individuals and families. The main problems arose from the 5-week waiting period, fluctuating payments due to calculation methods, and difficulty accessing the benefit due to its online nature.[31]

Talking about benefits

Benefits often get a bad press, especially if their recipients are considered to be 'undeserving'. This clouds the reality that in a discussion about poverty, benefits should be seen as part of the solution. The Joseph Rowntree Foundation's 'Framing Toolkit' reminds us that benefits exist to help people stay afloat when they are struggling, and should be recognised as part of the broader system of public services that we all value and rely upon (Figure 9).[16]

> All of us rely on publicly funded services and support systems like education, roads, railways and the NHS. And our public services are especially important to people who are struggling, such as our welfare system. We need to strengthen these supports to solve poverty and make sure everyone has a decent life.

Figure 9 – Presenting benefits in a positive light
(from JRF Toolkit[16])

* Partially rolled-back in January 2019, so that the cap will not be extended to families whose third or subsequent child was born before 2017[30]

Causes and effects of child poverty

Setting the scene

In 1991, Dahlgren and Whitehead published a famous framework setting out the factors that influence health.[32] Figure 10 adapts the idea of their diagram to focus on the main determinants of child welfare. It emphasises the central importance of the first 1,000 days of life, roughly from conception to weaning, when lifelong foundations are laid for physical and mental health and wellbeing. However, this is wrapped within several other layers of influence, all helping to determine whether a child will thrive, and all susceptible to the effects of child poverty.

Causes of the causes

It is easy to think that child poverty is primarily driven by the choices that parents make for themselves and their families – how many children they have, their parenting style and aspirations, dependence on benefits or indebtedness. However, any family can fall on hard times and find it difficult to make ends meet.

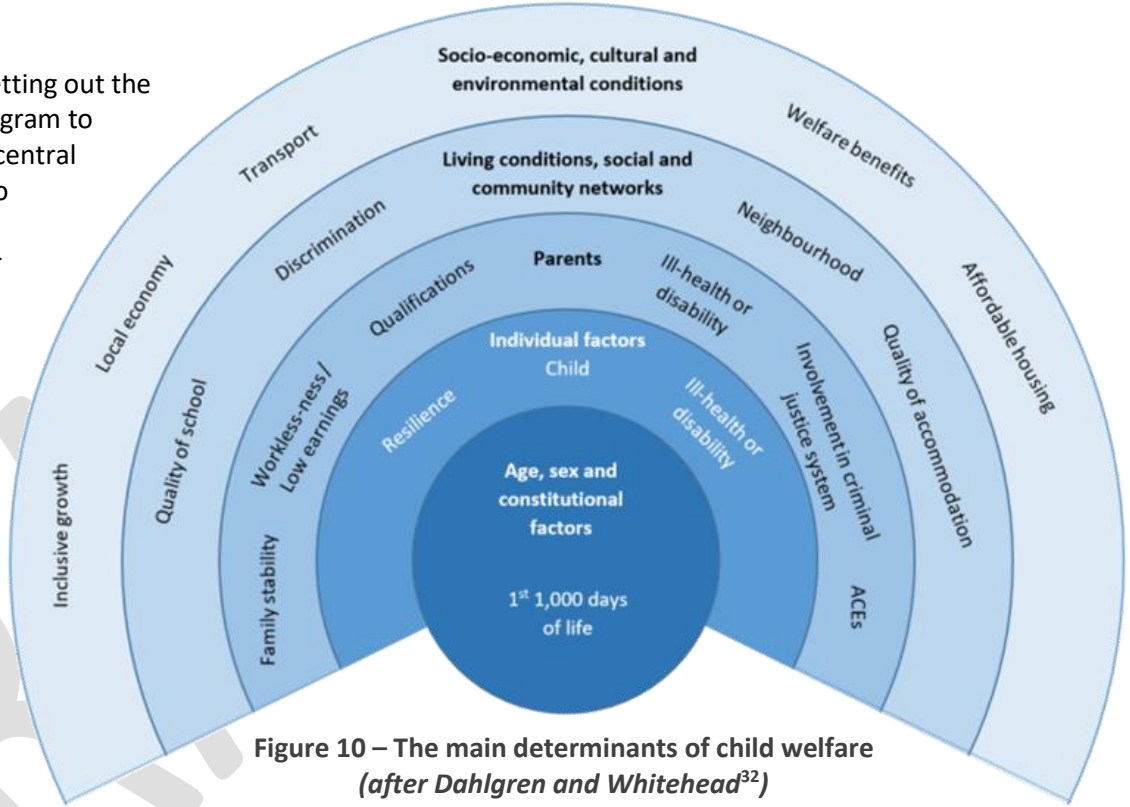


Figure 10 – The main determinants of child welfare
(after Dahlgren and Whitehead[32])

