



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



Co-production, Engagement and Communication Plan (Phase 2)

1. Purpose of the Document

Blackpool Teaching Hospitals NHS Foundation Trust, Cumbria Partnership NHS Foundation Trust, East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust are the four NHS Child and Adolescent Mental Health Service (CAMHS) providers across Lancashire and South Cumbria. We are working collaboratively with each other and with non-NHS providers and stakeholders, including CCGs (who are the commissioners of the service) on a significant project to develop the future model of care for Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) services across Lancashire and South Cumbria. This model is known as the Thrive model and has been developed nationally, and now requires local implementation. The introduction of the Thrive model for CAMHS in Lancashire and South Cumbria offers service providers, and service users the opportunity for a consistent and coherent service across the geographical footprint. As such the proposed service model will ensure that through consistency, children and adolescents who require these services will be able to access the same level of services wherever they live in Lancashire and South Cumbria.

To achieve the Thrive model, the four providers, and NHS funded VCFS providers will need to redesign the services available. The scope of the redesign includes all NHS funded services that could or should deliver activity towards the new national CAMHS access target.

The purpose of this document is to set out how the four NHS Trusts will collaborate with each other, non-NHS providers, stakeholders (including children and young people, parents and carers), as well as CCG commissioners to co-produce the future model of care (Thrive) for CYPEWMH services across Lancashire and South Cumbria.

This document outlines the activities to be undertaken, following the initial period of co-production (from January through to August 2018), and up until the development and implementation of the new





model of care, which is known as the Thrive Model. For clarity, the next phase of co-production will be described in this document as phase 2. The implementation and mobilisation of the Thrive model is reflected in this document and a more detailed communication and engagement plan, and is described as phase 3. This will be reviewed iteratively as we progress towards the implementation and mobilisation of the Thrive model.

2. Strategic Objectives for communication, engagement and co-production

This strategy and plan has three discrete strategic objectives for communication, engagement and co-production:

- 1) **Reach and involve** - Ensure that we reach and involve as many children and young people and other stakeholders as possible - either as service users, or with an interest or experience of mental health problems or services
- 2) **Listen and act** - Ensure that the voices of as many children and young people and other stakeholders as possible are heard and acted upon.
- 3) **Evidence and celebrate** - Ensure that we (providers, commissioners, the programme and partners) can evidence that we have involved people, listened and acted upon their views either through co-design, communication and engagement. Celebration refers to the importance of explaining what we are doing, and what we have done to involve children and young people, but more importantly, what we have done to improve services. Celebration of this will be through a programme of proactive PR case studies and testimonials.

In pursuit of these three strategic communication and engagement objectives, we propose that there are three guiding principles for communication and engagement. These are:

- 1) **Digital wherever possible**, but not excluding more traditional methods of communication
- 2) **Imagery whenever is best** – use video, infographic led information and imagery wherever possible
- 3) **Stories to illustrate and explain** – use patient (children, adolescents, parents, carers, families and staff) stories, case studies and testimonials to illustrate and explain how what we are doing is making a difference and improving people's lives.





3. Managing the distinction between communication, engagement and co-production

At the heart of this communication and engagement strategy is a desire to ensure that co-production is not only central to the redesign of CAMHS services, and the Thrive model, but that it is given due prominence. There is a recognition amongst the partner organisations that co-production can only be effective if our reach and engagement with children and adolescents, staff and stakeholders is effective and efficient.

Ensuring a good fit between the three elements of communication, engagement and co-production is therefore vital, and this is one reason why this is a communication, engagement and co-production strategy and plan, with associated joint documents.

Co-production will be led by Nicola Turner, and communication and engagement will be led by David Rogers. It is anticipated that the majority of the co-production will be commissioned from an independent provider, and communication and engagement support will be provided by additional capacity from communication and engagement specialists. Both Nicola and David are members of the Thrive Redesign Steering Group, and they will provide regular updates on the progress against this strategy and plan to the steering group.

4. Co-production

Co-production is about developing equal partnerships between people who use services, carers and professionals.

There are different definitions of coproduction but a consensus that working co-productively leads to improved outcomes for people who use services and carers, as well as a positive impact on the workforce. For the purposes of this strategy, the following definition of co-production, which is adopted by NHS England, has been used to underpin the recommendations for delivery of Phase 2 to ensure that the work effectively meets the needs of both young people and the Care Partnership: “Co-production is a way of working that involves people who use health and care services, carers and communities **in equal partnership**; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with ‘lived experience’ of a condition are often best placed to advise on what support and services will make a positive difference to their lives. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches.”





The co-production principles that we will be adhering to in this strategy and plan are:

- Co-production is an approach where people, family members, carers, organisations and commissioners work together in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.
- People who use our services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need them, which could be any one of us at some time in our lives.
- Real co-production means that people are truly involved in planning and designing services from the very beginning.

5. Lessons from the first phase of co-production

Following the first phase of co-production, the Thrive Redesign Steering Group commissioned the Healthwatch Collaborative (consisting of Blackburn, Blackpool, Cumbria and Lancashire Healthwatches) to undertake an independent review. This followed feedback both during the co-production period, but also during the gateway evaluation of progress to date. The Healthwatch Collaborative reviewed the process, and documentation, and as providers of the co-production events were able to reflect on lessons learned from those. The report from the Healthwatch Collaborative is at Appendix 1, attached.

The following observations were made by the Healthwatch Collaborative, and have been used to inform the recommendations that Healthwatch have made. These observations will inform the proposed activity for Phase 2: -

- The timescales for Phase 1 meant that the identification and training of children and young people and of families and carers was rushed and the potential for co-production working was not maximised;
- Not enough lead-in time was allowed for workshops to ensure a fully representative attendance from all stakeholders;
- The workshops were best when attended by larger numbers of children and young people – their stories prompted the most insightful debates;
- Everyone had a different view about what was meant by co-production
- There are a number of constraints/drivers which must inform what is possible





The Healthwatch Collaborative recommendations were that for co-production to be truly effective moving to the next phase, the following are in place: -

- An overarching communications and engagement strategy that allows for effective communication and feedback loops with young people, families and carers across the full period of delivery.
- A programme of activity that includes gathering of views from young people, families and carers across the whole geography of Lancashire and South Cumbria but also allows for more in-depth sessions with young people at a local level.
- This programme should be delivered in tandem with the communication and engagement plan and activities
- Engagement of one delivery organisation for the focused work with children, young people and their families/carers which has both coverage across the ICS area but also the capacity to deliver effective work at an ICP level with good connections with local educational and VCSF organisations to reach 'seldom heard' groups of young people
- Breadth of engagement with schools, colleges and the VCSF sector across the ICS area using digital surveys/questionnaires developed and shared by the Communications team
- Focused work at an ICP geography level to ensure consistent and high attendance by young people and meaningful co-production
- Establishment of 'patient advisory groups' of young people (name to be agreed by young people) who will play a key role in project management, quality assurance and communications and engagement in each ICP area and report into the delivery organisation and Communications team
- Opportunities for young people to engage directly with and question commissioners and providers through 'Citizens' Jury' style workshops over several weeks, focusing on key areas of provision to be fixed. Citizens' Juries are deliberative sessions where service users act as the jury in a presentation of a particular case or information, for example about a service or proposed changes to a service. Service users invite health and care experts, and other stakeholders to present their views and experiences for the service users to consider and form a considered view and judgement about a given service or service proposal.
- Similar Citizens' Jury style sessions delivered with families and carers, focusing on key issues that affect them.





This communication, engagement, and co-production strategy, and associated communication and engagement plan (attached at Appendix 2) have taken into account these recommendations and have actively considered them as integral actions within the communication and engagement plan.

6. Issues raised through the EIRA

More detail is provided about our response to the EIRA and action arising from it for phase 2 in the section on the EIRA below, however during phase 1 there were some key issues raised which were either addressed or in some cases were not. Key messages from previous engagement activities were reviewed and summarised into a summary document to aid further understanding of the issues, and these were used to inform the development of the service model. These key messages were summarised and are available, attached at Appendix 3 as a Summary of Key Messages, and at Appendix 4 in the "You Said, We did" document. Equally, targeted engagement to specific groups was undertaken via the stakeholder list (attached at Appendix 9) and through promotion by the communication and engagement support provided by the CSU. Key issues from specific groups have been collated in Appendix 4, attached – "You Said, We did". Detailed reports of the co-production events were produced, and a final report (attached at Appendix 5) has been published and promoted. The detailed analysis of themes and issues is attached, at Appendix 6. A feedback event took place in September 2018, where we sense checked the report findings, and the issues raised. Our evaluation of this event achieved positive ratings and a further sense check of our approach to engagement and co-production. While it was an aspiration of the project to produce visual notes of coproduction, these were not produced. A review of the reasons for this has been undertaken and lessons learned for phase 2 have been adopted which include, as mentioned in the strategic objectives, more emphasis on visual imagery more generally in the messaging, and the use of LearnLive Broadcasts targeting children and young people in primary and secondary schools. For the co-production in phase 2, we will ensure that as part of the co-produced outcomes, the offer of more visual notes is made and taken up, if requested. Provider staff sessions were held within each provider as well as co-produced sessions which form the basis of the Thrive Co-production report. Key messages were disseminated widely to stakeholders, however as part of this review for communication and engagement, it is clear that more could and will be done. The strategic communication and engagement objectives, set alongside the communication and engagement plan will ensure that this objective is met.