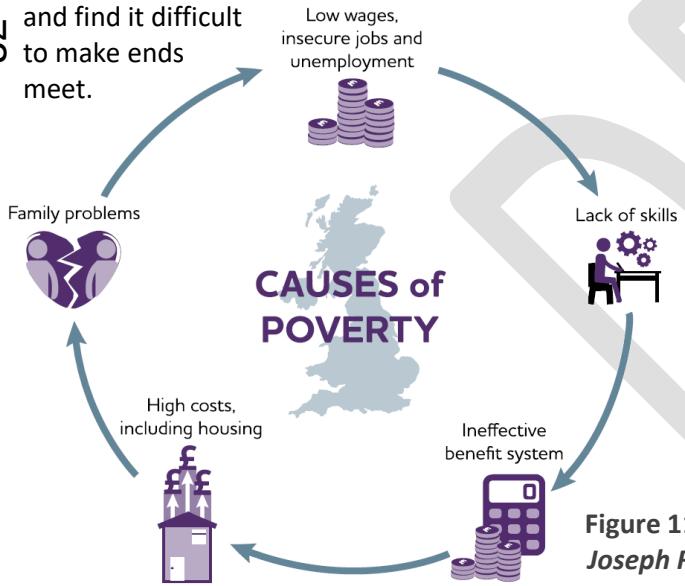


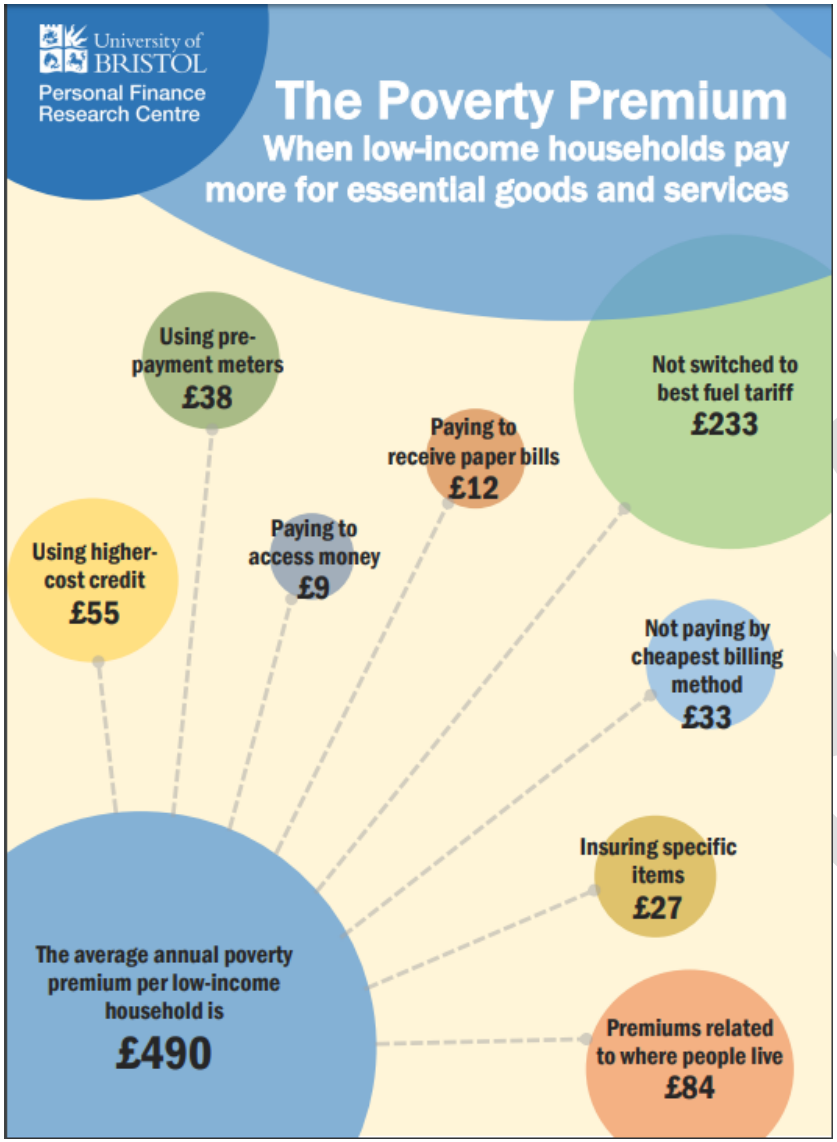
Figure 11 – Causes of poverty
Joseph Rowntree Foundation[33]

The Joseph Rowntree Foundation reminds us that poverty depends not only on the circumstances, capacities and choices of an individual or family, but also on factors operating at the level of the market and the state – what we might call the '**causes of the causes**':[33]

Market, state and individual: all three matter

Joseph Rowntree Foundation[33]

The 'Poverty Premium'



The misery of life on a low income is exacerbated by the '**poverty premium**' - the fact that poor families pay *more* for essential goods and services as a *consequence* of being poor.

Bristol University has estimated that this 'double whammy' adds an average of £490 to the living costs of each low-income household per year (Figure 12).[34]

Figure 12 – Poverty premium broken down by type
(infographic by Bristol University[34])

Figure 13 (below) shows the proportion of low-income families that are affected by each particular type of poverty premium:

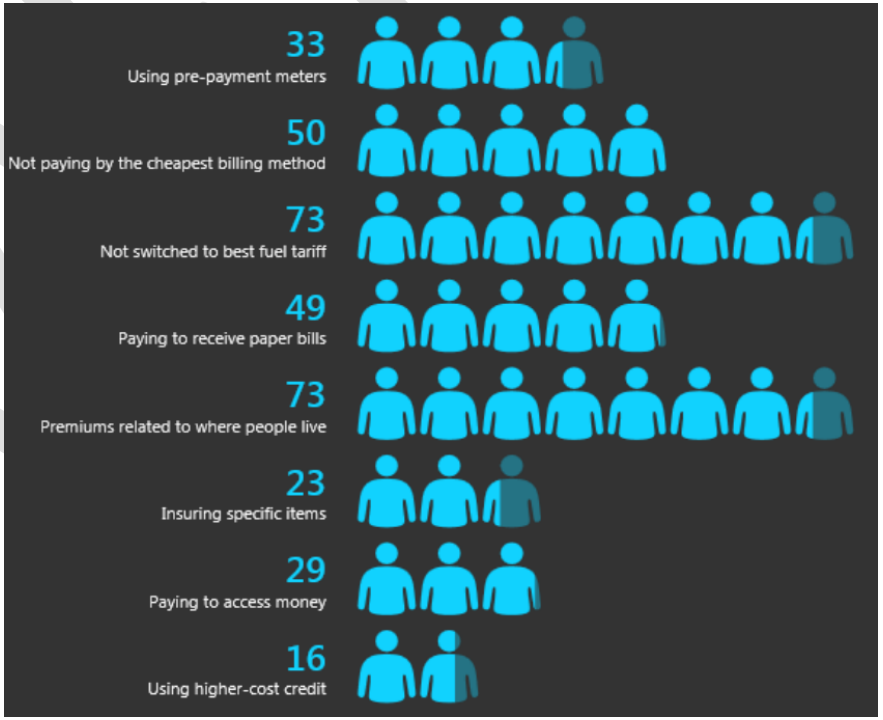


Figure 13 – % of low-income households incurring each type of poverty premium
(infographic by Bristol University[34])

Families with no bank account are particularly hard hit. It has been estimated that they suffer a poverty premium of nearly £500 pa for that reason alone.[35]

Effects of child poverty

On average, a child growing up in poverty experiences worse outcomes than a child from a wealthier family in all sorts of ways, from physical and mental health, to educational attainment and labour market success, to risky behaviours and delinquency.[36, 37,41] By age 16-24, they are twice as likely to be NEET (not in employment, education or training) as their better-off peers.[38]

How it feels

Poor children miss out on the things most youngsters take for granted: warm clothes, school trips, having friends over for tea. Figure 14, adapted from the Child Poverty Action Group[39], shows how this makes them feel. There is also new evidence that children in poverty are more likely to be lonely.[40]

Figure 14 – How Poverty Feels to Children *(adapted from CPAG[39])*

Mechanisms

Research at the London School of Economics has confirmed that children living in poverty have worse outcomes *because they are poor*, and not just because of other factors that may tend to go along with that (such as level of parental education, or parenting style).[41]

Poverty is believed to exert its effect on children in two main ways (Figure 15, next page):[41,42]

- The **investment pathway**. When faced with income shortfalls, poor families are often forced to cut back on essentials such as food and housing. The parents' inability to invest in goods and services that promote child development leads directly to poorer outcomes for the child.
- The **stress pathway**. This theory recognises that poverty in the household can lead parents to become stressed, anxious and depressed, which can in turn have a negative impact on the child. The mental wellbeing of adults in lone-parent household is particularly susceptible to poverty.[43]