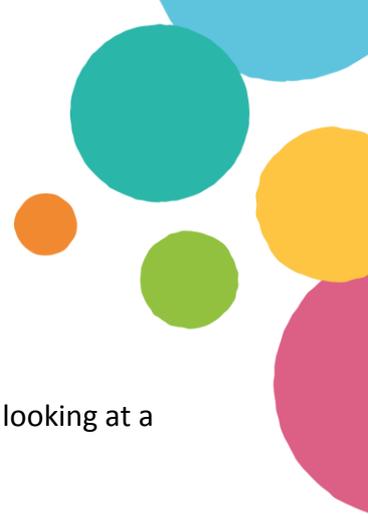
It is anticipated that the establishing of patient advisory groups, citizens juries and ongoing engagement to enable the co-production using these methods will be delivered by an independent co-production provider. The provider has yet to be confirmed but it is anticipated, will be in due course, and within the time frame of the planned preparatory stage.

7. Feedback from Thrive Redesign Evaluation Panel Grading (attached as Appendix 7)

The grading panel were broadly encouraged and supportive of the process for co-production. However for the submission and the grading, members wanted to see more detail from the co-production sessions as well as reference to wider, existing engagement and consultation findings as evidenced in this report and appendices. The feedback is that the panel would want to see this built upon further for the next phase and is expecting greater engagement with stakeholders as referenced in this plan. It was clear from the feedback that more engagement with the education sector was recommended, and this plan and strategy sets out how we will achieve this. The panel gave useful feedback about particular groups and networks that we could tap into, to help improve communication and engagement namely, the care leaver apprentices, 250 mental health champions, and groups such as 'Mates in Mind' and MH2K. We are working with colleagues from the CSU, VCFS, NHS provider organisations and CCGs to update our stakeholder list and analysis. The latest version of this is provided along with this strategy and plan, however we continue to update and revise this in partnership with the aforementioned groups and colleagues. We will also be developing a "reach metric" which will enable us to measure whether we have reached, or indeed have made clear and demonstrable efforts to reach the seldom heard, hard to reach as well as equality target groups, and as the evaluation panel indicated, the more vulnerable groups. This will need to be balanced with a considerable degree of sensitivity and care, and we will work with statutory bodies, groups and services to ensure that we endeavour to reach all of these groups.

It was clear from the evaluation panel feedback, that more communication and engagement about the co-production and the Thrive redesign process to stakeholders is required, in addition, this communication could include evidence of how much the findings of the first phase have influenced developments. Following feedback of the first phase of co-production, the Thrive report was promoted via traditional media (achieving good press coverage across the region), and on social media as well as via the Thrive and partner websites. It is clear that more needs to be done, and within the plan, we have specified for more proactive PR to be designed as a schedule to promote





the Thrive redesign, how we have used feedback to inform the model. We will be looking at a schedule of brief videos to support this.

8. Engagement Expectations

A detailed analysis and summary of the legislative duties and requirements around engagement and consultation for CCGs and NHS Provider organisations was produced as part of the assessment and preparation for the next phase of engagement. This is attached at Appendix 8. A summary of the salient points is set out below.

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) CCGs and NHS England have duties to promote the involvement of patients in their own health and care. This guidance is statutory and CCGs must have regard to it.

Section 1422 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 - public involvement and consultation by CCGs, states that:

“The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways): (a) in the planning of the commissioning arrangements by the group (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them and (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact”.

In addition, the Equality Act 2010 prohibits unlawful discrimination in the provision of services on the ground of ‘protected characteristics’, these are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race





- religion or belief
- sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires CCGs to have 'due regard' to the need to:

- eliminate discrimination that is unlawful under the Equality Act 2010
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it. This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

The principle of acting fairly is an important duty which applies to all public bodies and should the CCGs or NHS providers not act fairly in the discharge of their statutory duties (including public involvement and consultation), they may be open to challenge. The courts have established guiding principles for what constitutes a fair consultation (or indeed, engagement) exercise, known as the 'Gunning' principles.