Children raised in poverty may also have poorer employment prospects, and thus transmit the experience to their own children in turn. (Figure 15, next page).[36]

Box 2 – Adverse Childhood Experiences (ACEs)

- ACEs are stressful, traumatic events in childhood whose negative impacts may last into adulthood
- They include abuse; neglect; and parental loss, imprisonment or drug & alcohol problems
- Higher levels of ACEs are associated with living in a low-income household[44]
- Growing up in poverty may make it harder to escape the detrimental effect of ACEs[44]
- The stress of growing up in poverty could be considered to be an ACE in its own right[44]

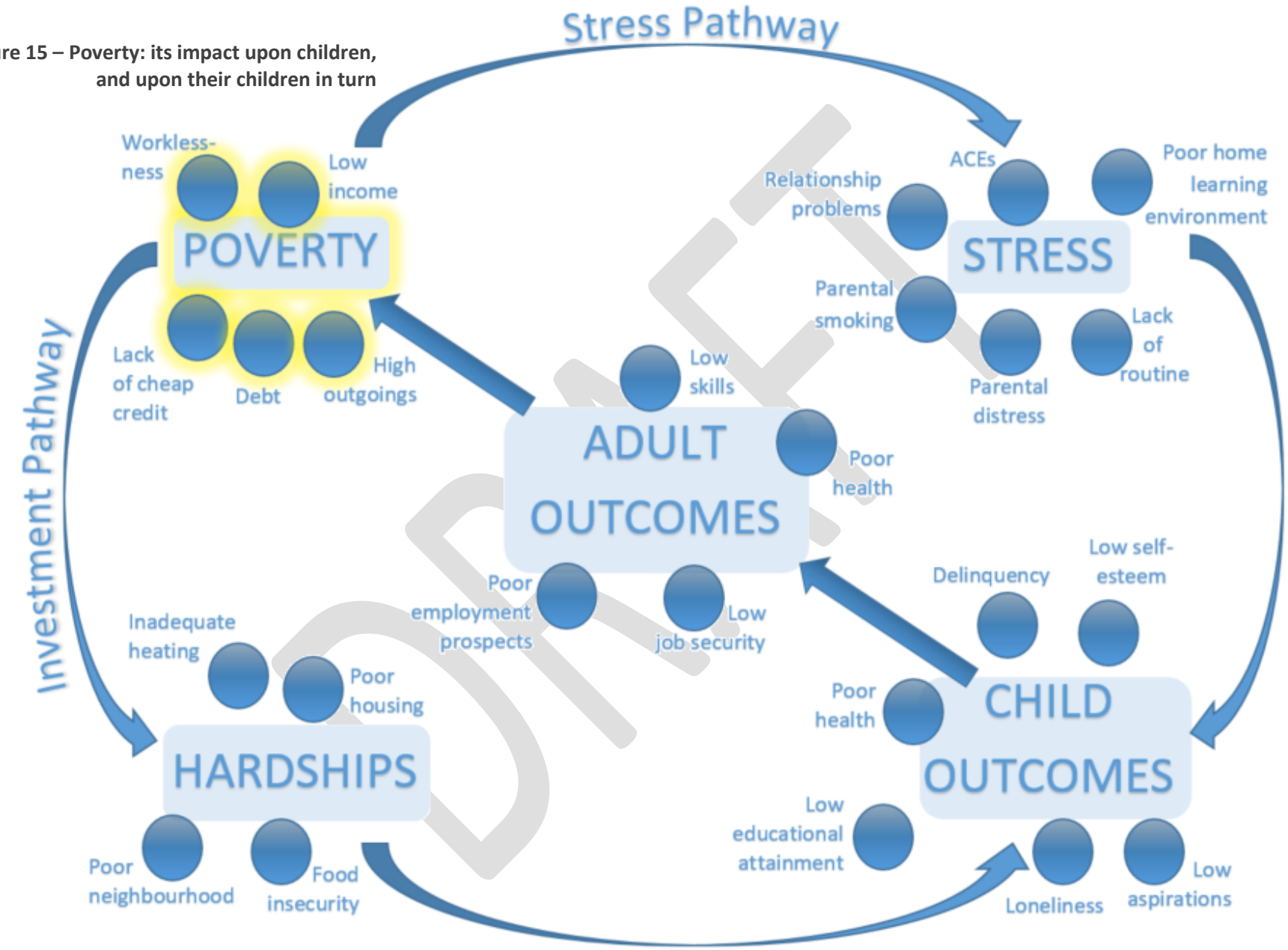
Health impacts[44]

Child poverty is associated with a range of negative health outcomes, including increased infant mortality[23], poor oral health[45], reduced physical activity[23,46] and higher levels of respiratory illness.[46] The worse the poverty, the greater the impact on health.[23] Persistent early years poverty is linked to lower cognitive development, even after controlling for background characteristics and parental inputs.[47]

Accident and injury rates are higher in low-income areas due to poor housing conditions, lack of safe outdoor play spaces, a lack of safety equipment (such as fire alarms), and living close to busy roads.[23] There is a greater prevalence of child obesity,[46] compounded by a lack of access to healthy food.[46,48] It has been estimated that for the poorest fifth of families, trying to follow the Public Health England 'Eatwell' Guide would mean spending over 40% of their weekly income (after housing costs) on food.[49]

Anxiety, depression and self-harm are inversely linked to income level at all ages – including for children[50] and their parents.[51] Poverty is also linked to increased levels of domestic violence, and to ACEs (Box 2).[52]

Figure 15 – Poverty: its impact upon children, and upon their children in turn



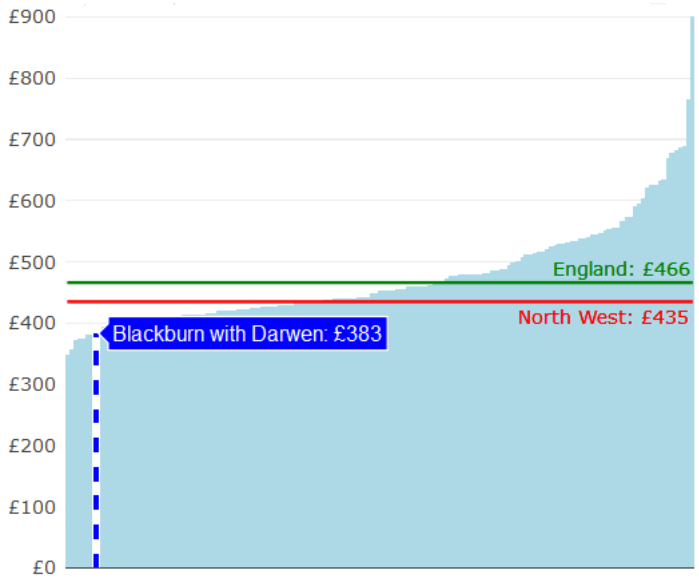
Low income in Blackburn with Darwen

Statistics on incomes and earnings generally portray Blackburn with Darwen as a low-wage economy.