These four principles relate to formal consultation and will not apply to every type of public involvement activity. However, they will still be informative when making arrangements to involve the public, whatever form these arrangements take. The Gunning principles are important principles to guide any form of engagement and as such we will be measuring our progress against these principles:

1. Consultation (including engagement and co-production) must take place **when the proposal is still at a formative stage**. Meaningful consultation cannot take place on a decision that has already been made. Decision makers can consult or engage, on a single proposal or 'preferred option' (of which those being consulted should be informed) so long as they are genuinely open to influence. There is no requirement, and it would be misleading, to consult on adopting options which are not genuinely under consideration, or are unrealistic or unviable – but it may be necessary to provide some information about arguable alternatives.
2. Sufficient information and reasons must be put forward for the proposal to **allow for intelligent consideration and response**. Those being consulted or engaged and involved in co-production, should be provided with sufficient information to enable them to understand what the proposal is, the reasons for it and why it is being considered. They should be made aware of the basis on which a proposal has been considered and will be considered thereafter, including any criteria to be applied or factors to be considered. This may involve providing information about (or at





least making reference to) arguable alternatives and the reasons why they are not also being considered. The level of detail provided will depend on the circumstances.

3. **Adequate time** must be given for consideration and response. People must have enough time to properly consider and respond to the consultation. There is no automatically required timeframe within which the consultation must take place.
4. The product of consultation must be **conscientiously taken into account**. Decision makers must properly consider what they have heard during the consultation when the ultimate decision is taken. This means that decision makers need to give the findings from engagement, or consultation, "due consideration and regard". They are not bound to a particular decision based on the findings, but the key principle here is that they should have given time and consideration to the findings and be able to argue why they have made a decision in the light of the findings.

Proportionality is another key consideration. While recognising the importance of and the legal duties to involve patients and the public, CCGs also need to consider their duty to involve the public alongside their duty to act effectively, efficiently and economically. It is recognised that health staff will need to consider the impact of proposals on people who may be affected. As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary. However, the nature and extent of public involvement required will always depend on the specific circumstances of an individual commissioning process. Staff should also consider the potential impact on other services which they may not commission, and issues for patients beyond the clinical services themselves, such as accessibility, transport links and ambulance availability.

People may need to be encouraged to give honest feedback and opinions, and sometimes reassurance that any negative views will not have any adverse consequences for them, e.g. in relation to future treatment, where people are critical of services they are using. Advocacy and support may be needed to help people express themselves.

Location, access and demographic issues need to be taken into account, for example, considering how a population in a rural area or how children and young people may be particularly affected by a change to services. In the context of the Thrive redesign, it has been clear that localised engagement and co-production is of critical importance, given the scale of the proposed redesign (ie across a wider geographical footprint). Our considerations regarding our approach to engagement and co-production have been informed by this aspect of proportionality.





9. Other critical principles for engagement and co-production

Following the formation of the coalition government in 2010, the then Secretary of State for Health, Andrew Lansley established four critical tests for large scale reconfiguration and change in the NHS. Known as the “4 tests”, these service as important principles for any engagement, whether that is engagement, co-production or consultation. The 4 tests are:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice

Alongside patient and public involvement, and engagement, a key principle of the four tests is “support from GP commissioners”. In essence this seeks to achieve agreement from CCG Governing Bodies which consist of GP representatives. However the principle also underlines the value and importance of GP engagement and involvement. This plan and the associated, detailed communication and engagement plan sets out GPs as key stakeholders to be engaged, informed and involved.

10. Managing communication, engagement and co-production

A communication and engagement task and finish group has been convened for the purposes of ensuring that the communication and engagement plan is delivered. In addition a co-production group has been established for oversight of the co-production. Co-production will be led by Nicola Turner, and communication and engagement will be led by David Rogers. It is anticipated that the majority of the co-production will be commissioned from an independent provider, and communication and engagement support will be provided by additional capacity from communication and engagement specialists. Both Nicola and David are members of the Thrive Redesign Steering Group, and they will provide regular updates on the progress against this strategy and plan to the steering group.