Earnings

At £383 per week, provisional median gross earnings for Blackburn with Darwen residents in 2018 were the 8th lowest out of 151 upper-tier authorities in England (Figure 16 on right). Lowest of all was Blackpool with £348, and highest was the City of London at just over £900 per week.[53]

Figure 16 - Provisional Median Gross Weekly Earnings of Residents - Upper Tier Authorities in England (2018)



Household Income

Gross Disposable Household Income (GDHI)[54] is the amount of money that individuals in households have left to spend after taxes and benefits. In 2017, the Blackburn with Darwen average of £12,623 per head was the lowest in the NW, and 3rd lowest in the UK, after Nottingham and Leicester (Figure 17).

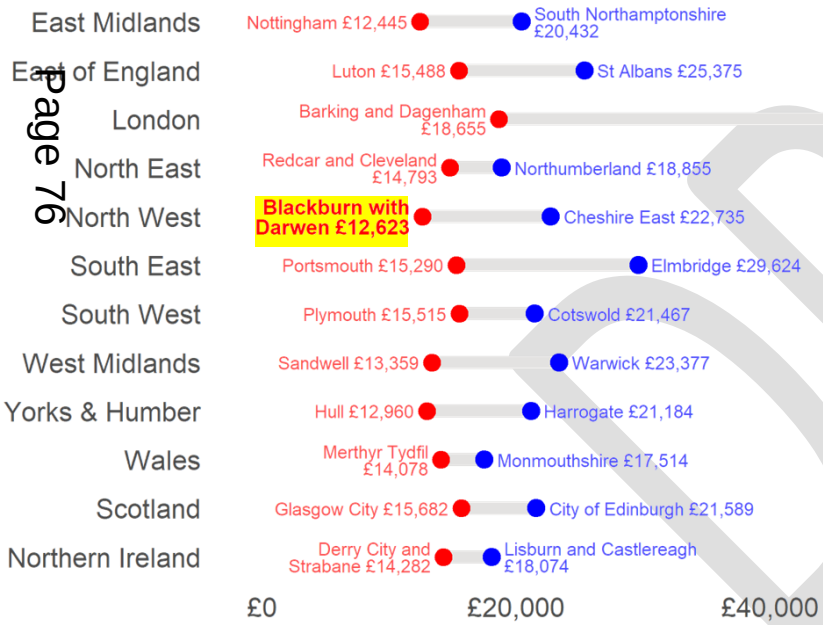


Figure 17 - Gross Disposable Household Income per head (2017, provisional) - lowest and highest per region

Estimates of household income are also available for small areas.[55] Figure 18 (on the right) shows how Annual Household Income (before tax) varies across the Borough.

The small shaded areas are called Middle Super Output Areas (MSOAs). Half of Blackburn with Darwen's 18 MSOAs are in the bottom 10% nationally. One of them, roughly equating to Audley, has the third lowest Household Income in England (out of 6791).

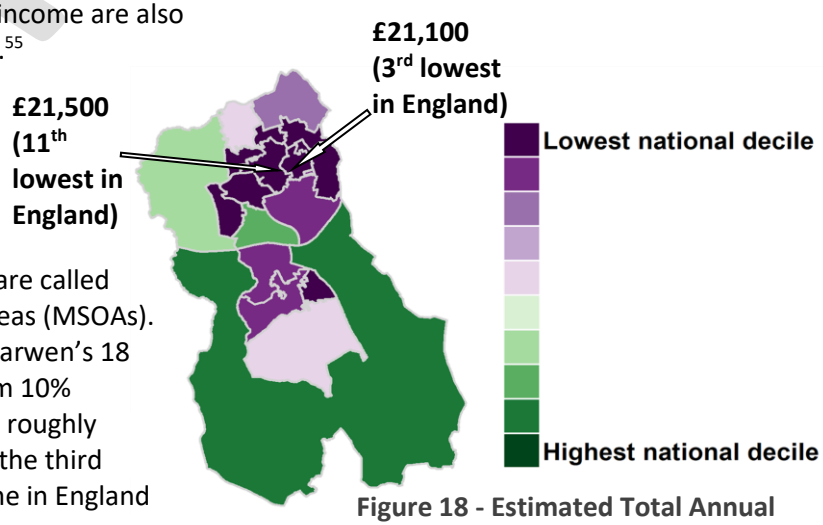


Figure 18 - Estimated Total Annual Household Income (MSOAs, 2015/16)
(income per household, not per head)

Child poverty in Blackburn with Darwen

Relative poverty

The surveys used to provide official UK poverty measures do not go down to the local authority level, so we cannot work out a Blackburn with Darwen rate in quite the same way. However, there are two main approximations available for districts and smaller areas. Of necessity, both of these are 'modelled'(or 'synthetic') estimates:

- HM Revenue & Customs (HMRC) uses benefits and tax credits data to produce its '**The Children in Low-Income Families Local Measure**'.[56] This gives an estimate of relative poverty *before* housing costs, and takes a long time to come out.
- Loughborough University produces the '**End Child Poverty**' estimates for the Child Poverty Action Group.[57] These are more timely, and are available on an *after* housing costs basis.

The latest 'End Child Poverty' figures came out just as this report was being finalised.[57] They indicated that relative child poverty in Blackburn with Darwen had risen in 2017/18 to **46.9%** of children living in poverty (after housing costs), giving it the fifth highest rate in the UK.

Even more of a shock were the ward estimates. Bastwell was estimated to have *the* highest ward rate in the entire country (**69.6%**), with Audley third highest (Figure 19):

Inevitably, this has prompted media interest. An item on the BBC website asks:[58]


NEWS

Home | UK | World | Business | Politics | Tech | Science | Health | Family & Education

Family & Education | Young Reporter | Global Education

Blackburn: What is the ward with Britain's highest child poverty rate like?

The article portrays Bastwell as a quietly respectable area, whose BAME community does not like to ask for help, but where the loss of services as a result of funding cuts has had a big impact.