The 4 NHS Trusts have identified the following officers to support the consultation and engagement activity, working alongside the CCG officers identified. In practice each Integrated Care Partnership (ICP) will have a communication and engagement group, which consists of CCG and provider communication and engagement staff and the representatives identified will work with these colleagues across the ICP to





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promote messages and support the communication, engagement and co-production.

A key role of the communication and engagement group, and the co-production group will be to monitor the progress against the plan, but equally to identify any issues and work with colleagues to address these.

NHS Trust	Named Officer	Email	Tel
Blackpool Teaching Hospitals NHS Foundation Trust	Derek Quinn	derek.quinn@bfwhospitals.nhs.uk	01253 956941
East Lancashire Hospitals NHS Trust	David Rogers	David.Rogers10@nhs.net	07717 677 380
Lancashire Care Foundation Trust	Safeera Ahmed	Safeera.Ahmed@lancashirecare.nhs.uk	07946515650
Cumbria Partnership	Kath Hughes	Kath.Hughes@cumbria.nhs.uk	01228602124

The 8 Lancashire and South Cumbria CCGs have identified the following officers to work alongside the 4 NHS providers in fulfilling the duties outlined above:

CCG	Named Officer	Email	Tel
Blackpool CCG	Nicola Turner	Nicola.turner@blackpool.gov.uk	01253 476387
Morecambe Bay	Julia Westaway	Julia.westaway@morecambabayccg.nhs.uk	07789905433
Chorley & South Ribble And	Sarah Ainscow Janet Ince	sarah.ainscow@nhs.net janet.ince@nhs.net	01772 214349





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Greater Preston			
Blackburn with Darwen And East Lancashire	Kirsty Hamer Jeanette Pearson	Kirsty.hamer@nhs.net Jeanette.pearson1@nhs.net	01254 282173
West Lancashire	Phil Winnard	Phil.winnard@nhs.net	07769 303594
Fylde & Wyre	Lesley Tiffen	Lesley.tiffen@nhs.net	01253 956439

11. Stakeholder identification and management

The independent review of the first phase of coproduction highlighted the importance of stakeholder analysis, identification and reach. Key stakeholders are clearly, children and young people in receipt of child and adolescent mental health services, as well as their parents, families and carers. A stakeholder list has been produced for each of the Integrated Care Partnership (ICP) areas and this will be reviewed and updated during the preparatory phase of phase 2 (attached, Appendix 9). Key stakeholders include the following, those whom we have asterixed will be key to co-production, while for all stakeholders mentioned we will engage and involve them:

- Children and Young people in receipt of child and adolescent mental health services*
- Parents, families, and carers of children and young people in receipt of services*
- Care Leaver Apprentices network
- Mental Health Champions network
- MH2K (Lancashire) and Mates in Mind (Cumbria)
- Schools (Head teachers, teachers and support staff)
- Colleges (Principals, lecture staff and support staff)
- Frontline staff delivering child and adolescent mental health services in each of the providers
- GPs and GP practice staff
- Local authorities
- MPs
- Councillors
- CCGs
- Children and Young people networks, groups and organisations*





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- VCFS providers
- Providers providing services to children and young people outside of CAMHS (ie A&E, paediatrics etc)*
- Ambulance Services
- Adult Mental Health service providers
- Police
- Substance Misuse Services
- Child and Adolescent Support Groups
- Patient Interest Groups linked to equality target groups, and long term conditions

Cross-referenced against this list, we will continue our focus on particular segments of the groups described. A key cross reference will be to ensure that we are reaching equality target groups (ETGs) and as part of the communication and engagement plan a “reach” metric will be established so that we can assure ourselves, and stakeholders that we are doing everything possible to reach not only the stakeholders listed, but ensuring that we reach, engage and elicit feedback from equality target group representatives.

A Mendelow analysis of the level of interest and involvement of stakeholders has identified that in the first instance, all identified stakeholders have high interest and high power in helping us manage or disrupting or mixing the message, therefore the communication and engagement plan seeks to involve all stakeholders through the provision of information and to encourage feedback and dialogue. The co-production element of the process will seek first and foremost to engage with and co-produce with those who have a major stake in child and adolescent mental health services, namely the children and young people, parents, families and carers, along with staff who provide services direct to children and young people.

In addition to the identified stakeholders, the stakeholder analysis highlighted the following key influencers in the context of child and adolescent mental health services as traditional media (print, radio and TV), and social media (including twitter and facebook, as well as instagram and snapchat). The role of influencers online and offline remains important and work is under way to consider key influencers at local and regional level, and identify how we can work with them to reach more children and young people, parents and families.