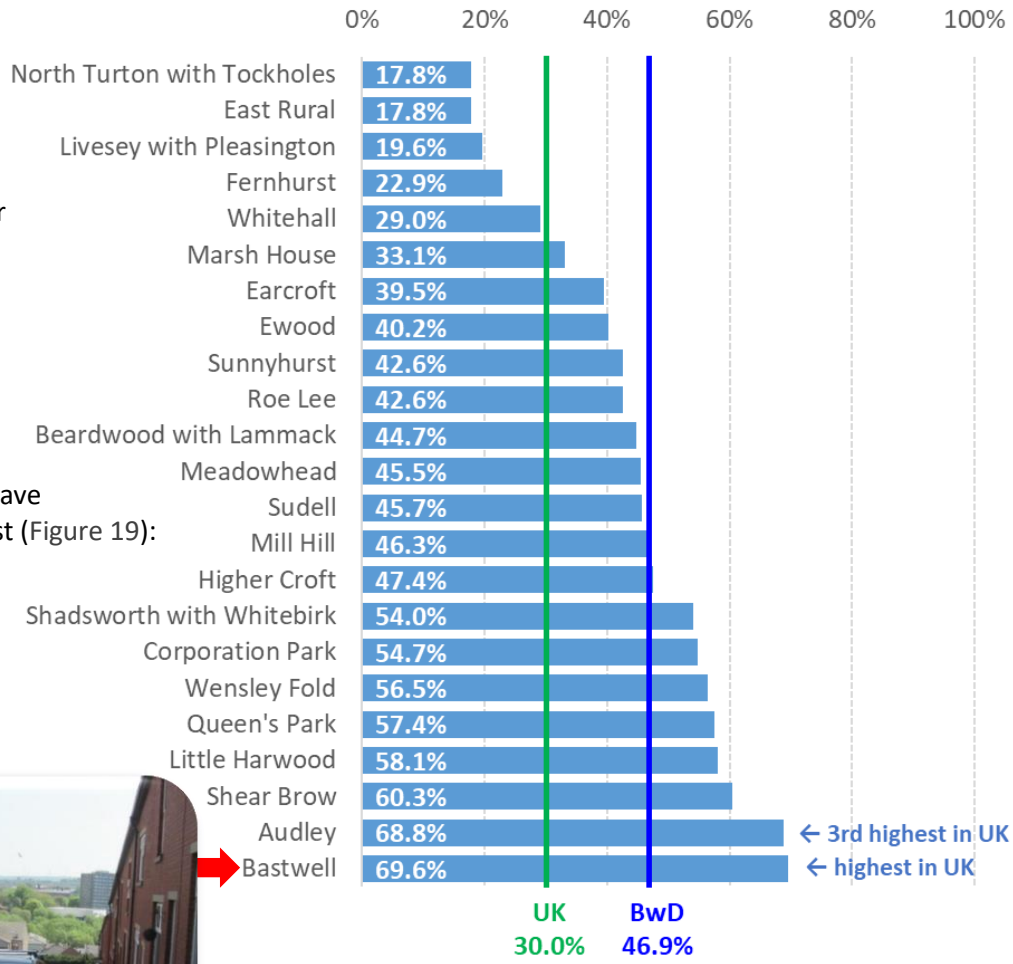


Figure 19 - 'End Child Poverty' estimates by ward
(2017/18, after housing costs. Pre-2018 ward boundaries)

Benefit cap

The 'benefit cap' is a limit on the total amount of benefit a person aged 16-64 can receive, usually implemented as a deduction from Housing Benefit. Latest figures show that 107 households in Blackburn with Darwen were subject to the benefit cap in November 2018.[59] More than 80% of these were single-parent families, and nearly all had three or more children, so the total number of children affected was close to 400.

Local impact

It was always clear that places with large families and/or big Asian communities would be hit particularly hard by the welfare reforms introduced in 2015.[60] Sheffield Hallam University predicted that by 2020/21, Blackburn with Darwen was set to lose £560 per working-age adult per year, the highest equal impact out of 378 local authorities.[61]

'There's never any money left': threat of welfare cuts alarms Blackburn families

A feature in the Guardian in 2015 found that low-income families in Blackburn with Darwen were stretched to the limit already, and could not comprehend how they would cope with cuts on the scale envisaged.[62] At the Audley and Queen's Park Children's Centre in Blackburn, parents described getting by on the proceeds of insecure and/or part-time low-paid employment, often on the minimum wage, and supplemented by tax credits:

"I don't expect to get stuff for free– we are trying to work, and trying to do the right thing."

"The job opportunities in Blackburn aren't great"

"A lot of the jobs you can get here are minimum wage jobs"

"There's nothing left at the end of the week after the nappies and the powdered milk."

"It goes on food and clothes …. People will struggle."

Almost four years on, young people in Blackburn with Darwen are voicing their own first-hand experiences of poverty - and particularly food poverty - through the Blackburn with Darwen Food Alliance's **'#DarwengetsHangry'** and '**#Blackburngets Hangry**' campaigns.[63] In a powerful video, students of Darwen Aldridge Enterprise Studio give an eloquent account of what it feels like to experience food poverty and the stigma that goes with it, and how it can affect behaviour in school.[64]

Figure 20 – Students of Darwen Aldridge Enterprise Studio talk about how food poverty affects them

What can we do about it?

What are we already doing?

At the start of their education, children in Blackburn with Darwen who qualify for Free School Meals (FSM) have relatively poor levels of school-readiness, even compared with similarly disadvantaged children elsewhere. However, they more than make up for this during their school years, across a range of indicators covering academic achievement and entry to higher education. By the end of their school years, according to the Social Mobility Commission, outcomes for this group in Blackburn with Darwen are only just outside the best quintile for FSM-eligible young people nationally.[65]

This remarkable turn-around is testament to the success of the efforts already being made across Blackburn with Darwen to try and offset the effects of child poverty. There are many local initiatives provided by the borough council, as well as by schools, Children's Centres, religious organisations, and voluntary groups:

Figure 21 - Volunteers making sandwiches for the Blackburn with Darwen Summer Lunchbox Scheme

BOX 3 – EXISTING LOCAL INITIATIVES

- Internet access and support with IT skills to ensure individuals are able to access Universal Credit
- Food and fuel banks to provide short-term support to people experiencing food and/or fuel poverty
- Support to access employment & volunteering opportunities
- Resource provision (baby equipment, toys etc)
- Signposting to debt and financial management support agencies
- Holiday lunchbox scheme to address lack of access to free school meals during school holiday period
- Breakfast clubs set up in schools

"A hungry child cannot learn well, and in the current economic climate, parents are struggling to make ends meet. Now, no child will be hungry."

Head Teacher of St Antony's School, upon establishment of new breakfast club[66]

What more can we do?

English local authorities are no longer required to publish a 'Child Poverty Needs Assessment'.[23] However, the Scottish Government has introduced a new duty to produce a 'Local child poverty action report', and published some useful guidelines on how to go about tackling child poverty at the local level.[44,67]

Drivers of child poverty

The Scottish Government has identified what it calls the '**three key drivers**' of child poverty. These all impinge on the family's income or outgoings, and are all structural factors, rather than matters of individual choice or behaviour.