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Media engagement will be primarily through the use of proactive and reactive PR and media management. A similar approach will be adopted to social media and other channels such as school parent newsletters and bulletins, and web based communication.

The stakeholder list will be subject to continuous analysis and update, refined as we progress through the phases. A key aspect of engagement and co-production will be to ask: "have we missed anyone"? to continuously sense check that we are reaching not only as many people as possible, but also, the right people.

Political stakeholders are critical to our reach and our sense-checking. As elected representatives they are able to determine whether their constituents are aware of the Thrive redesign, and also support our call for involvement in the co-production. MPs and Councillors can also help us amplify the messages about how we are not only listening to but also acting on the views of children and young people, as well as parents, families and carers. MPs and Councillors can act as a lightning rod for concerns and issues and as such it is important that we build strong connections with them. Each CCG and Provider will have their own relationship with political stakeholders, so the option will be to offer providers and commissioners the option of using the core script as a briefing, or for us to engage directly with them. In addition we will need to work with ISPs and the ISC to ensure that there is a consistency and coherence of message.

12. Outline of Plan (see Appendix 2, attached)

The communication, engagement and co-production plan at Appendix 2, attached, provides the detail of the plan however in order to achieve a robust process of communication, engagement and co-production we will take the following approach:

Coproduction

The Care Partnership commissioned Healthwatch (as independent partners in the first phase of co-production) to complete a review of this phase and make formal recommendations (for Phase 2) on co-production and engagement approach to be undertaken by the Care Partnership. We are now awaiting a detailed proposal to address the recommendations from Healthwatch, as well as meet the expectations of the Care Partnership around the delivery of co-production. The detailed proposal will, we anticipate include sessions which will focus on the top 6 areas identified in Phase 1 that need to be fixed, ie that there isn't enough support for young people from services, people in communities and





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professionals need more knowledge about mental health and its impact, waiting times are too long, criteria get in the way of accessing support, there needs to be more options for treatment, and there continues to be a negative stigma about mental health.

Key elements of this will include a locality (integrated care partnership footprint) based arrangement for patient reference groups and citizens juries, as well as support for ongoing communication and engagement to support this co-production approach.

The communication and engagement plan seeks to support the process of localised co-production through PR, social media and targeted communication to key stakeholders.

Communication and engagement

The communication and engagement plan (see Appendix 2, attached) is based on the strategic objectives and principles described earlier, and seeks to ensure that we meet these objectives.

The foundation of the plan is a suite of documents that support communication to all stakeholders, while at the same time allowing for segmented, targeted communications. This suite of documents includes:

- Core script (this will be updated regularly, and be used as core content for briefings, newsletter, bulletins and websites)
- Key messages (these will be regularly updated, and revised according to the progress of the programme, and based on feedback from stakeholders)
- Q&As
- Social media toolkit
- Engagement toolkit - for staff and stakeholders to facilitate common understanding of the process, and key messages, and ensure that "every contact counts" when engaging with children and young people to elicit their views
- PR schedule
- Engagement log
- Reach metric and plan

In addition, and once the above have been agreed the plan seeks to create marketing material to encourage engagement in colleges and via the school networks, for example, this could include and is subject to budget availability, banners, posters and leaflets. As the Thrive model is implemented and





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mobilised the need for clear and accessible information about services will become more important and we will work with service users and providers to develop these.

Alongside the engagement above, the communication and engagement plan includes provision for an open, online survey to all for continuous engagement, notably with parents, children and young people. The survey will be co-produced with children and young people.

In addition to these aspects of communication and engagement, we have made provision to commission LearnLive. LearnLive has been commissioned in Pennine Lancashire by NHS East Lancashire CCG and for use in Pennine Lancashire schools and colleges. The LearnLive process is a live broadcast to schools and colleges on matters of interest to schools and colleges, and typically is aligned with the curriculum needs of education; however we have worked with over 800 young people in Pennine Lancashire to develop a programme of broadcasts to meet the needs of children and young people. The current programme has been well received and offers not only live broadcasts with the provision for questions and answers, but also allows for the broadcasts, Q&As and other resources to be recorded and made available online for future use. We have found that parents, families, carers and teachers, as well as children and young people, all revisit the recordings as a useful source of information. We are seeking to host 2 broadcasts in the phase leading up to Christmas or the New Year, and then two broadcasts to support the implementation and mobilisation of the Thrive Model. The LearnLive broadcasts allow us to share useful information for children and young people, for example on mental health first aid, mental health and wellbeing (managing anxiety, stress, low mood etc); and introduce them to the Thrive model, and offer them an opportunity to tell us what they think, as well as get involved in the co-production.