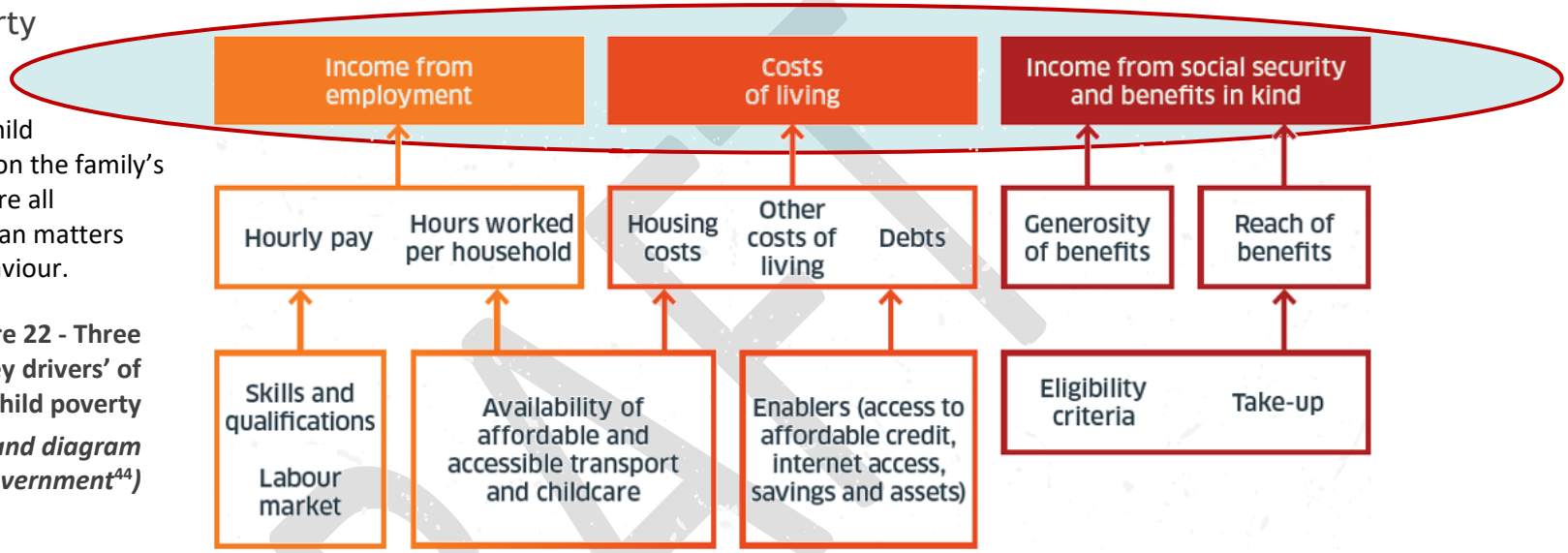


Figure 22 - Three 'key drivers' of child poverty

(definition and diagram by the Scottish Government[44])

As Figure 22 makes clear, the drivers themselves have deeper underlying causes. Some of these root causes need to be addressed nationally, but local areas can contribute by informing, influencing and lobbying for change. Others are amenable to direct action at the local level: [68,69,70,71]

Income from employment	Unemployment, economic inactivity, under-employment and zero-hours contracts all conspire to reduce income from employment. Local agencies can work with employers to boost skills, address poor terms and conditions, and promote flexible working arrangements, affordable childcare and transport.
Costs of living	Local agencies are well placed to tackle elements of the 'poverty premium', such as punitively high fuel costs and interest rates, which low-income families often face. They can also help in many other ways, such as by offering budgeting or cookery lessons[68], seeking to reduce the 'Cost of the School Day', and providing free activities in the summer.[68]
Income from social security and benefits in kind	Even without taking Universal Credit into account, several £bn goes unclaimed each year in income-related benefits and tax credits.[68,35] Universal Credit brings added barriers due to its complexity and online nature. Local initiatives can reduce local poverty by helping people to access the state support that they are entitled to.

Table 1 – Ways of addressing the 'key drivers' of child poverty

Levels of intervention*

To complement the 'three key drivers', the NHS in Scotland has defined three **levels of intervention** which can be harnessed to tackle child poverty.[69]

PREVENT: actions which can prevent families at risk from slipping into poverty (before it happens)

UNDO: actions which can help lift families out of the poverty they are already in

MITIGATE: actions which can lessen the negative impact upon children of the poverty they are in

- Preventing problems from arising in the first place gives the best results for individuals and for society as a whole, and is a more efficient use of public sector resources.
- 'Prevent' and 'Undo' do not necessarily call for different approaches. Often the same intervention will be of benefit to those *at risk of* poverty and those already *in* poverty.[37]

- Actions to offset the ill-*effects* of poverty upon children should by no means be dismissed. These are highly cost-effective in their own right - and the earlier they start, the better.
- Nobel Prize-winning US economist James Heckman is probably the best-known champion of early intervention for disadvantaged children, with a website full of compelling charts and factsheets[72]:

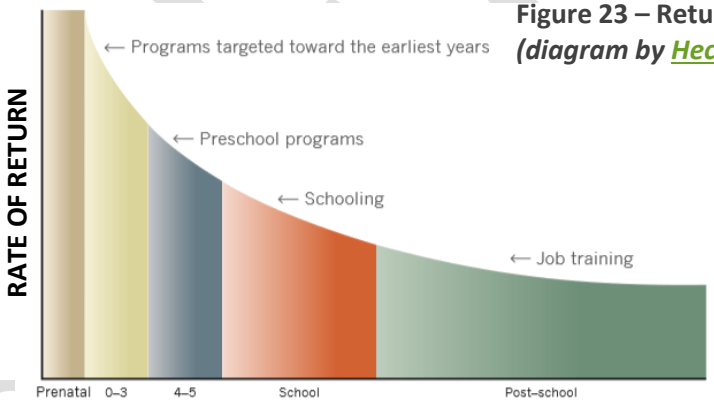


Figure 23 – Returns per unit invested (diagram by Heckmanequation.org[72])

"The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families"
James Heckman, 7/12/2012

Table 2 – levels of intervention

Cross-cutting themes for actions

We have also identified a number of cross-cutting themes, which local partners may wish to adopt as a matter of good practice:

- Take steps to avoid introducing a 'poverty premium' (see page 8) around access to public services or in paying for public services.
- Aim to design services which are available to all, but deliver increasing benefits to those at greater levels of need, to achieve a 'levelling up' effect.†
- Scrutinise policy and practice changes to ensure that they do not introduce or exacerbate barriers and stigma for those at risk of or experiencing poverty.
- Seek opportunities to engage local communities and/or service users in the development of actions and services which address child poverty.
- Explore opportunities to provide basic awareness-raising on the causes and consequences of child poverty with all frontline staff who are likely to come into contact with families at risk of or experiencing poverty.

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* *Icon attributions: Precipice by Magicon from the Noun Project; Ladder by corpus delicti from the Noun Project; Support by auttapol from the Noun Project (thenounproject.com)*
† *This is the 'Proportionate universalism' principle of Marmot (2010[73]).*

Beyond child poverty - inclusive growth

Poverty as a soluble problem

One of the hardest barriers to overcome is the attitude that poverty is inevitable. This leads people to suppose that there is no point trying to do anything about it.

The JRF Framing Toolkit[16] carries a strong message that the economy we have today didn't just happen – it was designed. And that means it can be *redesigned*, to tackle problems such as poverty (Figure 24):

Figure 24 – Driving home the message that poverty is not inevitable
(from JRF Toolkit[16])

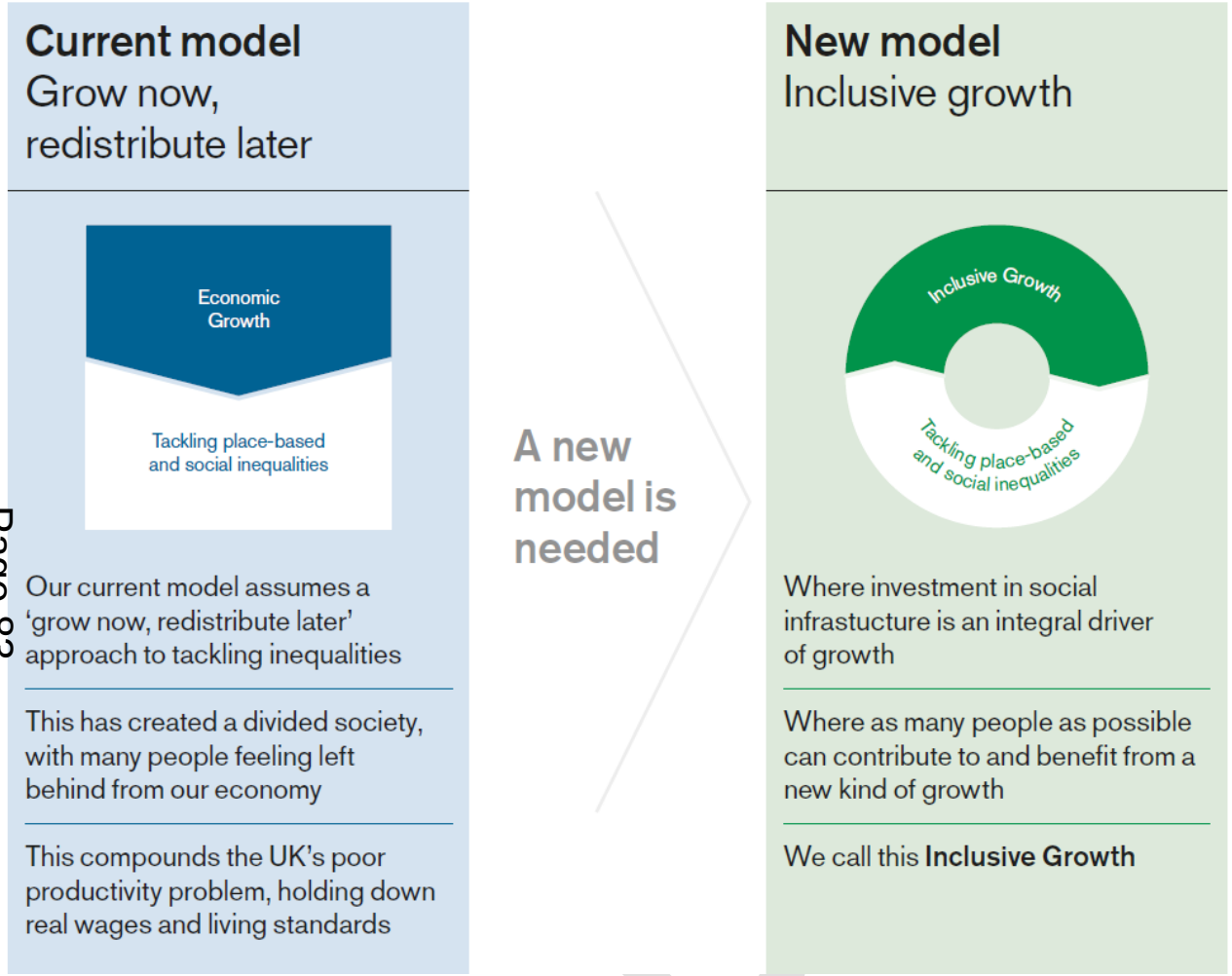
Inclusive growth

> "**Inclusive growth** is about enabling more people and places to both contribute to and benefit from economic success.[74] More specifically, it is about how poverty can be reduced through the creation of better jobs and better access to those jobs for people in or at risk of poverty. A policy or strategy that does not have a focus on living standards of those at the bottom of the income distribution cannot describe itself as an inclusive growth strategy." *Joseph Rowntree Foundation* [75]

A growing employment rate is no longer helping families out of poverty as it once did. People in many parts of the country are locked out of opportunities to access good jobs and we can no longer rely on previous assumptions that prosperity will trickle down. A growing body of evidence is showing that simply driving up output growth and the number of jobs in an economy is not guaranteed to improve living standards for people in or at risk of poverty. In-work poverty has been steadily rising and one in eight workers now live in poverty.[75,76]

Since the early 2000s, people getting stuck in low-paid jobs, along with high housing costs and cuts to benefits, all mean that the poorest fifth of households have seen next to no growth in real incomes after housing costs are taken into account.[77] This is why we need inclusive growth.[75]

RSA Inclusive Growth Commission



The **RSA Inclusive Growth Commission (2017)**[74] outlines a new model for inclusive growth that combines social and economic policy.

"The key shift required is from an economic model based on growing now and distributing later to one that sees growth and social reform as two sides of the same coin." [74]

Investment in social infrastructure should go hand in hand with investment in physical infrastructure and in business development (Figure 25):

Figure 25 – Moving to a new model of inclusive growth *(diagram by RSA[74])*

In practice this means that while thinking about policies that would boost job creation, we should at the same time be thinking about:[75]

- skills strategies to improve basic skill levels and enable people to access those jobs
- interventions that can improve the quality of jobs
- how people can be supported to progress in work
- where jobs are located, and the cost and accessibility of public transport to get to those jobs

Plan for Prosperity

Local Industrial Strategies, covering sub-regions such as Lancashire, will soon be rolled out across the whole country.[78] Bodies such as the Joseph Rowntree Foundation welcome this as an opportunity for local leaders to be explicit about how they intend to focus on inclusive growth.[75]

Blackburn with Darwen has already had its own **Plan for Prosperity**[79] since 2014. Although this pre-dates the work of the RSA Inclusive Growth Commission[74], many of the key principles of inclusive growth are already in place:

Figure 26 – Blackburn with Darwen Plan for Prosperity[79]

What more will we do ?