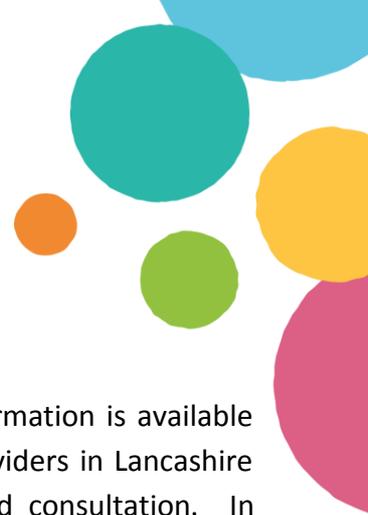
Workforce (staff) engagement will be key to the communication and engagement plan, as we know that not only every contact counts, but also staff can be incredibly influential and help service users and their families in shaping their views about any proposed service change. On this basis, we will seek to ensure that staff are communicated and engaged with, and their views are actively considered throughout the period of phase 2, and into the implementation and mobilisation phase.

13. Previous Consultation and Engagement Findings





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It is good practice in engagement, and consultation to consider what existing information is available about the topic of focus. In the case of children and young people, CCGs and providers in Lancashire and South Cumbria have undertaken a considerable amount of engagement and consultation. In preparation for the first phase of co-production, a review of engagement, and consultation was carried out by the CCGs with a variety of stakeholders via a range of engagement methods (see Appendix 10, attached). A summary of findings was produced during the first phase and this summary of findings so far, has been actively considered by the Steering Group and has formed the basis of the focus of the co-production sessions with service users, staff and third sector providers. Alongside the first phase of co-production it was clear that other organisations have also undertaken engagement with children and young people. The Pennine Lancashire CCGs commissioned Healthwatch Blackburn to undertake engagement with children and young people in the Pennine Lancashire area, and this work elicited the views of over 800 young people (see Appendix 11, attached). Following this, Healthwatch Lancashire adopted this methodology to elicit the views of children and young people in Lancashire (see Appendix 12, attached). Both of these projects have been added to the review of existing findings and been considered in the development of the service model, as well as helping us in our development of co-production. This process of triangulating data and findings from other, relevant engagement work will continue throughout the project and we will work hard to ensure that we have adequately reflect these views wherever possible.

In addition to this, there is considerable scope to review and consider “soft intelligence” from other sources of information and as part of the ongoing and iterative nature of the engagement, we will continue to source soft intelligence, and triangulate this against the Thrive model to help us test, and retest our thinking around the model and its adoption in Lancashire and South Cumbria.

14. EIRA (see Appendix 13, attached)

A number of risks were identified and actions required following the completion of the Equality Impact Risk Assessment (EIRA), these are detailed below and are addressed here. We recognise that the risks identified in the EIRA relate to the development of the model. The table below documents how we will address those risks in relation to the co-production and engagement sessions. We will ensure that these risks are discussed at each development session and highlighted as issues we need to address in the new model – some ideas are detailed in the table below. We will produce a ‘you said, we did’ document detailing how each risk have been actioned to eliminate the negative impact these risks may have. We





will ensure any relevant equality feedback resulting from future co-production and engagement events are shared with the CCG officers and the Project Team so that if necessary adjustments can be made to the EIRA and associated action plan. In recognition that seldom heard and marginalised groups rarely, if ever, attend workshops, we will with the support of our voluntary sector advisors go to them.

Risk identified	Co-production and engagement events will be used as opportunities to understand the needs and mitigate against any negative impact of the identified risks :
CYP with mental health needs may have co-morbid physical disabilities. It will be essential that these needs are recognised and met by the service.	We will undertake targeted engagement with CYP with co-morbid physical disabilities e.g., Unique Kids (Lancaster), Aiming Higher. In addition we will work with organisations that promote and support people with physical disabilities and ensure that these organisations and groups are factored into the stakeholder list.
There are higher numbers of people from minority ethnic communities in some parts of the county than others, it will be important for services to be culturally appropriate and reflect the needs of the population they serve.	Measures we will take to address this include: <ul style="list-style-type: none"> • Targeted invites to CYP and families from minority ethnic communities. • Co-production events to be held in areas with high ethnic minority populations. • Interpreters (where required) • Targeted engagement with ethnic minority groups and their representatives such as Lancashire BME, Lancashire Council of Mosques, Aawaz access point, and the Interfaith Network for Lancashire.
Lesbian, Gay, Bisexual, Transgender (LGBT) CYP may be at higher risk of suffering an mental health problems	Measure we will take to address this include: <ul style="list-style-type: none"> • Targeted engagement with LGBT CYP and families e.g LGBT Lancashire, UR Potential, Out in the Bay.
In the absence of significant data, equality monitoring arrangements will need to be made through the service monitoring processes	We will use a demographic monitoring form, agreed by the steering group which will be used to capture to monitor the diversity of CYP, families and professionals involved in the co-production, according to the characteristics as below: <ul style="list-style-type: none"> • Age. • Disability. • Gender reassignment. • Marriage or civil partnership (in employment only) • Pregnancy and Maternity.





	<ul style="list-style-type: none"> • Race. With reference to Black and minority ethnic (BME) (specifically areas with significant BME communities as outlined in the EIRA) • Religion or belief • Sex • Sexual orientation
Communication & Accessibility	Communication from the Co-production and Engagement Events will be provided in plain English, with options for easy read versions, as well as where possible, visual notes and representation of co-production will be made.
Any Future Consultation and or Engagement	We will learn from co-production and engagement events as we go along and capture learning in the “You said, we did”

15. Engagement Log (see Appendix 14)

In order to demonstrate compliance with the legislative and statutory requirements for engagement and consultation set out earlier, a process of monitoring and evaluation has been established to ensure that we can evidence fidelity with the strategy and the plan, as well as our statutory duties. This includes an engagement log and the means of capturing demographic data. Clearly, the communication and engagement plan, and strategy will be a useful basis for monitoring the effectiveness of our reach, and fidelity to statutory duties. Therefore a communication, engagement and co-production metrics dashboard will be established to ensure that we are not only delivering on the plan, but also meeting our statutory obligations. An engagement log has been established, and has been regularly updated. This will continue to be updated throughout the next phase of co-production and engagement.

16. Strategic Protocols

Communication protocols have been established for the following aspects of the communication and engagement plan. These will be reviewed and revised in the preparatory stage of the phase 2 co-productino and engagement process.

1) *Media/MP/Councillor messages and queries*

- a) Each respective organisation will take ownership for briefing their own MPs and Councillors and ensure that in ICP localities, there is no unnecessary duplication or mixed messaging. To achieve this, the communication and engagement team will ensure that the key messages and core scripts will be shared





with organisational and ICP communication and engagement representatives, as well as steering group representatives (commissioner and provider).

- b) Where face-to-face meetings are planned, and take place, and where questions are raised and require answers, the relevant communication and engagement lead will alert the communication and engagement team for the Thrive redesign to ensure fidelity to the script, and that it is logged in the engagement log.
- c) Upon receipt of a media or MP enquiry about the Thrive programme, the receiving organisation should record the enquiry and make named communication and engagement leads at respective organisations aware of that enquiry. This could be via the comms and engagement lead, or staff working on the project. If the enquiry is specific to the organisation then the comms lead will proceed to draft a response and ensure that the steering group members of that organisation approve the response before any local

media/MP protocols are followed. Comms leads at all organisations should be forwarded copies of responses sent.

- d) If the enquiry relates to the THRIVE programme in its entirety then the receiving organisation should seek advice and approval through the governance structure.
- e) Policies around complaints, FOIs, and translation/interpreting are held with each respective organisation and any requests will be dealt with accordingly. Requests will be escalated through the steering group and relevant structure to ensure all providers are sighted and agree with any responses.





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17. Timeline and milestones

The high level timeline below sets out briefly the engagement and co-production activities that will be undertaken during phase 2 and 3 of the project to develop and test out the development of the revised service model in line with the mandate.

Activity	Timescale
Communication and Engagement, and co-production planning, preparation and readiness	12 weeks - from start of November 2018 – to end of January 2019
Communication, Engagement and Co-production including events, communication and engagement activities with all feedback to be triangulated to the design, followed by:	20 weeks – February – June 2019
Finalisation of implementation plan, followed by:	12 weeks – from July 2019 – September 2019
Implementation period (Yet to be defined, but will be set out in the implementation plan above)	tbc