We are already doing a lot of good work in Blackburn with Darwen to address child poverty, but there is more that we can do.

The **recommendations** below provide a framework for how we can build on our existing work, and address gaps, to tackle child poverty locally.

Recommendations

1. The Health and Wellbeing Board is asked to champion action amongst partners to tackle child poverty. In doing so, it should promote as good practice the '**Cross-cutting themes for actions**' identified on page 16 of this report.
2. Poverty is one of the three cross-cutting priorities of the Blackburn with Darwen Health and Wellbeing Strategy.[80] The Health and Wellbeing Board will therefore request an annual report from the Children's Partnership Board, the Live Well Board and the Growth Board, on the actions they have taken in the previous 12 months, and plans for the next year, in tackling child poverty in the Borough. In making their reports, it is proposed that the Scottish model is adopted, of classifying interventions by both:
   a) their impact on one or more of the three **key drivers** of child poverty –
      - Income from Employment,
      - Cost of living,
      - Income from Social Security
   b) the **level of intervention** on child poverty -
      - Prevent
      - Undo
      - Mitigate

The Blackburn with Darwen Ambition

Looking ahead, it is difficult to commit to a specific target poverty rate, when the very definition may be about to change.[14,15] However, we can aspire to close the gap between Blackburn with Darwen and the rest of the country, however that may be measured:

By 2030, in Blackburn with Darwen, we will aim to have

reduced our child poverty rate to the national average

on whatever may be the official headline measure at that time

This target is ambitious but we believe, through co-ordinated and concerted efforts by all partners in the borough, that it is achievable. We owe it to local children to strive to deliver the best possible services to reduce child poverty as much as we possibly can.

Further reading

Joint Strategic Needs Assessment

If you have found this Public Health Annual Report interesting, you may be wondering where you can find further information about Blackburn with Darwen: the borough, its residents, and the social, economic and environmental determinants which influence their health and wellbeing. Like all upper-tier local authorities, Blackburn with Darwen is required to keep these issues under ongoing review in its **Joint Strategic Needs Assessment**, or **JSNA**. The JSNA, in turn, informs the borough's Joint Health and Wellbeing Strategy and commissioning decisions.

JSNA Summary Review

For a succinct overview of Blackburn with Darwen's JSNA, have a look at our annual JSNA **Summary Review**. This illustrated document starts with a profile of the borough's population and local economy, and then proceeds through the life-course, with sections entitled 'Start Well', 'Live Well' and 'Age Well'. You can try the new online version at https://bwd-ph.github.io/jsnabook/.

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HEALTH AND WELLBEING BOARD

Health & Wellbeing Board

Start well | Live well | Age well

TO:	Health and Wellbeing Board
FROM:	Dominic Harrison, Director of Public Health and Wellbeing
DATE:	18th June 2019

SUBJECT: Annual Report of the Director of Public Health, 2018/19

1. PURPOSE

To ask the Health and Wellbeing Board to approve the latest Annual Report of the Director of Public Health.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Board is asked to:

1) Note the content of the Public Health Annual Report 2018/19

2) Support the recommendations of the report, which envisage the Health and Wellbeing Board championing efforts to tackle child poverty and receiving annual reports from partners.

3. BACKGROUND

Under the Health & Social Care Act 2012 (section 31), the Director of Public Health has a duty to write an Annual Report on the health of the local population. Within the same section of the Act, the Local Authority has a duty to publish the report.

The Public Health Annual Report is traditionally a professional statement about the health of local communities and increasingly an important vehicle by which Directors of Public Health can identify local issues, flag problems and report progress. The report is publicly accessible and a key resource to inform local inter-agency action for health and wellbeing.

The 2018/19 report addresses the growing issue of child poverty, which is a matter of increasing concern across the UK. It coincides with the publication of modelled estimates suggesting that Blackburn with Darwen has the fifth highest child poverty of any UK local authority, and Bastwell the highest of any ward.

4. RATIONALE

The Public Health Annual Report, which should be considered alongside the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, is publicly accessible and a key resource to inform local inter-agency action for health and wellbeing.

The 2018/19 report addresses the growing issue of child poverty, which is a matter of increasing concern across the UK. It coincides with the publication of modelled estimates suggesting that Blackburn with Darwen has the fifth highest child poverty of any UK local authority, and Bastwell the highest of any ward.

5. KEY ISSUES

The report looks at how child poverty is defined and measured, examines national trends including the effect of 'austerity' policies, and presents evidence on the causes and effects of child poverty, including the effects upon health.

It then switches attention to Blackburn with Darwen, reviewing the borough's generally low income and earnings, the new child poverty estimates prepared by Loughborough University for The Campaign to End Child Poverty, and the impact of that poverty upon local children and families.

After a review of what we are doing to tackle child poverty in the borough, and what more we can do, the report presents the case for a new 'Inclusive Growth' approach to economic development.

It ends by recommending that the Health and Wellbeing Board should champion partnership work to tackle child poverty. This work should follow good practice guidelines, target identified drivers of child poverty, and aim to either 'prevent' or 'undo' the problem, or 'mitigate' its impacts. An ambition is expressed to close the child poverty gap between Blackburn with Darwen and the rest of the country by 2030.

6. POLICY IMPLICATIONS

Poverty is already one of the three cross-cutting priorities of the Blackburn with Darwen Health and Wellbeing Strategy. This report recommends a key role for the Health and Wellbeing Board in overseeing efforts to tackle child poverty in particular.

7. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this paper.

8. LEGAL IMPLICATIONS

There are no direct legal implications arising from this paper. Under the Health & Social Care Act 2012 (section 31), the Director of Public Health has a duty to write an Annual Report on the health of the local population. Within the same section of the Act, the Local Authority has a duty to publish the report.

9. RESOURCE IMPLICATIONS

There are no direct resource implications arising from this paper.

10. EQUALITY AND HEALTH IMPLICATIONS

There are no direct equality and health implications arising from this paper.

11. CONSULTATIONS

The Public Health Annual Report is a professional statement of the Director of Public Health and not in its own right subject to consultation. The ISNA Leadership Group, which is a partnership organisation with representation from council departments, has seen and discussed an earlier draft of the report.

VERSION:	**1.1**

CONTACT OFFICER:	Anne Cunningham (anne.cunningham@blackburn.gov.uk) and Gifford Kerr (gifford.kerr@blackburn.gov.uk)

DATE:	24th May 2019
BACKGROUND PAPER:	Blackburn with Darwen Annual Report of the Director of Public Health (provided separately)